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of the

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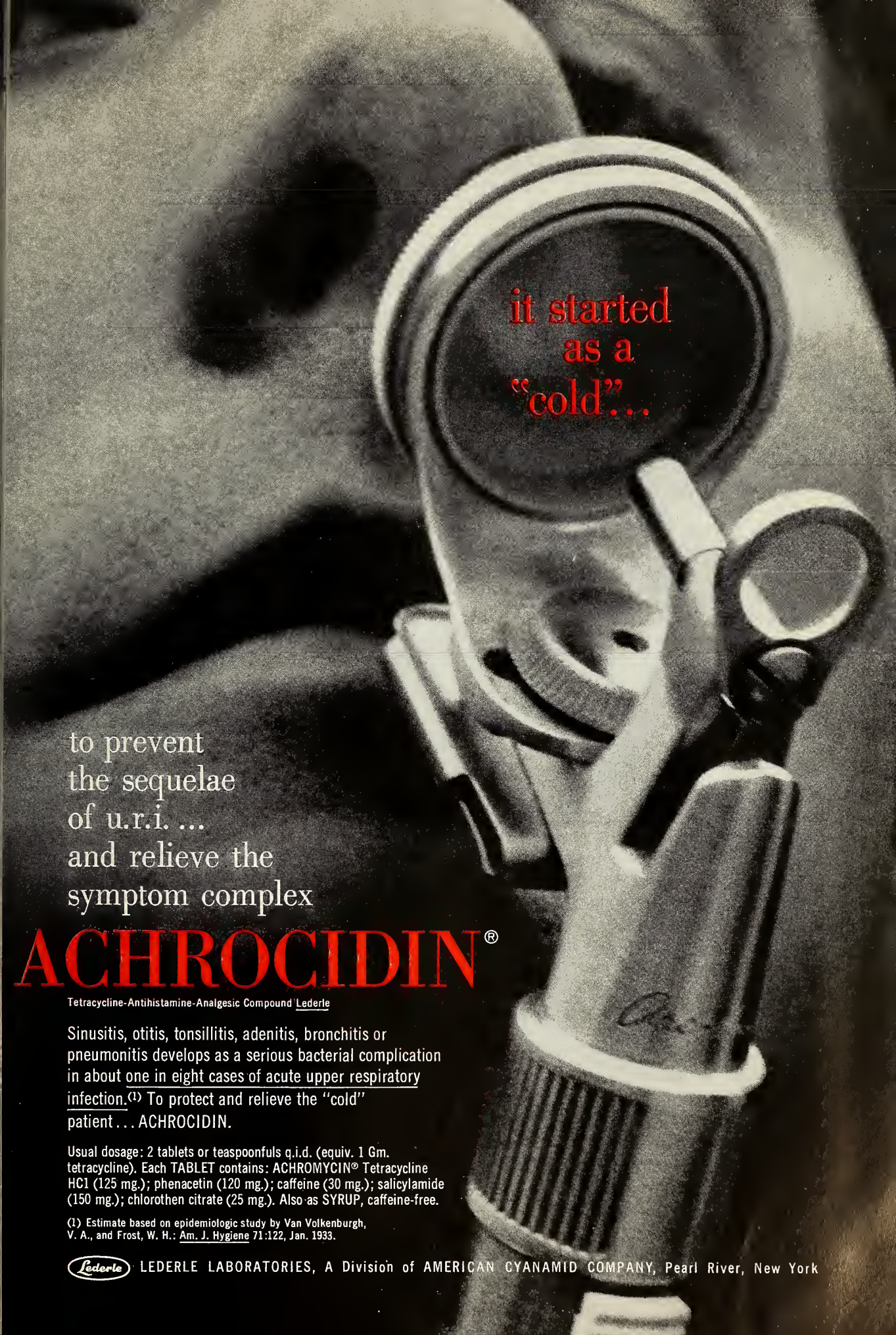
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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month.

THE MONTH IN WASHINGTON

Washington, D.C.—It is now well recognized that the new 86th Congress, heavily spiced with newly-elected Democratic liberals, will set out to make an impressive record for itself. Health legislation will not be neglected.

On the basis of developments last session, and the known interests of many of the new members of Senate and House, here are the health areas where intensive activity is assured, with prospects for enactment of a number of bills either this year or next year, the final session of the 86th and also a presidential election year:

Social Security. Labor has announced that it will work this year for substantial changes in social security, the most important being a program for hospital-nursing home care for the aged and other beneficiaries. On this the unions are supported by the Democratic Advisory Council, which reflects the views of the Truman-Stevenson-Butler element of the party but generally finds itself to the left of Senate Leader Johnson, House Speaker Rayburn and some other Congressional leaders.

Under social security, the AFL-CIO and the Democratic Council also would lower or drop the age 50 requirement for disability payments, increase the OASI taxes, bring more income under the taxes, and raise benefits all up and down the line.

American Medical Association, joined by scores of other associations and individuals in health and other activities, successfully opposed the social security hospitalization plan last session. They are prepared to wage just as determined a fight this year.

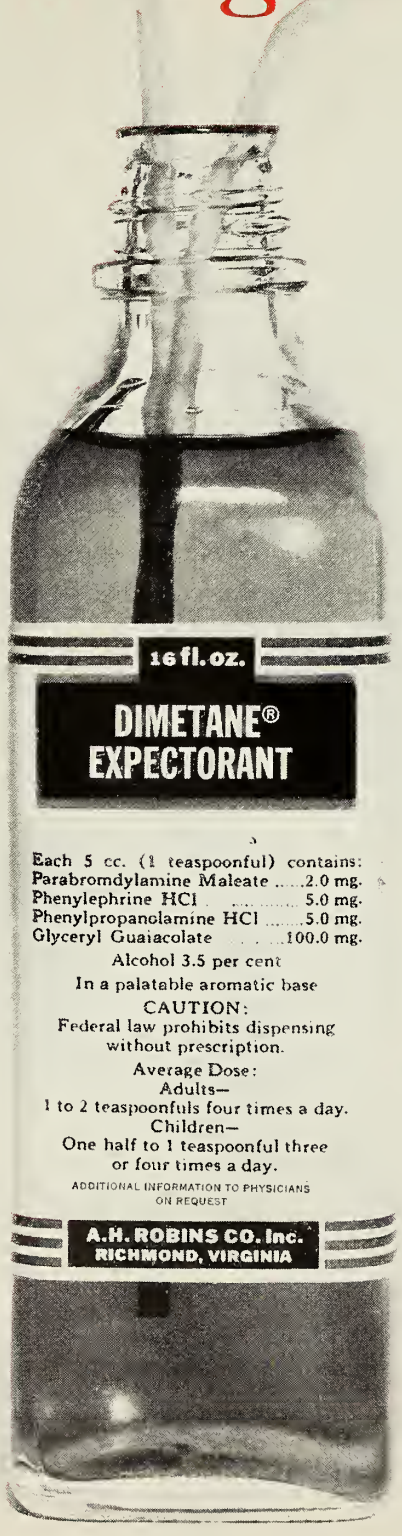
Aid to Medical Schools. An effort was made in Congress last session to provide grants to medical schools for building and equipping teaching facilities, to complement the research grants program already in effect. While the administration supported the attempt, it did not throw behind it all the energy it is expected to exert this year. Top officials of the Department of Health, Education, and Welfare, from Secretary Flemming on down, have been talking up aid to medical schools all fall. When time comes to testify, they will be strengthened by the activities of a new committee appointed to look into the schools' problems, as well as by the Bayne-Jones report which calls for the immediate start on construction of between 14 and 20 medical schools.

American Medical Association supports construction and equipment grants for medical teaching facilities. Strongest opposition this year is likely to come from some influential members of Congress, who succeeded in bottling up the legislation last session.

The Keogh bill. Last session this legislation to permit the self-employed to pay taxes on money withdrawn from retirement funds

Continued

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Month in Washington

Continued

passed the House but failed to get out of committee in the Senate. Its sponsors, including the AMA, are hopeful that the Senate objections can be removed this year.

Medicare. Congressmen already have received protests from back home about restrictions imposed on the civilian phase of Medicare, mostly the channeling of service families to military facilities. This issue is sure to come up when appropriations hearings start on the Defense Department's budget. It may come up sooner if Medicare runs out of money and requires a deficiency appropriation.

The Doctor Draft. The special draft, which hasn't actually been used in two years, may be invoked by the Defense Department this spring, if there isn't a better response on the part of interns and residents to the appeals for volunteers. Should the law have to be used this year, the Defense Department will have a pretty convincing argument that it should be extended beyond its scheduled expiration date of next June 30.

Medical Research. While the Federal government currently is spending at a rate of more than $324 million on medical research through the National Institutes of Health, a still higher record of appropriations is in prospect for next year. The Senate Appropriations Committee has announced that never again will the pace of research be slowed through lack of dollars. This is also the attitude of the AFL-CIO and the Democratic Advisory Council, among other groups. The pattern usually is for the House to increase moderately Budget Bureau figures for medical research, then for the Senate to vote large additional increases. The House then generally agrees to spend close to what the Senate wants.

Contributory Health Insurance for Federal Workers. A new effort to bring about a contributory health insurance program for civilian federal workers is expected, with federal employee unions leading the drive.

Other Prospects. A number of amendments will be proposed for the Hill-Burton act. Some effort will be made to strengthen the law under which labor-management health and welfare funds must keep records and file reports. Hospitals are looking forward to low-cost loans under a community facilities bill and nursing homes to mortgage guarantees. The feud over VA's closing of 5,000 beds likely will be renewed.



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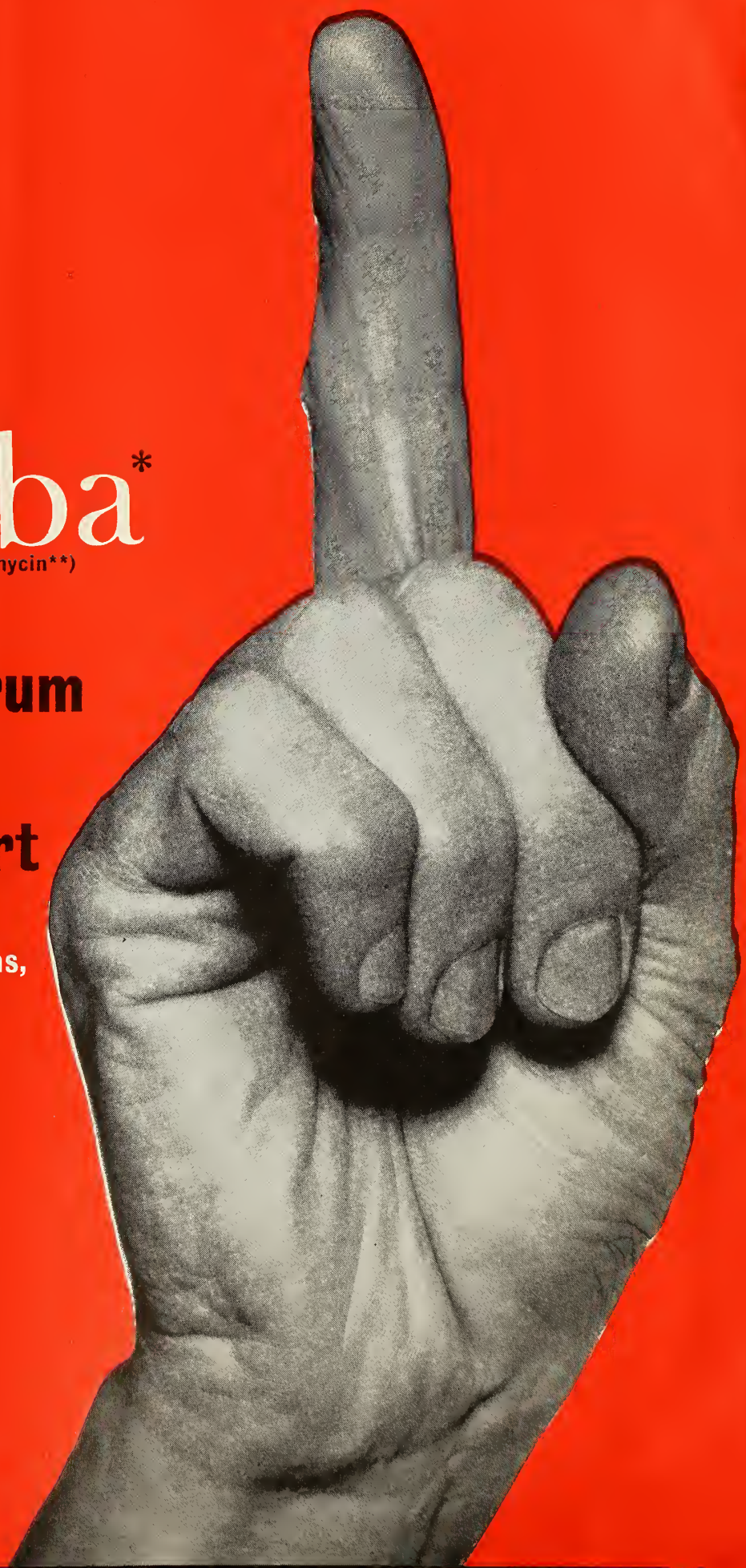
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The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Doctors' Prescription

In welcoming Hoosier doctors to the 109th Indiana State Medical Association convention opening here today, we can thank them for one of the best suggestions we've heard for a long time.

A resolution will be introduced, we understand, asking the next legislature to create a Department of Forensic Sciences which will, in effect, offer the skills of medical and other science to law enforcement. The "crime doctor" department would be located at the IU Medical Center. Its services would be available to police, sheriffs and courts throughout the state.

The need is obvious. Too often crimes—including murder—go undetected for lack of medical evidence. County coroners need scientific help. Courts and commissions need scientific testimony. Such an agency would be a long step forward.

—*Indianapolis Times*
Oct. 12, 1958

We Breathe Dirty Air

A prominent medical educator said at the National Conference on Air Pollution that the rise in lung cancer is "quite as referable to increased city traffic exhausts as to cigarettes." Whether or not this view is fully substantiated by tests, one thing is sure: the problem of dirty air has become so troublesome that it needs to be dealt with on a broad scale.

Though greatly improved methods of curbing the industrial smoke nuisance have been developed and put to at least limited use in recent years, the menace of polluted air in our cities continues to increase. One of the major reasons for this, perhaps the biggest reason of all, is the tremendous growth of automotive traffic.

The amount of exhaust gases poured forth into the air along a heavily traveled street in the course of a day is astonishing. Some or a great deal of this gas, depending on atmospheric conditions, remains in the air city dwellers breathe. Dr. Chauncey D. Leake, assistant dean of the college of medicine at Ohio State University, believes that these fumes may have as much to do with causing lung cancer as cigarette smoking does.

Dr. Leake had some stern words for the automotive industry. When, he asked, are auto and truck manufacturers going to tackle "the essential but tough job of controlling exhausts?" It is a question pertinent to the whole matter of air pollution. The development through which autos have gone during the past half century gives every reason to suppose that the engineers could devise means of controlling exhaust gases if they set their minds to it. They ought to get busy at the job.

—*Kokomo Tribune*
Nov. 28, 1958

Doctors Urge Use of Safety Belts in Cars

"It's smart to use seat belts." This slogan was adopted Wednesday when the American Medical Association, the United States public health service, and the National Safety Council launched a national campaign to popularize the use of seat belts in automobiles.

Authorities have found that passengers have a greater chance of surviving an accident if they are not hurled out of cars, and that seat belts tend to prevent this.

Col. McCormick Pioneer

Many years before his death on April 1, 1955, Col. Robert R. McCormick, editor and publisher of THE CHICAGO TRIBUNE, began advocating the use of seat belts, using them in his own car. In 1953, Col. McCormick paid for installation of belts in automobiles of Tribune photographers.

Held Practical Solution

In opening the national campaign Wednesday, the three groups invited other agencies, groups, business organizations, and officials of states and

"It is concluded that the addition of buffering agents to acetylsalicylic acid in the concentrations used serves no clinically detectable useful purpose."[1]

[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:183, August, 1958.

Nonbuffered Material Used—Bayer® Aspirin.

Continued

cities to promote installation of belts in cars of employes and members and to conduct campaigns to urge the public to use them. "We realize, of course," the sponsors said, "that seat belts are no antidote for carelessness, nor can their use alone prevent traffic tragedy. But they do offer a practical way to minimize the tragic results of highway accidents and save life and limb.

"Remember—a seat belt can save you and your family from death or painful, disfiguring injuries."

—*Chicago Tribune*
Dec. 11, 1958

Private Spunk Is Needed

A group of consultants to the Secretary of Health, Education, and Welfare has made a report on the advancement of medical research and education. It deals mostly with the role of the Federal government. The dominant tone of the report, in the words of Dr. Thomas P. Carney, vice-president of Eli Lilly and Company and a member of the group, is one of "conservatism and caution—caution against government control, caution against overexpansion, and caution against the substitution of quantity for quality."

In view of this tone of caution, it is surprising that the report readily accepts an inevitability of continued and expanded Federal support for medical research and education. Its conclusion on this point is that "total prospective funds from all non-Federal sources combined do not appear to be adequate to finance expanding requirements." Here is the nub of this point. Who decides what is a requirement and what is only a desirable objective?

One of the big dangers of government influence in research is the potential for government dominance over the development of new products—in this case the effect would be chiefly on new drugs. The conclusion of the consultants is that research aimed at new products should be left to private industry. Some Federal projects in this field, known as service center type programs, have aroused enthusiasm in Congress to such an extent that it has recommended more of them. The secretary's consultants are less enchanted with the service center enterprises, and urge that they be studied more critically before any expansion is undertaken.

The report is critical of the earmarking of funds by Congress for specific research projects. It argues that this "cannot prove constructive over the long run." A way to get away from this and allow the experienced research scientists more responsibility for selection and direction of projects, of course, is to rely more on private funds and less on Congress.

The report points out the danger that dependence on Federal funds will lead to various kinds and degrees of Federal control over individuals and institutions. Yet this caution is expressed in the next breath after accepting the inevitability of continued and expanded Federal support. Elsewhere in the report the consultants conclude that large Federal appropriations to build new medical schools will be required unless there is a marked change either in private giving or state appropriations.

Between the lines of this report may be found, in the field of medical research and education, the same great need which exists in so many other fields of activity. It is the need for the guts to stop leaning on Uncle Sam's chest and rekindle the individual enterprise and the sense of individual responsibility which made this nation what it is—or what it was before the image of a mother hen replaced the eagle on the coat of arms. Of course there are dangers in living on Uncle's allowance. From time to time Uncle is going to expect something in return; the longer he doles it out the more he will expect. Let's use more of our brainpower figuring ways to do things for ourselves. Then we won't have to spend so much of it on ways to keep Federal controls from becoming too dangerous.

—*Newspaper Unknown*

How Deal With Drunken Drivers?

Since the proposal was first made several weeks ago to change the Indiana laws dealing with drunken drivers, much comment has appeared in newspapers of the state.

The Tribune has published several editorials from other papers on the subject. Here is another editorial, this one from The Richmond Palladium-Item:

"The public will have to keep its eyes on the Indiana general assembly's action on proposed drunken driving legislation next January.

Continued

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Thiamine HCl (B_1)	10 mg.
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Fourth Estate

Continued

"A report from the governor's Traffic Study Commission indicates that it has in mind a plan under which suspension of driver's licenses for drunken driving convictions will be fewer.

"Instead, it is proposed that courts could give more jail terms.

"Indiana's present law calls for suspension of a driver's license for a year on first offense drunken driving. The license is lost for two years providing the offender comes back two or more times on drunken driving charges.

"The Indiana State Bar Assn. is said to be back of the move to have fewer license suspensions and more jail terms given by judges before whom the offenders appear.

"Suspension of licenses would be determined by the court under the proposed plan. Some jail sentences could not be suspended where property damage was involved.

"By giving the court discretion over suspending licenses the law would make it possible for judges to return drunken drivers to our highways quickly.

"Where there was no property damage or personal injury it would appear that a convicted drunken driver could be freed by the court without going to jail or without loss of his license to drive.

"If this kind of law is passed a drunken driver soon would be out on our streets again. The next time we heard from him he might have qualified as one causing property damage or injury to other persons.

"Many of our Indiana judges have dealt softly with drunken drivers. With license suspensions in their hands to decide it is unlikely that many drunken drivers would lose their right to drive."

—*Kokomo Tribune*
Dec. 12, 1958

Proposed Drunken Driving Law

The Governor's Traffic Study Commission has announced that it will recommend a change in the drunken driving law to the next General Assembly, under which suspension of drivers' licenses would be left to the judge.

Most attorneys know that as long as the suspension of a driver's license is permissive rather than mandatory, defendants will be able to avoid the loss of their licenses by taking changes of venue from judges who attempt to crack down on drunken drivers.

As a sop to those who are opposed to light penalties for drunken drivers, the commission at the same time is recommending that a fine of $250 to $500 be assessed if the drunken driving results in property damage, with a fine of $250 to $5,000 and a jail sentence of 90 days to five years if the drunken driving also results in personal injury.

Under such conditions, the poor man would suffer far more than the driver in better financial circumstances. A heavy fine is hardly the way to keep drunken drivers off our highways, but a jail sentence for those causing personal injuries certainly has some merit.

If the General Assembly desires to lessen the present heavy penalty of a year's mandatory suspension of right to drive for first offenders, the change which is most needed is an amendment permitting the issuance of limited licenses in hardship cases whereby the convicted persons would be permitted to drive only during business hours and for business purposes. Thus some defendants would not be wholly deprived of their



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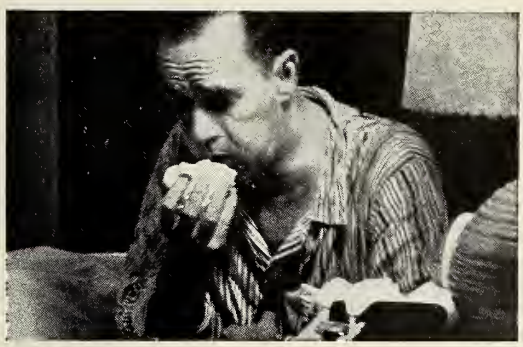
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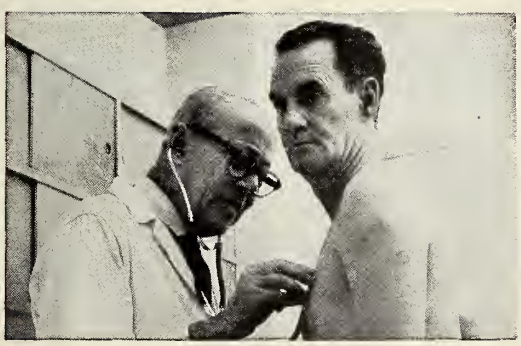
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Patient, factory worker, age 43, had suffered for months with persistent, dry cough, which he termed "smoker's hack."



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Fourth Estate

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means of making a living as they are under the present statutes if they must operate a motor vehicle in their work.

—Logansport Pharos-Tribune

Nursing Homes Checkup

The majority of hospitals in the United States come at least reasonably close to meeting high standards of medical care. Those that fall below acceptable standards feel rather strong pressure, economic and otherwise, to improve.

This has come about very largely because of an annual rating and inspection carried out by the American Medical Association, the American Hospital Association, the American College of Surgeons and the American College of Physicians. Hospitals strive for accreditation by these groups, and the public benefits.

When it comes to nursing homes, the situation is much different. Though they are subject to a certain amount of state supervision, many fall very far short of meeting high standards. A principal reason for this is the lack of any system of inspection and rating such as that which applies to hospitals.

It is excellent news that a move has been started to list nursing homes throughout the nation and subject them to an annual check. The American Nursing Home Association has begun a pilot study, and a committee of the American Medical Association is working on the problem.

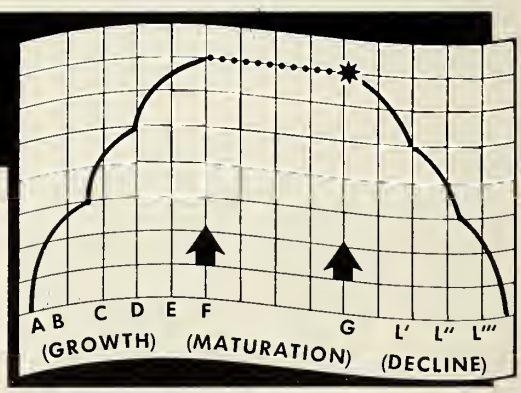
The extent of the need is suggested in an editorial in Journal Lancet by Dr. Willard A. Wright of Williston, N. D., chairman of the AMA committee. Nursing homes now range, he writes, "from the very good to the very bad." There is reason to believe that annual inspection and accreditation would do much to improve the bad nursing homes and maintain the excellence of those that are good. Medical groups undertaking this work deserve enlightened public support.

Kokomo Tribune
Dec. 5, 1958

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Rutin	10 mg.	Niocinomide	20 mg.
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B-12	1 mcg.	Mognesium	5 mg.
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Vitomin A	5,000 I.U.	Choline Bitartrote	40 mg.
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*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

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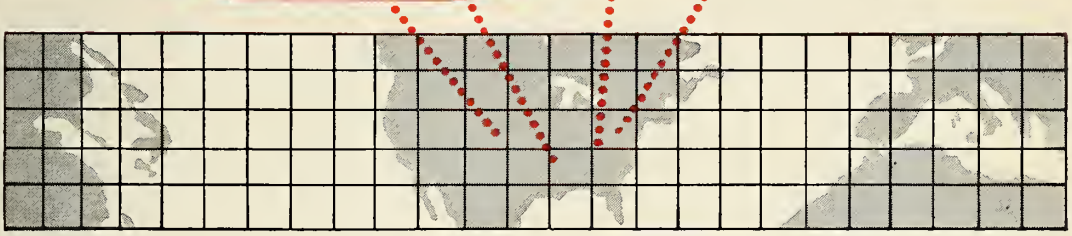
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Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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Science for the World's Well-Being

SPONTIN IN SERIOUS

A Special Report from Abbott
to the Medical Profession
on a Year's Clinical Experience
with SPONTIN®
(Ristocetin, Abbott)

In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia – plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

Few more dramatic records have been written in such a short space of time. SPONTIN has proved itself to be a good answer, perhaps the best answer at present, to the resistant staphylococcal problem – and of real value in other serious coccal infections. It may well be your answer when you're confronted with a serious infection.

Abbott

901066

STAPHYLOCOCCAL INFECTIONS

Excerpts from Reports Read at the Antibiotics Symposium

Spontin In Treating Severe Respiratory Infections —"In 13 of 20 patients the results were excellent, with clinical response being evident within one to four days after institution of therapy. In three additional patients, there was some degree of improvement in pneumonic processes superimposed on tuberculosis in two cases and on pulmonary neoplasm in one. In all other cases, serious antecedent pathology undoubtedly influenced the negative or equivocal response to ristocetin therapy.[6]"

Spontin In Treating Staphylococcal Infections—After successfully treating 28 patients, the authors wrote, "Ristocetin or Spontin has proved to be bactericidal and bacteriostatic, particularly for the *Staphylococcus aureus,* which is often resistant to many other antibiotics.[5]"

Spontin In Treating Seven Difficult Cases — "Ristocetin has produced excellent results in eradicating, mitigating or preventing infection in seven selected difficult cases. Six of the seven cases involved *Staphylococcus aureus* which did not respond to chemotherapy with other antibiotics.[7]"

Spontin Blood Levels In Children — "Ristocetin was administered as a single intravenous injection of 12.5 milligrams per kilogram. This resulted in serum levels ranging from 1.3 to 10.6 mcg. after two hours with a gradual fall to a level of 0.7 mcg. per cubic centimeter or less after 12 hours.[8]"

Spontin In Treating Staphylococcal Pneumonia —"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults — "Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.
2. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
3. Romansky, M. J., and Holmes, R., Successful Short-Term Therapy of Enterococcal and Staphylococcal Endocarditis with Ristocetin—Seven Patients. Preliminary Report, Antibiotics Annual, 1957-58, p. 187.
4. J. A. M. A., 167:1584, July 26, 1958.
5. Bush, L. F., et al., The Use of Ristocetin (Spontin) in Staphylococcal Infections, In Press, Antibiotics Annual, 1958-59.
6. Billow, F. J., et al., Clinical Observations on Ristocetin—A Preliminary Report on its Efficacy and Toxicity in 20 Unselected Severe Respiratory Infections, In Press, Antibiotics Annual, 1958-59.
7. Miller, J. M., et al., Ristocetin in the Treatment of Seven Selected Difficult Cases, In Press, Antibiotics Annual, 1958-59.
8. Asay, L. D., et al., Ristocetin Serum Levels in Children, In Press, Antibiotics Annual, 1958-59.
9. Schumacher, L. R., et al., Experiences with Ristocetin in Staphylococcal Pneumonia: Observations in 23 Cases, In Press, Antibiotics Annual, 1958-59.
10. Terry, R. B., Ristocetin in Children and Adults, In Press, Antibiotics Annual, 1958-59.

Words Worth Repeating

". . . doctors, almost to a man, are opposed to socialized medicine—by which term I mean tax-supported medical services provided and operated by the Government. Most people, I fear, assume that we oppose socialized medicine because it would hurt the doctors. They think we are a closed-shop union that wants to have complete control of medical practice in order to promote our own selfish interests. We failed to show the public that our opposition to socialized medicine is not because it would hurt us, but because it would hurt the public.

"As a matter of fact, socialized medicine wouldn't hurt most doctors financially. The superior doctor can get ahead under any system. The poor or even average doctor would probably be about as well off financially under socialized medicine as under free competition.

"So, it is not because we are doctors that we oppose socialized medicine; it is because of what we know as doctors about the practice of medicine.

"The public has been taught to believe, by those who are more active in public affairs than we, that socialized medicine would give more and better medical care for less cost. Doctors know it would give less and poorer medical care for greater cost.

"Doctors know that there are at least three essentials to good medical practice, all of which would be lost under socialized medicine.

"First, the relationship between the patient and the doctor must be wholly voluntary on both sides. It has to be completely voluntary on both sides. It has to be completely voluntary on the part of the patient, or she is not going to have full confidence in the doctor. It has to be completely voluntary on the part of the doctor or his heart is not fully in it. Under government management the relationship cannot be wholly voluntary. It is the patient who will suffer, not the doctor.

"A second requirement is that there be complete privacy and no intermediary between the patient and the physician. When the doctor gets paid by the patient, the doctor works for the patient. When the doctor gets paid in part or whole by the government, then little by little he comes to work for the government. Again, the doctor may be better off, but God help the patient.

"A third essential for good medical practice is that there be maximum incentives for the doctor to do his best, to get ahead, constantly to improve himself. One such incentive is financial reward in accordance with his ability and his effort. In every profession there are some individuals who have 'self-starters.' Regardless of financial compensation or any other considerations, they give everything they have. But such persons are probably in the minority in our profession as in others. Most men work harder and do better if they believe that will get them ahead financially.

"Another major incentive is professional recognition and advancement. You want the respect and confidence of your patients—and you will work hard to win it. But even more to be coveted is the respect of your colleagues.

"Both of these powerful incentives—financial reward and professional recognition—are largely killed under governmental management where promotions are made on the basis of seniority—or, as it is sometimes called in Washington, senilty.

"All these things that we know as doctors make us oppose socialized medicine. But it is not enough for us to be right. We must tell and sell our reasons to the public far better than we have. We can't do that by just talking to each other at medical meetings. We don't need to convince each other. We have to reach the public and the politicians, not to put something over on them, but to help them understand the situation so that no one else can put something over on them."

Hon. Walter H. Judd, Minnesota
J.A.M.A. 168: 99-103 (Sept. 6) 1958

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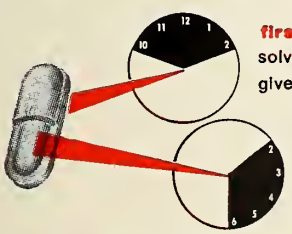
Provides well-tolerated APAP (N-acetyl-p-aminophenol) for prompt and effective analgesic and antipyretic action to make the patient more comfortable.

Provides Dormethan (brand of dextromethorphan HBr) for non-narcotic antitussive action on the cough reflex center in the medulla—as effective as codeine but without codeine's drawbacks.

Provides terpin hydrate, classic expectorant to thin inspissated mucus and help the patient clear the respiratory passages.

†Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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first—the outer layer dissolves within minutes to give 3 to 4 hours of relief

then—the inner core releases its ingredients to sustain relief for 3 to 4 more hours

also available for those patients who prefer liquid medication: **Tussagesic suspension**

Each TUSSAGESIC tablet provides:

TRIAMINIC®	50 mg.
(phenylpropanolamine HCl	25 mg.
pheniramine maleate	12.5 mg.
pyrilamine maleate	12.5 mg.)
Dormethan (brand of dextromethorphan HBr)	30 mg.
Terpin hydrate	180 mg.
APAP (N-acetyl-p-aminophenol)	325 mg.

Dosage: One tablet in the morning, midafternoon and in the evening, if needed.

Tussagesic* *timed-release tablets*

Contains* **TRIAMINIC *to* STOP *running noses* *and open stuffed noses orally*

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Report on Actions of the House of Delegates American Medical Association

12th Clinical Meeting
December 2-5, 1958
Minneapolis, Minn.

MINNEAPOLIS, December 5—Health care of the aged, the report of the AMA Commission on Medical Care Plans, osteopathy, expansion of medical education facilities, the Association's administrative changes, the report of the Committee to Study AMA Objectives and Basic Programs, and voluntary health organization fund-raising were among the wide variety of issues considered by the House of Delegates at the American Medical Association's Twelfth Clinical Meeting held December 2-5 in Minneapolis.

Dr. Lonnie A. Coffin of Farmington, Iowa, was named the 1958 General Practitioner of the Year for his outstanding contributions to the health and civic affairs of his home community. Dr. Coffin, who is the first Iowan to receive the annual GP award, accepted his gold medal on behalf of "all the men who have dedicated their lives to the general practice of medcine."

Speaking at the Tuesday opening session of the House, Dr. Gunnar Gundersen of La Crosse, Wis., AMA president, called upon the medical profession to exert leadership and imagination in meeting the problems of these changing times. Urging practical actions to solve medico-economic challenges, Dr. Gundersen declared that "the time has passed for policies based on generalities, platitudes and flag-waving." He also suggested that the Association offer support and cooperation to proposals for an International Medical Year.

Governor Orville L. Freeman of Minnesota, who also addressed the opening session, asked for "the help of the leaders of the medical profession in working out a program that will most adequately meet the needs of our older citizens for health care and services of the highest quality."

With half a day still to go, total registration Thursday evening had reached 4,880, including 2,870 physicians.

Health Care of the Aged

Responding to Dr. Gundersen's call for action and Gov. Freeman's plea for help in meeting the health care needs of the aged, the House of Delegates adopted the following proposal submitted by the Council on Medical Service and endorsed by the Board of Trustees:

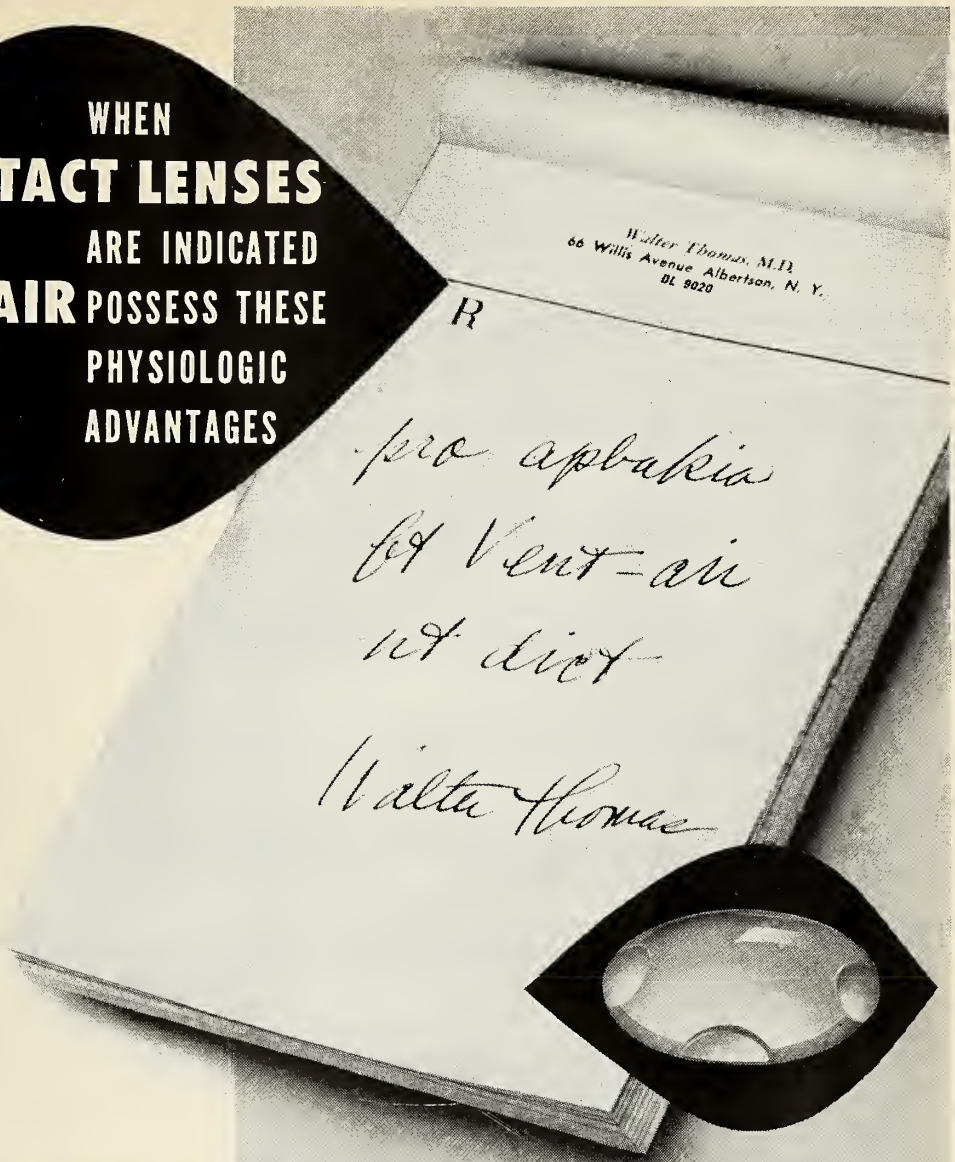
"For persons over 65 years of age with reduced incomes and very modest resources, it is necessary immediately to develop further the voluntary health insurance or prepayment plans in a way that would be acceptable both to the recipients and the medical profession. The medical profession must continue to assert its leadership and responsibility for assuring adequate medical care for this group of our citizens.

"Therefore, the Council on Medical Service recommends to the House of Delegates the adoption of the following proposal: That the American Medical Association, the constituent and component medical societies, as well as physicians everywhere, expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income; that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate."

In order to effect the immediate implementation of such a program, the House directed that copies of the proposal be distributed to medical society approved plans, including Blue Shield

Continued

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Hyper-thinness of edge or center	Maintains uniform thickness in high myopia or hyperopia approximating .20 mm irrespective of power
Widest range of inner radii	From 5.0 to 10.00 mm providing for extremes of keratoconic and megaloglobic dimensions
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AMA House

Continued

and private insurance programs, requesting their cooperation.

Commission on Medical Care Plans

The long-awaited report of the Commission on Medical Care Plans, appointed at the 1954 Clinical Meeting in Miami, was discussed for two hours at a reference committee hearing, but the House decided to defer action until the June, 1959, meeting. In so doing, the delegates adopted this statement:

"We respectfully suggest to the constituent associations reviewing the report in the interim, that their attitude regarding the report will be clarified if they arrive at some decisions in regard to the following basic points:

"1. *Free Choice of Physician*—Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?

"2. *Closed Panel Systems*—What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

"These suggestions acknowledge that the policy of the American Medical Association to encourage and support the highest quality of medical care for all patients remains unchanged. They question, however, whether attitudes toward the free choice of physician and the closed panel system may be undergoing evolutionary change."

The House recommended that the Board of Trustees invite the constituent associations to forward their replies to these questions to the executive vice president 60 days in advance of the June, 1959, meeting.

Osteopathy

Considerable discussion centered on a resolution which would have recognized that constituent medical associations have the right to establish the relationship of the medical profession to the osteopathic profession within their respective states. The House decided, however, that the resolution in question did not offer the appropriate solution to the osteopathic problem. Instead, the delegates requested the Judicial Council to review past pronouncements of the House on osteopathy and the status of the laws of the various states in this regard. The Council was asked to present its report and recommendations at the June, 1959, meeting. The House "noted with favor that the American Osteopathic Association has amended its objectives as stated in its constitution by deleting reference to the cultism of Andrew J. Still."

Medical Education

The House approved a statement by the Council on Medical Education and Hospitals supporting the development of additional facilities for basic medical education, and it urged the entire profession to give that policy strong support in order to correct misinterpretations of the Association's viewpoint regarding the supply of physicians.

"American medicine," the statement points out, "fully recognizes the needs being brought about by the increasing population, social and economic trends, and the changing dimensions of medical knowledge and its application." Urging careful analysis of those needs, the statement says that existing medical schools should consider the possibility of increasing their enrollments and developing new facilities. It also declares that American medicine has the responsibility to encourage the creation of new four-year medical schools and two-year basic science programs by institutions of higher education which can provide the desirable setting.

AMA Administrative Structure

A Board of Trustees report on the administrative structure of the Association was approved by the House, which termed the reorganization of the headquarters staff as a long and important step in the right direction. The report informed the House that the Chicago staff has been divided into the following seven divisions: Business Division, Law Division, Communications Division, Field Division, Division of Scientific Publications, Division of Socio-Economic Activities and Division of Scientific Activities. The latter two are still in the process of development and are temporarily under the direction of the assistant executive vice president. The Board also reported that the Committee on Legislation has been renamed the Council on Legislative Activities, with the Director of the Law Division as council secretary. This new council will undertake an enlarged, strengthened legislative

Continued

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AMA House

Continued

program, closely coordinated with the activities of the new field staff and the Washington office. The latter also has been reorganized, with overall direction coming from Chicago.

AMA Objectives, Basic Programs

The House received and commended the report of the Committee to Study AMA Objectives and Basic Programs, which it said may be a significant milepost in the Association's history. In approving one of the committee's recommendations, the House referred to the Council on Constitution and Bylaws the following suggested amendment of Article II of the Constitution: "The objectives of the Association are to promote the science and art of medicine and the betterment of public health and an understanding of the socio-economic conditions which will facilitate the attainment of these objectives."

The House also recommended that the Board of Trustees establish a mechanism which will assume the responsibility for promoting active liaison with each national medical society. "In the scientific fields," the House declared, "the role of the AMA should be primarily that of leadership, but every endeavor should be made to bring about coordination of the special fields of scientific interest of the other national medical organizations." The delegates also approved a recommendation that the Board of Trustees give serious consideration to opening the publications of the Association to a free and open discussion of socio-economic problems applicable to medicine.

Fund-Raising

Once again considering fund-raising problems which have arisen since development of the concept of united community effort, the House passed a resolution which pointed out that the action taken last June in San Francisco has been interpreted by some as disapproving the inclusion of voluntary health agencies in United Fund drives. It then stated that "the American Medical Association neither approves nor disapproves of the inclusion of voluntary health agencies in United Fund drives." The resolution also requested the Board of Trustees to arrange a top-level conference with the voluntary health agencies, the United Funds and other parties interested in the raising of funds for health causes, with a view toward resolving misinterpretations and other difficulties in this area.

Miscellaneous Actions

In dealing with a wide variety of other subjects, the House also:

Took notice of the recent restrictive changes in the *Medicare* program; expressed regret at the substitution of federal facilities for private care in the areas mentioned, and urged the Association to encourage the re-establishment of services under the free choice principle to accomplish the original intent of the act;

Recommended that the Social Security Act be amended by Congress to permit states to combine the present four *Public Assistance* medical programs into a single medical program, administered by a single agency and making available uniformity of services to all eligible Public Assistance recipients in the state;

Authorized the Council on Medical Service to sponsor at the earliest practicable date a *Congress on Prepaid Health Insurance;*

Approved a plan to develop *Buyers' Guides* which will be sent to physicians to help their patients analyze the merits of available health insurance programs;

Approved a Bylaw amendment which will allow *dues exemptions* for interns and residents serving in training programs approved by the Council on Medical Education and Hospitals;

Called to the attention of all individuals or institutions responsile for *intern and resident* training that medical services provided to patients in hospitals are the responsibility of duly licensed physicians;

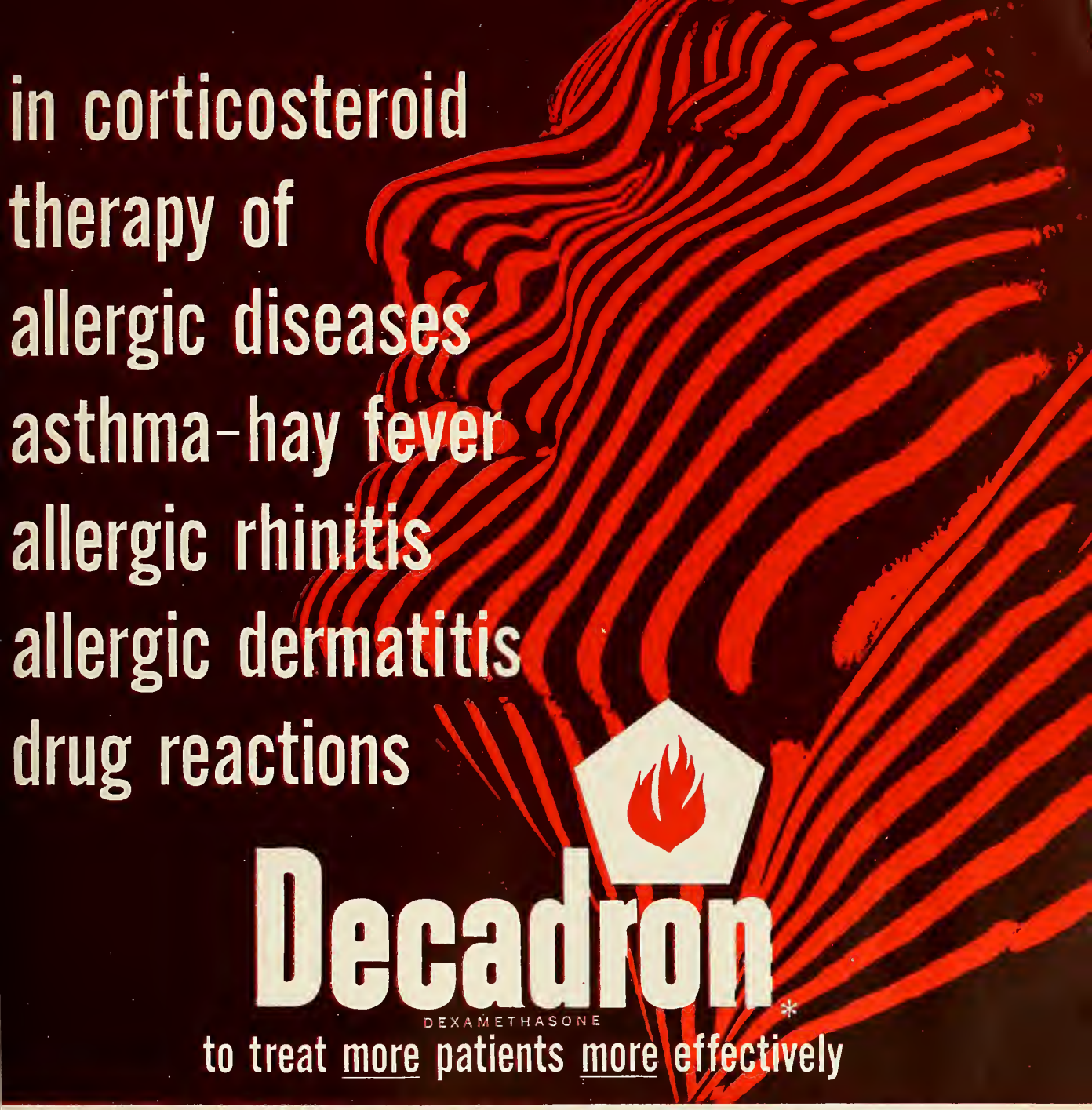
Encouraged the voluntary registration of the *paramedical personnel* who assist physicians, but opposed the extension of governmental licensure and governmental registration at this time;

Heartily approved and lauded the purpose, content and format of *The AMA News* and recommended continuance of the publication under its present and established policies;

Agreed with the Committee on Medical Practices that *relative value studies* should be conducted by each constituent medical association but not on a national or regional basis by the AMA.

Urged each constituent society to establish a committee on *rehabilitation* to carry out activities recommended by the Board of Trustees;

Continued on page 34



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Excellent and good-to-excellent results are reported† with DECADRON in nearly all of 362 patients with various allergic disorders, including a number of cases who had failed to respond to other corticosteroids. **No major reactions** were observed in these extensive clinical studies even after four months of continuous therapy—DECADRON produced no peptic ulcer, no diabetes, no significant hypertension, no sodium retention, no potassium depletion, no edema, no undesirable psychic reactions, and no unusual or new side effects. Less than five per cent of patients experienced minor reactions, none of which prevented continuing administration of DECADRON.

Moreover, several investigators report that side effects induced by previous corticosteroid therapy such as gastric intolerance, peripheral edema, headache, vertigo, muscle weakness, ecchymoses, flushing, sweating, moon facies, hypertension, hirsutism, and acne **often disappeared during therapy with DECADRON.** †Analysis of clinical reports.

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Detailed information on dosage and precautions is available to physicians on request.

Supplied: As 0.75 and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100.

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Pearl River, New York

AMA House

Continued from page 32

Called for continued activity at all levels to stimulate the development of effective *poliomyelitis inoculation programs;*

Suggested that the Association take immediate steps toward developing a plan whereby reserve medical units and individuals not immediately involved in military operations could be used to supplement *civil defense* operations, and

Expressed gratitude and appreciation for the long years of devoted service by *Dr. Austin Smith,* who has resigned as editor of the *Journal* of the American Medical Association.

At the opening session, six state medical societies contributed a total of almost $250,000 to the American Medical Education Foundation. The gifts were: California, $150,305.75; *INDIANA, $35,110;* New Jersey, $25,000; New York, $19,608; Utah, $9,977.50, and Arizona, $8,657.50. In addition, the American Medical Association announced a contribution of $100,000 to the Foundation.

It also was announced on the opening day of the meeting that Dr. W. Linwood Ball of Richmond, Va., AMA vice president, had been appointed to the Board of Trustees to fill the vacancy caused by the recent death of Dr. Warren Furey of Chicago. Dr. Ball, who will serve on the Board until next June, said he will not be a candidate to succeed himself.

Indiana Delegates:

Earl W. Mericle, M.D.
Indianapolis
E. S. Jones, M.D.
Hammond
Gordon B. Wilder, M.D.
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Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Adult Dosage: one teaspoonful q. 6 h. May be habit-forming.
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Army Provides Wind Chill Table To Help Prevent Cold Injury

A Wind Chill Table designed to gauge in advance the severity of the weather will be provided to Army commanders in an effort to further reduce the already low incidence of cold injury among troops this winter. The Table, developed at the U. S. Army Medical Research Laboratory, Fort Knox, Ky., is included in Department of Army Circular No. 40-33, dated November 3, 1958.

Results derived from the Wind Chill Table are startling. Everyone knows it feels colder when the wind blows, but they don't know how much colder it actually is. For example, the Wind Chill Table shows that if the temperature to be expected is about 35° Fahrenheit and the expected wind velocity is 20 miles per hour, then the effect on exposed flesh is the same as 38° below zero with no wind—the same as being in a deep freeze.

Wind chill, one of the most important factors in the production of cold injury, may be prevented by proper use of the new table, which shows equivalent temperatures, so that when a unit commander has a forecast of the temperature and wind speed he can learn the approximate temperature equivalent against which he must protect his men.

1958 INDEX

The 1958 index will be late in publication. It will appear in a subsequent issue of the Journal as early in 1959 as possible.

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Deprol ► acts promptly to control depression *without* stimulation

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Deprol is unlike amine-oxidase inhibitors

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► causes no excessive elation

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Deprol is unlike central nervous stimulants

► does not cause insomnia

► produces no amphetamine-like jitteriness

► does not depress appetite

► has no depression-producing aftereffects

► can be used freely in hypertension and in unstable personalities

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. **166**:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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Literature and samples on request ® WALLACE LABORATORIES, *New Brunswick, N.J.*

Medical Schools Reach Record Enrollment

CHICAGO—American medical colleges had a record enrollment of 29,473 students in 1957-58.

Sixty of the 85 operating medical schools reported major construction, costing 47 million dollars, in the planning, beginning, or completion stages.

Forty-nine schools reported major developments and changes in administrative organization, methods of student selection, curriculum and financing.

An estimated 275 million dollars was spent by the medical schools in 1957-58, an increase of 13% over the preceding year.

These were among the many facts and figures in the 58th annual report on medical education by the American Medical Association's Council on Medical Education and Hospitals. The 90-page report appears in the current (Nov. 15) Journal of the AMA.

The report illustrates some of the changes and developments being made in medical schools to meet the changing medical needs of the American people.

It also noted the AMA's continuing support in developing additional facilities for basic medical education. "The increasing population together with various other facets of the shifting [population] pattern obviously indicate the need for constantly increasing the number of physicians," the report said.

This means that existing medical schools must consider expanding their facilities, and institutions of higher education without medical education programs need to give serious consideration to the development of medical programs.

Curriculum Developments

Major developments in curriculum and teaching methods were reported at several schools. These include a plan at Duke University to produce physicians who are also skilled medical research scientists; a greater emphasis on education methods for medical teachers at the University of Buffalo, and an experimental program at the University of Pittsburgh whereby medical students may adapt their medical education to one of the specific fields of research, clinical specialties, or general practice.

There are 78 approved 4-year medical schools in the United States, along with four 2-year schools of basic medical sciences. In addition, 3 newly developing schools have provisional approval by the AMA council and will be graduating students within the next few years. Ten years ago there were 77 schools, including seven 2-year schools of basic medical sciences.

A total of 6,861 physicians was graduated from the 78 schools in 1958, as compared with 6,796 in 1957. The record year for graduates was 1955 with 6,977.

A new record was established in 1957-58 for the number of entering freshmen—8,030. The preceding year the number was 8,014 and 10 years ago the number was 6,487.

Other Items

Among the other items the report showed were:

—A total of 1,644 women was enrolled in medical school, and 355 were graduated in 1958. Women's Medical College, Philadelphia, enrolls only women, while Dartmouth and Jefferson enroll only men.

—Of the 72 schools reporting that the supply of cadavers used for teaching anatomy was probably adequate for the needs of first-year students, 13 reported an insufficient supply for the more advanced students. The other 13 schools reported a "frankly inadequate supply." The report urged more states to give legal recognition to individual bequests of bodies to medical schools.

—The American Medical Education Foundation raised $984,787 from physicians for medical schools in 1957. The National Fund for Medical Education, which receives its money from industry, contributed $3,078,825 to the medical schools in January, 1958.

—The median annual cost of medical school to a student, including tuition, minimum board, room and supplies in a private institution was $1,958. In a state-owned school, the cost was $1,395 to a resident of the state and $1,731 to a non-resident.

—The median amount of money spent by a 4-year school during 1957-58 was between 2.3 and 2.4 million dollars.

The survey of medical schools this year showed that only 7—all state-owned—limited their first-year enrollment to residents of the

state in which the school was located. This is a drop of 5 schools from the preceding year.

However, the publicly owned schools had only 4 to 9% of their students from outside the state in which each school was located. As a consequence, the publicly owned schools had only one fourth to one fifth as many applicants as did privately owned schools, the report said.

Although the proportion of the total entering classes enrolled in each kind of school was about equal, the number of students lost to medicine by poor scholarship during the first year was significantly larger in each of the past 4 years in publicly owned schools.

Geographic Restrictions

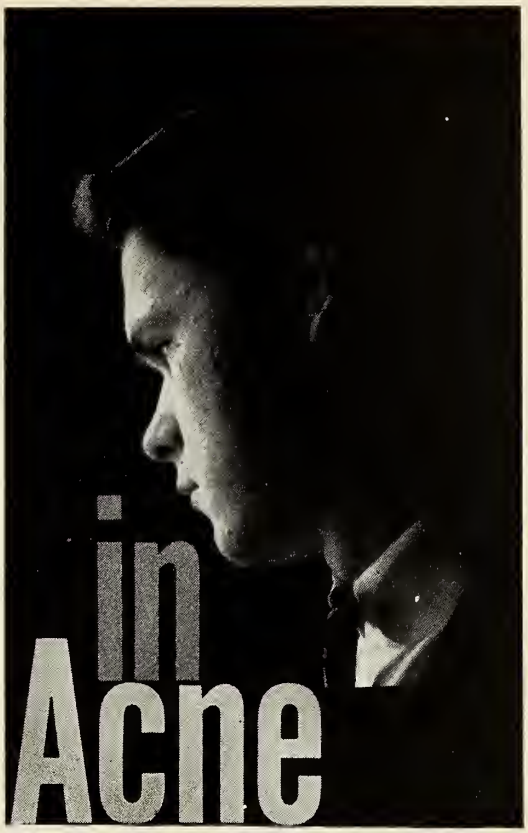
The report said the problem is that their geographic restrictions on residence limit applications by and choice of as many highly capable students on the part of publicly owned schools as are turned away by the geographically non-restrictive privately owned schools.

The report expressed the hope that state legislators and other public officials concerned with these matters will cooperate with university and medical school administrators "in bringing the policies restricting admissions into a more realistic and socially useful focus."

Also included in the report was one by A. J. Carroll, business officer of the State University of New York, which criticizes the "inadequate financial reports" of medical schools. However, the W. K. Kellogg Foundation has made a grant to underwrite a study of medical school financing. It will "be able to prove the financial needs of medical education and to establish new standards of management efficiency," Carroll said.

The report included extensive information about Canadian medical schools. There are 12 4-year schools, enrolling a total of 3,686 students. They graduated 828 physicians in 1958.

There were 82 United States citizens enrolled in the first medical year in Canadian schools as compared with 4 Canadians enrolled in the first-year classes of United States schools. The report pointed out that this favorable balance of 78 Americans in the first medical year of Canadian schools represents the "equivalent of another United States school having a class size larger than that of 28 of the United States medical schools."



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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.

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references:
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Surgical Technics For Improvement of Hearing†

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Indianapolis

IN RECENT years the otologists have been developing new surgical technics for improvement of hearing in both suppurative and non-suppurative types of conductive hearing losses. These new technics have been made possible by the development of microscopic operative procedures first introduced by Lempert, and by improvement of lighting and the operating microscopes. Following these developments a greater understanding of the physiological principles of the sound-conducting apparatus have been achieved.

Before any operative procedure can be successful it must be established that the nerve of hearing is capable of receiving 500, 1000 and 2000 sound vibrations at, or above, the 30 decibel level in order to understand the spoken voice. This can be determined by the pre-operative examination. If the auditory nerve is found capable of receiving the spoken voice sounds, then surgical methods must be developed in order to mobilize the perilymphatic fluids of the internal ear in order to carry the sound waves to the nerve endings in the cochlea. To accomplish this peri-lymph movement, there must be two functioning windows into the internal ear. If either the round window or oval window function is inhibited by bony fixation or infection, the peri-lymph will be immobile and the sound waves cannot stimulate the nerve of hearing.

The development of surgical technics for the improvement of hearing in non-suppurative types of conductive hearing losses has long been the prime consideration of the otologist. Deafness due to otosclerosis has received the major amount of research in these new technics, beginning with attempts to mobilize the fixed stapes by Kessell in 1876. This was later followed from 1890 to 1900 by Blake, Jack, Burnett and Sieberman. These early attempts to mobilize the stapes were not successful and this approach to the solution of deafness due to otosclerosis was

† Presented at the American College of Surgeons, Indiana Chapter, annual meeting, April 23, 1958. Indianapolis.

discarded. In 1953 Rosen re-introduced the stapes mobilization operation and since that time many improvements have been developed. These improvements have been made possible by better lighting and magnification equipment now available, and particularly by the development of the Zeiss operating microscope which magnifies the operative field up to 40 times. The first attempts to mobilize the stapes were made after the drum was elevated and the ossicular chain exposed. Manipulation and pressure was made upon the head of the stapes or through incostapedial articulation directed to the foot plate in order to break the fixed foot plate loose from the oval window. A large percentage of these cases failed because these manipulations resulted in a fractured crura of the stapes. The crura are often atrophic in cases of otosclerosis and are fractured very easily, and if fractured, the fixed stapes foot plate would remain immobilized in the oval window and no improvement in hearing would be accomplished. With better magnifying equipment it is now possible for the operator to visualize the foot plate itself, in most of the cases, and to see the otosclerotic lesion fixing the foot plate in the oval window. Direct attacks upon the foot plate are now made by small needles, chisels, and small drill points, thereby loosening and removing portions of the otosclerotic bone around the foot plate and facilitating movement of the foot plate itself without disturbing or making pressure upon the crura. Results from these technics have been more satisfactory; however, they are still in the developmental stage. Another type of approach is to create a fenestra directly into the foot plate of the stapes, although merely making an opening into the foot plate does not seem to mobilize the perilymphatic fluid as well as the mobilization of the entire foot plate itself, and the hearing improvements have not been as satisfactory. It is true that improvements have been made in the last few years in this operative technic, but it still has not reached the percentage of results that is desirable. At the present time favorable results are only in the range of about 50%. The stapes mobilization operation is not a substitute for the fenestration operation and should be considered a preliminary procedure which may be successful. There are many pitfalls in this procedure with reasons for failures such as crural fractures and the refixation of the foot plate of the stapes after it has once become mobilized. If the mobilization operation is not successful, it can be followed by the fenestration operation at a later date.

The stapes mobilization operation does have certain advantages over the fenestration operation inasmuch as it requires only 2 days hospitalization. This operation is done under local anesthesia and is usually accompanied by little or no post-operative discomfort. Because of this it can be done in the older age groups or on the cases where the nerve of hearing is not considered good enough to subject the patient to the fenestration operation.

The fenestration operation for deafness due to otosclerosis had its origin with Holngern of Sweden in 1916, and later by Surdille of France; however, it was not until Lempert presented his classic "Fenestration Technique" in 1938 that a practical one-stage fenestration operation was devised. The idea of the fenestration operation is to replace the oval window, which has become closed by otosclerosis, with a new fenestra or window and to create a new air conduction route to the internal ear. This operation has withstood the test of time, and today this procedure gives the patient with deafness due to otosclerosis his best chance of hearing improvement. In cases with good auditory nerve function, about 88% of the cases operated will get a practical hearing result.

The trans-tympanic approach, as used in stapes mobilization operation for deafness due to otosclerosis, is also of great value in the surgical treatment of hydrops of the labyrinth, or Meniere's Disease for relief of vertigo. In recent years the otologist has been approaching this condition by a transtympanic labyrinthotomy. This is accomplished by elevating the ear drum, exposing the ossicular chain, then severing the incus from the head of the stapes. The stapes is then removed from the oval window, opening the internal ear or labyrinth. A small aspirating tip is placed in the vestibule of the labyrinth, and the endo-lymphatic membranous labyrinth is removed by aspiration. The ear drum is replaced in its normal position, and a few pledgets of gelfoam packing soaked in topical thrombin are placed against the ear drum and in the external canal. This operation is completed in about 20 minutes with little or no shock. From the viewpoint of the otologist, this approach directly attacks the seat of the pathology and is more practical than the neuro-surgeon's intra-

cranial method of severing the vestibular division of the eighth nerve in cases of Meniere's Disease.

The following recent developments have been accomplished with the possibility of improving the function of the sound conducting apparatus in the chronic suppurative diseases in the middle ear and mastoid. These operations are considered as plastic procedures and are re-constructive in type. Before any such operation can be successful, it is important that all bone necrosis and disease in the affected parts be thoroughly controlled by antibiotic therapy or by surgery before any re-constructive operation upon the sound conducting apparatus will be successful.

1. Myringoplasty

Myringoplasty type of operation is used when there is a permanent perforation of the ear drum, central in type, in which there is no evidence of bone necrosis, granulations or cholesteatoma, and the ossicular chain is intact. The perforation in the drum is closed by the following method. The outer layer or the epithelial layer of the drum and the adjacent external canal is removed by a fine sharp curette. A full thickness skin graft is placed over this perforation and held in position with pledges of gelfoam packing soaked in topical thrombin, and left in position for about 10 days, at which time the remnants of the gelfoam can be removed by gentle aspiration. It is important before this operation is attempted that the middle ear is dry and no evidence of infection is present.

2. Epitympano-Mastoidectomy

This operative procedure is used when the ossicular chain is intact and functioning, and there is a marginal perforation with attic bone necrosis in which granulation tissue or attic cholesteatoma may be present. This operative procedure requires the use of the endaural approach and the eradication of the diseased and necrotic bone in the mastoid process exposing the attic and ossicular chain occupying that region. The integrity of the remaining portion of the ear drum and ossicular chain are preserved. After the microscopic removal of all evidence of granulation tissue and cholesteatoma involving the ossicular chain is completed, a full thickness skin graft is applied to the bared remaining surface of the ear drum, the ossicular chain and the adjacent mastoid cavity.

3. Columella type tympanoplasty

This type of surgical procedure is applied in the cases where the disease process has already caused an interruption in the ossicular chain along with the necrosis of the mastoid and attic cells. If the stapes still remains intact and in its position in the oval window, it is capable of functioning and conducting sound waves to the internal ear. This type of reconstruction surgery requires the complete removal of all disease in the mastoid cells and the middle ear, care being taken to preserve the stapes so that it will not be dislocated in the oval window. In such a case it is necessary to lower the facial ridge very radically in order that the skin graft used later will have good apposition at the head of the stapes. The skin graft is then placed over the middle ear cavity, head of the stapes and mastoid cavity.

4. Total tympanoplasty

This type of surgery technic is applied to cases in which all the ossicular chain including the stapes has been destroyed by the suppurative condition. This requries the total mastoidectomy to be done with the microscopic removal of disease tissue, a skin graft then covers the round window area but leaves an air space communicating with the eustachian tube, while the oval window is left open and exposed in the middle ear and is not covered by the graft. In this method the skin graft acts as a baffle over the round window area and sound waves reaching the middle ear cavity will strike the unprotected oval window with more intensity than it will strike the round window which has been baffled by the skin graft. This allows a greater possibility of mobilization of the endo-lymphatic fluids in the internal ear with a greater chance of hearing improvement. In come cases of suppurative mastoiditis the operator finds at the time of surgery that a labyrinthine fistula has been caused by this infectious process. In such a case he is often able to convert this labyrinthine fistula into a functioning fenestra into the vestibule (as is used in the fenestration operation), covering this fenestra with a skin graft. In many of these cases marked improvement of hearing will be accomplished. It is important to re-emphasize the necessity of a thorough microscopic removal of all diseased tissue in these operative procedures before any operation upon the sound conducting apparatus will be successful. It is also important that the cochlear function be

evaluated and shown to be capable of receiving sound at a serviceable level before these plastic procedures are initiated.

In summarizing the recent advances in otological surgery these new technics have been chiefly directed to improving the hearing function of the ear.

These operating procedures have been enhanced by superior lighting and magnification equipment, now available to the otological surgeon; however, this is meticulous surgery and special training is necessary in order to properly perform these procedures.

The surgery to improve hearing in non-suppurative ear involvements, mainly otosclerosis, have received the major amount of attention to date and have given the patient the best results by the development of the fenestration and stapes mobilization technics.

The surgical attempts to improve hearing and at the same time eradicate suppurative conditions are at present very much in the experimental stage, and further refinements in these technics may produce better results in the near future.

The use of the trans-tympanic approach, now employed in the stapes mobilization operation for deafness due to otosclerosis, is now being used in the labyrinthotomy technic for relief of vertigo due to Meniere's Disease.

It is important that the otologist carefully evaluate the potential value of the nerve of hearing before any operative procedure is initiated. If this nerve is not capable of receiving sounds at a serviceable level, any operative procedure employed will fail to give satisfactory results.

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The Shotgun Capsule

A few decades ago, before medicine became as precise and scientific as it is today, doctors' prescriptions often consisted of 6 to 8 or more ingredients, many of which were more or less inert. The prescriptions were written in Latin, and the mystery of the ingredients constituted part of their virtue. Gradually, most of this sort of unscientific and meaningless procedure was abandoned; professors of medicine and of pharmacology taught students to use simple drugs for precise reasons and for definite periods. Gradually, with the intense development of chemotherapy, of antibiotic therapy, of antihistaminic therapy, of endocrinologic therapy and of vitamin therapy there has been a mushrooming of drug manufacturers who are in desperate competition. The commercialistic factor has crept into therapeutics to such an extent that physicians everywhere are confused and misled by the literally thousands of drugs increasing in number daily. Dozens of expensive commercial brochures, sample drugs and elegant preparations reach one's office daily and are promptly disposed of in the wastebasket. Many of these modern preparations are mixtures of drugs, some of which are dangerous, some of which are useless, and most of which would be more intelligently given as separate drugs rather than in a shotgun capsule.

Claude E. Forkner, M.D.
in *The New England Journal of Medicine*, p. 439, Aug. 28, 1958
(Reprinted in *United States Armed Forces Medical Journal*)

Notice

MEMBERS

Notice

The 1959 Yearbook with Roster will be issued in May instead of July.

The May issue is made up in April. To be included in the membership roster, members' dues must be in the state office before that time.

Get Your Dues in Early!

Nosocomial Infections with Resistant Staphylococcus†

JOHN M. McKAIN, M.D.*
Omaha, Nebraska

THE specific problem with which we want to deal briefly today is that of nosocomial infection with Micrococcus pyogenes variety aureus —hereafter to be called by its more common name of staphylococcus aureus. This general problem has incited a great deal of thinking and research activity in this country and England in the past few months. [1, 2, 3, 4]

The introduction of sulfapyridine and other chemotherapeutic agents of the sulfa group beginning about 1938 marked the onset of the modern era of treatment of gram positive bacterial infections.[5] With the subsequent introduction of antibiotics in the early 1940's, it was the impression of many that infectious disease no longer was a serious challenge. A few, however, were heard protesting that resistant strains could once again become a problem. These protestations have proved accurate. There has followed in the ensuing 20 years an interesting race between the technology and ingenuity of our drug houses and the bacteriae.

It has been known for some time that hospitals, where antibiotics are now ubiquitously used, are areas where antibiotic resistant strains of staphylococci flourish. In most recent studies, about 80 to 90% of hospital personnel have positive nose and throat cultures for staphylococci, 50% of which are coagulase positive and 5 to 10% are virulent strains by phage typing.[2] Into this environment patients are brought who are afflicted with a variety of medical and surgical disorders, many of which lead to an increased susceptibility of a tissue or the entire organism. Is it any wonder then that occasional outbreaks of furunculosis, pneumonia, wound infections, enterocolitis and lung abscess occur? These are then spread centrifugally through open wards by mechanisms outlined in Diagram 1. It is always of concern to surgeons and nurses that infections not be propagated to and through the operating room to patients.

A specific hospital problem about which there has been much written in the current literature is the cross infection between the newborn nursery and nursing mothers (Diagram 2). You will recall the recent outbreak in Texas with its high toll in neonatal deaths from pneumonia. Fortunately, this has not been a problem for us as yet.

In the past 3 months at the Indiana University Medical Center, an alarming increase in staphylococcus aureus infections of the coagulase positive type has occurred. During the month of December, 1957 alone, 6 significant infections in postoperative patients occurred ranging from pneumonia to enterocolitis.

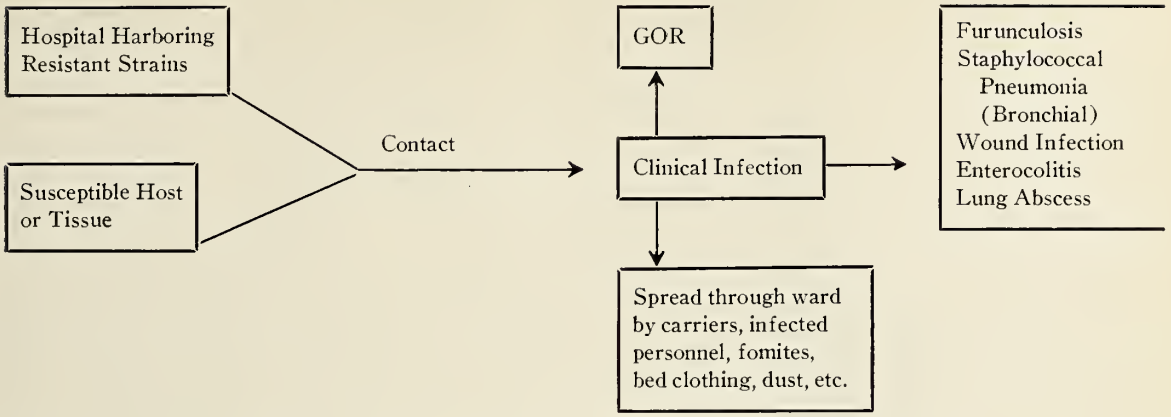
In the same period of time surgical decortications of the lung were performed on 4 pediatric patients with total staphylococcal empyema. This was just after the influenza pandemic. Ward infections with staphylococcus aureus have also been a problem on the orthopedic and neurosurgical services recently with high morbidity and mortality.

How does one deal with this problem once it has become apparent in the hospital environment? This may be considered under 3 avenues of approach. First, hospital housekeeping must be improved to protect personnel and other patients. Floors should be mopped with damp mops

† Presented at the American College of Surgeons, Indiana Chapter, annual meeting, April 23, 1958. Indianapolis.

*Assistant Professor of Surgery, Creighton Medical School.

Diagram #1 Nosocomial Infection with Staphylococcus Aureus



soaked in antiseptic solution. Bed clothes must not be interchanged. Isolation should be carried out in as strict a manner as feasible, including washing with hexachlorophene soap and rinses with 70% alcohol The dressing cart must be supervised by a competent nurse, trained in sterile technic.

Secondly, there must be an investigation of personnel. Infected employees and professional people must be laid off. Carriers must be warned about their technic of care and conduct around patients. The sterile technic in the operating room and on the ward must be reviewed and critically appraised.

Thirdly, the specific infections must be treated properly. This involves obtaining cultures and sensitivity of all infections, if possible, prior to treatment. Incision and drainage of abscesses must be timed properly. Specific antibiotics must be selected when available. The role of autogenous vaccines remains a controversial one.

It should be pointed out that in large and loosely organized hospitals, care must be taken to tabulate and review periodically the attack rate of infections incurred in patients during a hospital stay; for it is only with constant vigil in these attack rates that serious outbreaks can be recognized early and measures taken to control the individual situation.

Diagram #2

Newborn Nursery ⟶ Mothers on Ward
(Pneumonia) ⟵ (Breast Abscesses)

Finally, the "routine" use of antibiotics should be mentioned only to condemn such a practice.

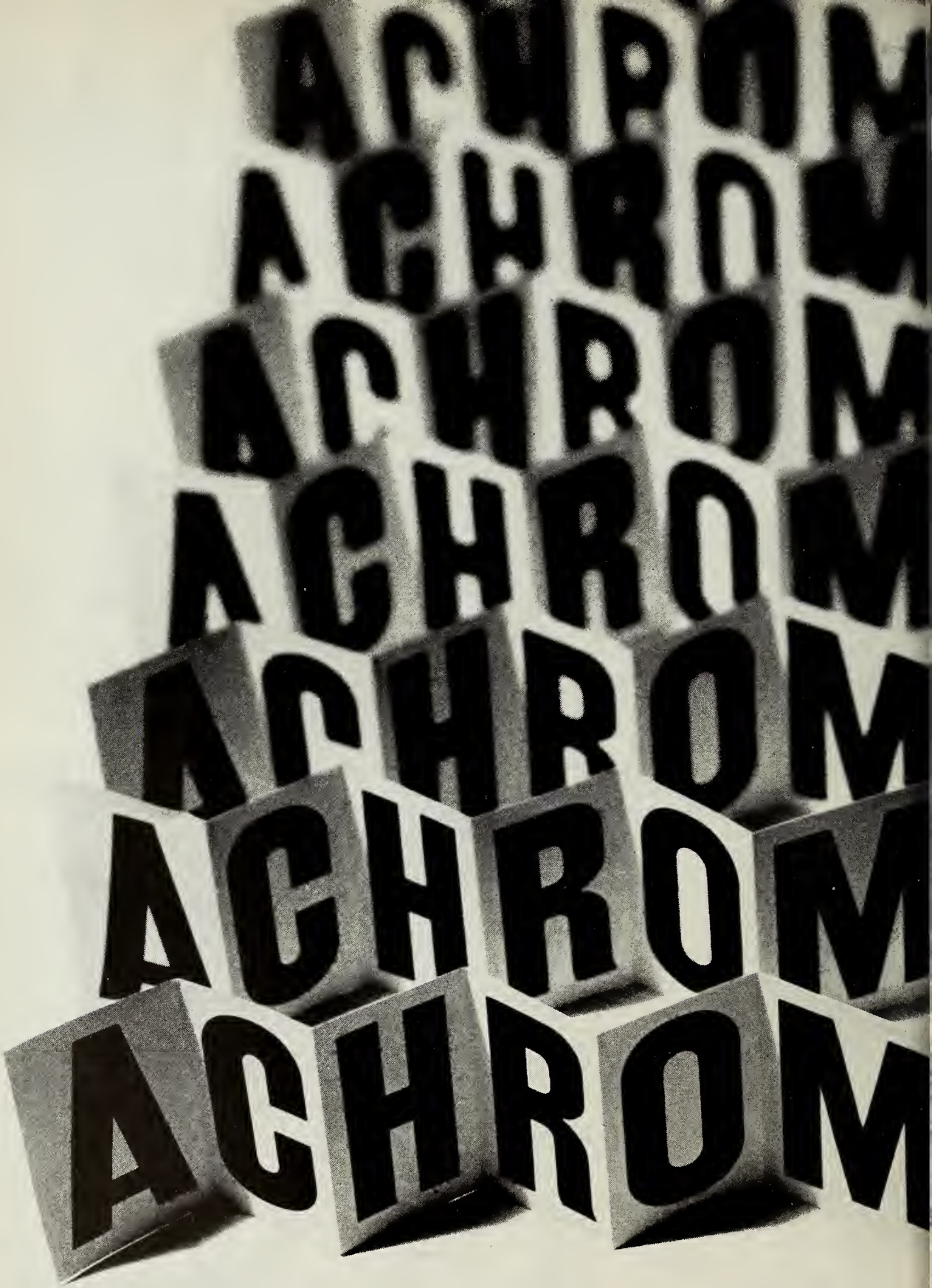
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Chart 1

Pt.		*Operation*	*Complication*	*Result*
RS	WM 18	Total Colectomy	Wound Infection	Recovery
RD	6 wks	Thoracostomy	Contralateral pneumonia	Recovery
OE	WM 56	Expl. Laparotomy	Enterocolitis	Recovery
WS	WM 60	Colecystectomy with CDE	Bronchopneumonia	Recovery
AR	WM 52	Gastrectomy	Bronchopneumonia	Recovery
IS	WM 70	Abdomino-Perineal	Bronchopneumonia	Recovery


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Bones—Metals—Surgeons†

CARL D. MARTZ, M.D.
Indianapolis

ORTHOPEDIC surgeons, by their very nature, find themselves concerned and active in human engineering with bone and metal. To the general fund of surgical knowledge they must contribute not only understanding of bone as a tissue and an organ, but also as the important structural member of the musculo-skeletal machine which provides body motion. Reinforcement and replacement of this structure by metallic device plunges into depths of metallurgy, stress analysis, engineering and design in which there are many unknowns. An area of bio-mechanics is emerging which combines the contributions of many special fields into an understanding of the mechanical aspect of body function.

Serious limitations exist in our understanding tools, materials, design and the strategies which are employed clinically. Surgery itself often seems to be that procedure which represents the best apparent compromise for the problem at hand.

Cooperation is needed between the surgeon and those who design, manufacture and test the devices used to reinforce or replace body parts. The problems common to all concerned must be described in a common language and the strategies, principles of design and technical practices planned for the solution of these problems be understood by all.

Stress analysis of metallic devices and of bony parts must be pursued to the point that we can understand and provide for the in-service loadings of ordinary life.

The determination of how much force will be exerted upon a device and how much force it will tolerate in a given interval of time can be and should be found by tests other than those in the bodies of patients.

Study of such loadings poses tremendous problems to physiologic experimentation and the modern spectrum of trauma offers such a bewildering mass of clinical data that it seems proper at this time to use as a thesis or model the natural strength of the bones themselves as the target for preparing reinforcement or replacement systems of bone and metal. Perhaps even greater strength may be needed, for bone is self restoring in relation to fatigue effects—metals are not.

Stress and strain in bones have been studied chiefly by three different methods: (1) Study of bone specimens, (2) Recording stress-strain phenomena in bone models, and (3) Analysing stress-strain phenomena in intact bones by the use of strain sensitive lacquers or the insertion of strain gauges.[3, 4]

The study of bone sections, gross and microscopic, has been historically the oldest and most extensively used and has given rise to the trajectorial theory of bone form and Wolff's law of bone transformation. Elaborate description, interpretation and conjectures have been presented by many students since the time of Galileo in 1638, Borelli in 1681, the Webber brothers in 1836, Von Meyer in 1867, Roux in 1885, Wolff in 1870, Koch in 1917, Janssen in 1920, Carey in 1929, Marique in 1945 and many others.[5, 14, 18, 7, 6, 2, 10] On the basis of such studies, a general law of bone (the adaptation of form to function) has been described mathematically and mechanically for the human femur and has been extended to other bony structures. Most of such ideas on the part played by mechanical stimulation in bone formation and architecture are still largely theory and need support from more experimental data. Evidence avail-

† Presented at the American College of Surgeons, Indiana Chapter, annual meeting, April 23, 1958. Indianapolis.

able indicates that mechanical stress is not the only or necessarily the most important factor responsible for the orientation and replacement of the osteon systems.[3, 4] A primary genetic pattern seems to be present in bone which may be influenced by congenital, developmental, nutritional and vascular conditions to produce changes in its internal and external architecture.

The use of models of bone for the study of stress and strain relationships has been used since the time of Leonardo Da Vinci (1452-1519).

Perhaps the most famous illustration is that of the mathematician, Culmann, in 1867, whose trajectorial diagram and comparison to a Fairbairn crane was popularized by Von Meyer.[14] Roux and more recently Milch and Pauwel have used photoelastic plastic models.

In more recent years the industrial technics employed for stress-strain analysis of engineering structures have been used on intact bone structure and both the strain sensitive lacquers and strain gauges have been used with actual loadings on bone specimens to determine the stress concentrations and breaking strengths. Companion studies have been made of metallic devices, separately and in combination with the bony parts which they reinforce or replace. Kuntscher, Evans, L. D. Smith, and others have used engineering testing technics in the determination of both static and dynamic loads to failure.[8, 3, 4, 17, 11, 12]

Physical properties of bone have been extensively studied as have been the physical properties of the common metals used in the preparation of devices. The reaction of such metal to bone is still under consideration and much is yet to be learned.

My own work has been concerned with the direct measurement of static loads to failure of bone and metallic devices used for the reinforcement or replacement of bone. Test materials consisted of metal devices of standard manufacture available on the open market and experimental devices made of some of the newer alloys. Bone specimens were random samples of about the same age, of equivalent moisture content and without apparent bone disease. I found the average femur head load applied in anatomic posture necessary to cause failure in the femoral neck to be about 1930 pounds.[11] In the femurs tested by the late Dr. L. D. Smith the average force was 2092 pounds.[17] It was an interesting

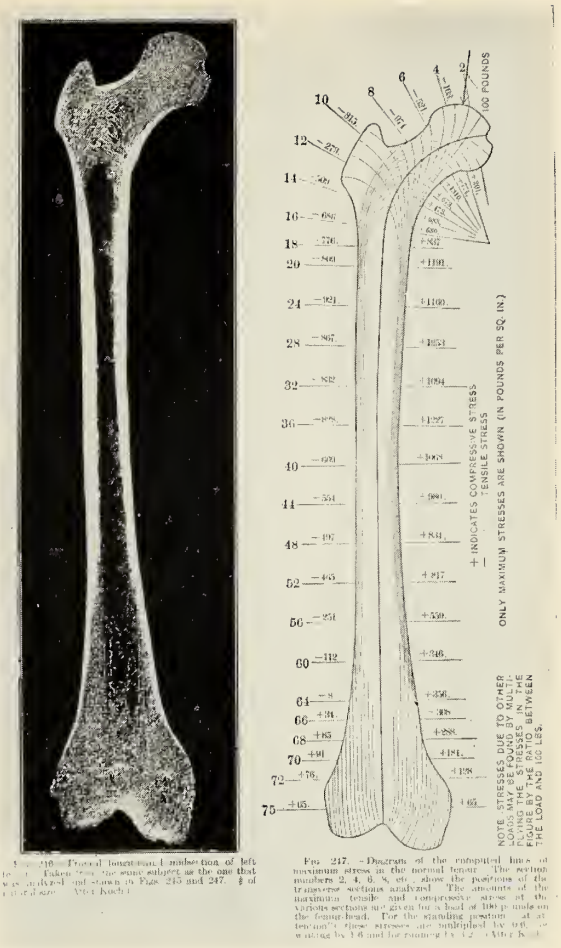


FIG. 217. — Diagram of the computed lines of maximum stress in the normal femur. The sections numbers 2, 4, 6, 8, etc., show the positions of the transverse sections analyzed. The amounts of the maximum tensile and compressive stress at the various sections are given for a load of 100 pounds on the femur-head. For the standing position, at attention, these stresses are multiplied by 0.6, or walking by 1.6 and for running by 3.2. (After Koch.)

coincidence to find, as I reviewed some of the literature, that similar findings had been made many years before by the Webber brothers in 1836, Messerer in 1880, Kuntscher 1935, and Evans in 1948.[13, 8, 3] Perhaps the most extensive of these studies was that by Messerer who found that the load to failure at age 25 equaled 2970 pounds, at age 32, 1870 pounds, at age 78 years 1870 pounds, and at age 82 years, 980 pounds.[13]

Koch's diagram of 1917, which was reprinted in Gray's Anatomy and is reproduced here, was a calculation by standard mathematical and engineering tactics for Koch was both a graduate engineer and a physician. His calculation of femoral neck strength was 1820 pounds.[7]

Insofar as the femoral neck then is concerned, it seems that we should provide for a femur head load tolerance in the vicinity of 1800 to 2000 pounds.

When studying Koch's diagrams it should be remembered that he considered the stress produced by a suddenly applied load without impact

to be double those produced by a gradually applied or static load of the same amount. He also asked that his diagram use factors of .3 for standing load on the femur head, .8 for the walking load on the femur head, and 1.6 for the running or climbing load on the femur head. A factor of safety of 5.68 was found to be present in the femoral neck structure with a still higher factor of safety in the shaft of the femur. Koch was satisfied that the inner structure and the outer form of the femur were governed by the condition of maximal stress to which the bone was subjected by the preponderant load on the femur head and thought that the adaptation of form to function held true mathematically and mechanically. Another of his interesting findings was that the tensile strength of compact bone is 230 times as great as muscle for a similar cross-sectional area and he calculated that the greatest possible action of all thigh muscles could develop only 1/7 of the strength of a normal femoral shaft. His study suggested that the inner architecture of the shaft was adapted to resist in a most efficient manner the combined shearing, axial and bending stresses of normal use.

Pauwel in 1935 represented the mechanical loading factor on the femur head to be 4 times body weight and his various calculations as brought to us in Dr. Blount's essay, "Don't Throw Away The Cane," are most informative. Still further study of his fundamental work is in order with particular reference to the manner in which muscles and ligaments act as traction braces to reduce the magnitude of stresses within the femur.[16, 1]

In the planning of reinforcement devices, recognition should be given to the role played by the supporting fibrous envelopes of periosteum, intramuscular septa, muscular components, and also to the apposed though broken bony fragments.

It would seem that the best guide in the light of our present understanding is to relate the strength of devices and their assembly to the test findings upon bone samples. These vary in accordance with the design and nature of the experiment. Static loads on femur heads bring tensile failure to the femoral neck at 1800 to 1900 pounds. Static loads on the trochanter bring tensile failure to the femoral neck at 560 pounds. Femoral shaft fractures have been recorded by transverse bend testing at 390 pounds and torsional tests have shown failure at 166-inch pounds. Dynamic loadings on femur heads brought failure in the neck and trochanteric areas at 327-foot pounds. From many studies of this type, common denominators will emerge and a reasonable target for imitation can be established.

Additional consideration should be given to endurance limits. This is the highest unit of stress to which a material or device can be subjected to a large number of successive loadings without evidence of failure. The ultimate strength of a structure can be related to endurance by factors of safety. This rule-of-thumb value is determined as the ratio of ultimate strength to allowable stress. For example, when a whole load or nearly a whole load is likely to be alternately put on and taken off, the safety factor to the engineer would be 5 or 6. It is interesting to again refer to Koch's work who calculated 5.68 for the factor of safety provided by nature in the neck of the human femur.

Using Koch's factor, an old lady of 120 lbs. should be provided a femur head load tolerance of about 2000 pounds for running up and down stairs. Is not this a reasonable target for the modern old lady and the modern fracture surgeon?

The problem of practical fatigue is removed somewhat from the realms of conventional testing and requires special tests of design as well as material. Studies of the part for locations of levels of stress concentration could very well precede the consideration of material. The "estimated life" as determined on full sized specimens with the stress concentration of service would be of most practical significance in the choice of device, after care, and performance expectancy in a patient.

Demands upon reinforcement devices are more difficult to determine than those of replacement devices, for little is known of returning strength gradient of healing bone. One of the few references to this phenomenon is that of Lindsay and Howes in 1931 who studied the breaking strength of healing fractures in rats. They found essentially no strength in the bone until 6 days had passed and a slow increase thereafter until the 21st day when a remarkable decrease in the breaking strength from 21 to 30 days was noted, and finally a gradual increase to normal strength by the 45th day. A firm callus forma-

tion was achieved by 25 days but vascular continuity in the haversion system was not achieved until after 35 days.[9] It is difficult to transfer this to the human skeleton for want of the proper reference factor but such data is to be preferred over the so-called time-tables of fracture healing in humans with little but conjecture for a basis.

The supporting role of fascial envelopes and muscle masses are of great help to the surgeon but little is known of the mechanical benefits that they provide. More than vague guesses, ancient or modern, are needed to guide in the use of supplementary fixation, walking aids and supervised activities.

Out-rigger devices such as blade plates, nail plates or plates with screws depend in essence upon the withdrawal and bending loads of the screws. Testing machine findings of individual screw fixations in cortical bone revealed withdrawal loads of 115 to 160 pounds and bending loads of 140 to 160 pounds which fall far short of the service loadings of 560 or more pounds in the trochanteric area. Even these withdrawal loads may not be achieved in clinical situations because of faulty technics employed by surgeons in drilling bone and inserting screws. Fundamental studies and recommendations of the Bureau of Standards and by Collison and Peterson have long been available. Accurate drilling, relating drill size to screw, machine threading and proper use of the screw-driver are all worthy considerations. Here, also, biologic reactions between the bone and metal become of paramount importance.

The serious problem presented by surface defects not only involves the manufacturer but definitely demands attention by the surgeon himself. Every technic that brings about scratching, bending or notching of devices should be discarded. This is essential, for it is surface defects that begin fatigue failures. Corrosion resistance depends almost entirely upon the preservation of optimum surface conditions. There is no excuse for roughening or bending a device designed to reinforce or replace a vital body structure. Even the use of engraved labels upon devices in any areas except those far removed from expectant stress concentration should be challenged. From the very beginning a surgical device should be planned to fit the problem or the solution of the problem should accept the surgical device without revision in the surgical theater. Cold bending of devices to fit surgical needs is to be condemned, for single bending may initiate failure in many commonly employed metallic devices.

Re-use of metallic devices, screws, plates and inserts makes them more liable to breakage in that internal and external defects may have developed in the course of prior use. Even thorough individual stress analysis of each part, a procedure routine to the automotive and aviation maintenance divisions, fail to reveal all of the accumulated stresses which develop within metals as the result of use within the body. Most often their removal involves surface marring by instruments used for the removal.

We still must learn more of the strength gradient of healing bone and of the strength provided in the efforts toward repair, remodeling and reconstruction. Testing of bone and metallic reinforcement or replacement devices should continue and determination should be made of the endurance or "estimated life" of these devices in normal use.

Orthopedic surgeons are studying with great care the behavior of metallic implants in the body and the reaction of body tissues to these implants and are presently endeavoring to win the cooperation of pathologists so that implants and surrounding tissues when removed will be studied in the same manner as other body tissues submitted for study. Accumulation of data concerning mechanical failure is imperative and such failing devices discovered in surgery or pathologic laboratories will benefit from further study by stress analysts and metallurgists. The Committee on Bio-Mechanics of the American Academy of Orthopaedic Surgeons is diligently endeavoring to pursue this search for information so that improvement in material, design and application of implants may be achieved.

An American Surgical Materials Association has been organized under the sponsorship of the American Academy of Orthopaedic Surgeons, the American College of Surgeons and the American Medical Association with a similar purpose on a much broader scale. The cooperation of surgeons everywhere in this endeavor would be most helpful.

912 Hume Mansur Bldg. (4)

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Find Out How the World Looks to Him

"Commonly, when the other fellow starts to resist your ideas, the very fact of his resistance is threatening to you, because it seems to be a criticism of your intelligence that he won't accept your ideas right away. So you begin to tense up and you redouble your efforts and, therefore, we find so often in communication the same situation you find on children's playgrounds and in international relationships—two parties screaming at each other, neither getting anywhere and neither understanding a word the other is saying, each of them intently pursuing his own purposes and banging away. Notice that the longer this goes on, the more likely that fighting begins in the playground or that shooting begins between nations. Because when linguistic means of attaining agreement fail, the only alternatives are non-linguistic means, which in the playground is fists and internationally is bombs and planes. The way to get out of this vicious circle of mutually mounting hostilities and threats and fears is to suspend the pursuit of your own goals and listen to the other fellow—find out how the world looks to him.

S. I. Hawakawa, Ph.D., from highlights of his address before AMA Woman's Auxiliary as printed in *A.M.A. Woman's Auxiliary Bulletin,* pp. 62-3, 1958

Some Current Concepts of the Treatment of Head and Neck Cancer†

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ALTHOUGH cancers about the mouth, face and throat are easily accessible for early diagnosis, cure rates are considerably lower than for cancer of some of the more inaccessible regions of the body such as cervix, rectum and breast. The low survival figures are in part due to failure of early diagnosis, but certainly in part due to the unwillingness of the doctors to accept a certain degree of functional disability and external deformity which is unavoidable if the cancer is to be approached with the same vigorous attitude that exists concerning the treatment of cancer in those more unexposed parts of the body. Block dissection of lymph nodes in cancer of the breast and radical removal of the lymph node bearing area of mesentery in cancer of the bowel are accepted procedures in spite of the fact that cancers in these two regions spread both by lymphatics and by blood stream; however, bloc dissection of lymph nodes of the neck has only recently become part of the armamentarium in the treatment of head and neck cancer, although it is well known that cancer of the head and neck spreads primarily by lymphatics; and there is a considerable time interval before thoracic duct invasion, hence blood stream invasion, occurs. During this period of time the cancer is still confined to a localized area of the body where it can be extirpated by either surgical or radiological means. It is indeed rare for cancer of the head and neck to terminate fatally as result of distant metastasis.

A review of statistics at one of our large private hospitals in Indianapolis reveals that during a three-year period from 1955 through 1957, 160 cases of malignancy of the floor of the mouth, tongue, lip, buccal mucosa, upper and lower gingiva, salivary glands, oral-pharynx, hypopharynx, larynx and thyroid were admitted and only 26 radical neck dissections were performed. There were no radical neck dissections in some 30 cases of cancer of the thyroid. There were 5 radical neck dissections in 52 cases of carcinoma of the larynx; 21 radical neck dissections in 78 cases of cancer of the oral cavity and pharynx. Undoubtedly a lot of these cases were inoperable when first seen, but I think that it is easy to see from these figures that there is some reluctance to accept this type of therapy in the treatment of these cancers.

Early attempts at surgical removal of cancer of the head and neck were abandoned due to high mortality and morbidity rates and due to rapid advances in the field of radiation. Occasional cures produced by radiation in extensive lesions led to acceptance of this type of treatment. However, as studies progressed it became apparent that the major factor in the x-ray failures was the presence of cervical metastasis. The inability of x-ray to sterilize the cervical metastasis again directed the thinking toward surgery as a salvage method. Although occasional cases of cervical metastasis have been successfully treated by radiation it is today generally conceded that block dissection of lymph nodes is the superior method of treatment.

In the last few years advances in surgery, such as perfection of endo-tracheal anesthesia, use of antibiotics, understanding of nutritional repair, blood banks, understanding of electrolyte balance and better understanding of the treatment of shock; advances in the knowledge of cancer, such as better understanding of the spread of cancer,

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* From the Tumor Clinic, Indianapolis General Hospital and Department of Surgery, Indiana University Medical School.

% OF LYMPH NODE INVOLVMENT IN PATIENTS WITH HEAD AND NECK CANCER

SITE	ON ADMISSION	LATER
Lip	24% (16-25)	9% (8-10)
Buccal Mucosa	36% (30-50)	15% (14-20)
Lower Gingiva	65% (34.5)	31% (15.4)
Upper Gingiva	38% (6-27)	19% (16)
Hard Palate	28% (22.6)	12% (8)
Soft Palate	58% (41)	29% (23)
Antrum	61% (29)	(15)
Tongue	71%	11 (40)
F/M	63% (34)	(24)
Tonsil	80% (68-76)	7% (29)
Pharynx	75%	

Table 1

better understanding of the origin of these tumors, and the knowledge that so frequently these cancers are of multicentric origin arising in pre-conditioned epithelium which is less radio sensitive than matured cancer; and a better understanding of radiation problems such as the previously mentioned inability of x-ray to sterilize cervical metastasis, inability of radiation to effect a cure of cancer which has already invaded bone, the problems of radio-necrosis with attendant pain and sepsis, and the low survival figures in the specific types of cancer such as tongue, led again to the consideration of surgery as a primary approach to the problem of head and neck cancer. So gradually the neck dissection, like the radical mastectomy and the abdomino-perineal resection of the rectum, has become a standardized operation in most localities.

Radical Neck Dissection

A few words may be in order about the procedure know as radical neck dissection, since this forms a basis for the entire treatment of the lymph node metastasis in head and neck cancer. By radical neck dissection we mean *en bloc* removal of all non-essential structures of the neck with associated lymph nodes, the lymph-bearing tissue and areolar tissue. The structures usually included in this dissection are external and internal jugular veins, the sternomastoid muscle, omohyoid muscle, superficial branches of the cervical plexus, the spinal accessory nerve, contents of the sub-maxillary triangle including the sub-maxillary gland and in some cases the digastric and stylohyoid muscles. In rare cases the phrenic and vagus nerves must be sacrificed and this is possible without serious consequence. At this juncture I would like to point out that the radical neck dissection as we know it today was first described by the father of one of our guests of honor at this meeting—Dr. George Crile, Sr. As early as 1906 this remarkable pioneer surgeon recognized the importance of removing cervical metastasis and his report on this method of treatment stands unique in that it remains accurate even to the present time. Not only did Dr. Crile practice the radical neck dissection but also reported on incontinuity dissections for both mouth and tongue lesions along with neck dissections. Radical neck dissection should be performed today with a surgical mortality rate not exceeding 1 to 2%, even when the operation is performed in unselected cases and despite any or all supposed medical contra-indications such as advanced age, cardiovascular disease, diabetic disease.

Incontinuity—Jaw-Neck Dissection

When mortality rates in radical surgery began to decline with the advent of the newer technics of surgery and physiology, attention was redirected to some of the more radical approaches to cancer in keeping with the concept of the ideal cancer operation. Work of Halstead in breast cancer, Miles in colon cancer and many others was sufficiently successful that it became apparent that

TABLE II — *Five-Year Survival Rates in Neck Dissection when Nodes are Positive: for Carcinoma of the Head and Neck (Combined Procedures not included).*

Site of Primary Lesion	Percentage of patients with nodes involved	Percentage of 5-year Survivals
Lip	1 to 30%	24 to 47.8%
Tongue	35 to 68%	4.6 to 21.7%
Gingiva	25 to 65%	25 to 26.6%
Palate	25 to 40%	10 to 30 %
Tonsil	58 to 87%	12.5 to 26 %
Buccal Mucosa	33 to 50%	29.6%
Floor of Mouth	25%	21.7%
Major Salivary Glands	32%	14.3 to 17.9%
Thyroid	34.8 to 75%	
Malignant Melanoma	49 to 60%	7 to 14 %

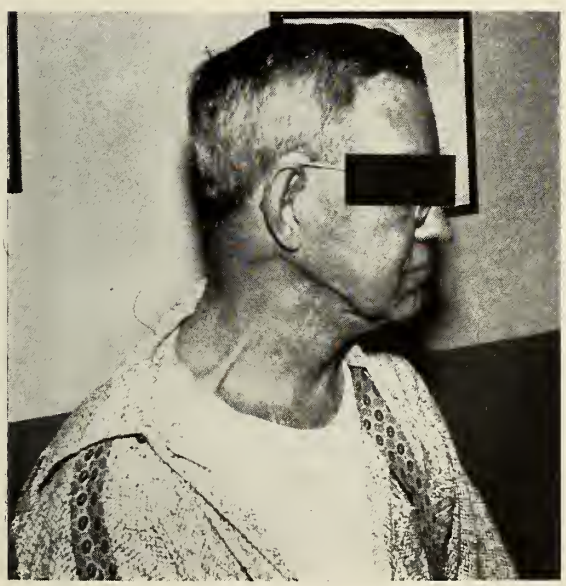
(1) Compiled statistics from the literature, representing highest and lowest percentage rates encountered.

Table 2

the ideal cancer operation was one which involved excision of the primary lesion, intervening lymphatics and regional lymph nodes. This concept was first applied to the surgery of intra-oral cancer by Dr. Hayes Martin and his associates at Memorial Hospital in New York. Grant Ward was another of the earlier perfectors of this type of surgery. Due to the propensity of cancer of the head and neck to remain confined to the head and neck in contra-distinction to some of the other types of cancers which spread by blood stream invasion rather early, this method on the grounds of logic seems much more applicable to intra-oral cancer than any other type of cancer. Slaughter states that prior to the application of the combined operation, his longest survival of cancer involving the mandible was 18 months. By using this type of procedure, many 5-year survivals are recorded and it appears that the percentage of 5-year survivals will be up 40%. The technic of this operation consists of the standard radical neck dissection with anterior limb of the incision extended up to the point of the chin, transecting the lip in the mid-line into the mouth, and sectioning the mandible in the midline. Considerable variations in the incision may be exercised, depending on the location of the tumor. If the lesion is in the tongue and a hemiglossectomy is necessary, the tongue can be split and the excision carried back as far as the anterior pillar; however, if the tumor occupies the floor of the mouth, the tongue may be spared if there is sufficient room to stay wide of the lesion. The amount of mandible to be removed depends upon the extent of the lesion and if there is at least one cm. distance between the mandible and the lesion, the mandible may be spared and sutured back in place, preserving the contour of the lower portion of the face. The surgical specimen then consists of one bloc including the contents of the neck, the floor of the mouth and primary tumor with or without mandible as the case may be. Reconstruction of the mouth is not too difficult; suture of the buccal mucous membrane to the tongue after mobilization of the mucous membrane results in a very satisfactory closure. The operation is usually done with a tracheostomy for a safety measure, and this can be removed whenever it is apparent that the patient is swallowing and breathing without difficulty. This procedure comes as near to satisfying the requirements of the ideal cancer operation as any that has been devised.

Carcinoma of Lip

Cancer of the lower lip can be successfully treated by either radiation or surgery. The advantages of surgery are that histological proof of diagnosis is obtained. Radiation results in a better cosmetic result in small lesions, but in large bulky lesions the cosmetic results are much better with surgery. Survival figures are probably equally as good with either of the two methods, and to some extent, the treatment is a matter of individual preference among surgeons. Survival figures in the treatment of carcinoma of the lip should be in the neighborhood of 60 to 80%; however, some 10 to 20% usually present themselves with evidence of lymph node involvement at the time of the first visit; in these cases radical neck dissection is a treatment of choice In the





Figs. 1 and 2 Routine radical neck dissection 3 years operative to show minimal deformity.



Fig. 3 Cancer of lower gingiva.

group of patients presenting themselves with lymph node involvement 30 to 50% will survive 5 years following neck dissection. Because of the fact that some 3 to 4% of people having clinically negative lymph nodes on microscopic examination will be found to have positive nodes and because possibly 2 to 3% of these will die of cancer of the neck, some people have advocated prophylactic neck dissection in this disease. Martin, however, in a series of some 237 cases, found that only 10% of the 237 developed cervical lymph node metastasis after primary lesions had been controlled. Of this 10%, 40% were successfully treated by lymph node dissection, leaving only 6% of the total or 1 in 16 cases in which prophylactic neck dissection would have proved of benefit. Considering this it does not seem feasible to do 16 unnecessary neck dissections in order to help one case.

Recurrences of lip cancer after the primary treatment must be individualized. Certainly if these cases do not seem too far advanced, but if lymph nodes are present, one should not hesitate to do radical neck dissection. Some, because of the midline location, will present with bilateral metastasis in which case if the node involvement is not too extensive, bilateral dissection can be done. This is not an operative procedure to be taken lightly but can be done satisfactorily and with reasonably lower mortality, especially if it is done in two stages with an interval between the two. The longer the interval, the less the morbidity. If care is taken and one keeps in mind the abnormal physiology involved in bilateral jugular vein ligation, this operation need not be considered too formidable a procedure. Indeed, in two of the larger series of bilateral neck dissections, that of Moore and Smith with 66 cases, and that of Bocca with 112 cases, there were no deaths and only 2 cases where alarming findings were present; that is, fall in blood pressure. Before leaving the subject of lip cancer, I should mention that there are certain cases in which the mucous membranes of the lip have been pre-conditioned of cancer. Slaughter has proven in some of these situations a multicentric origin of the cancer. Patients who have had x-ray therapy for benign conditions about the face and who have atrophic mucous membranes for other reasons, will benefit from the removal of this pre-conditioned epithelium.

Tongue

Aside from carcinoma of the lip, carcinoma of the tongue is the most common form of intraoral cancer; it carries a very poor prognosis for





Figs. 4 and 5 Patient same as in figure 3; 9 months post-operative after jaw-neck dissection.

many reasons. First of all, collected series from several sources including Martin, Wood, Wookey and several others reveal an incidence of clinically involved lymph nodes in from 35 to 68% of cases of cancer of the tongue when first seen. In addition to this, Ward states that some 14% of cases which have clinically negative nodes on admission will be found to have positive nodes microscopically after neck dissection has been performed. The figure of 19% is given by Taylor and Nathanson. Ackerman and Regato state that 40% of those without nodes when first seen will develop them later. Buxton reports 1 out of 3 cases with clinically negative nodes proved to be positive microscopically. Saphir reports that of nodes called negative on routine microscopic, 30% will be positive on serial section. A further breakdown by Taylor and Nathanson reveals that in patients whose primary lesion had been present for three months, 40% presented metastasis; 90% of those who had lesions present for 1 year had metastasis. Patients with lesions measuring 1 cm. in diameter, had an instance of 22% positive nodes, whereas those presenting a lesion of 4 cm. had positive nodes in 92% of the cases. Martin presented a series of 120 cases of carcinoma of the tongue which did not have cervical involvement at the time of admission and found that in this group, 30% developed lymph node involvement later. So from the above it is obvious that the prognosis in cancer of the tongue is very closely related to the fact that in addition to treatment of the local lesion there must be adequate treatment of lymph node involvement. That lymph node involvement is best treated by radical neck dissection is a point which is conceded by all concerned in the treatment of this condition. However, whether neck dissection should be combined with surgical excision of the local lesions, whether it should be combined with irradiation therapy or whether incontinuity dissection of the local lesions along with the neck dissection should be accomplished is a matter of considerable controversy. Some of the newer surgical technics have as their best recommendation the fact that miserably poor results have been obtained with former methods of treatment as evidenced by the following facts: Marchetta and Mattick, reporting on 247 cases from the Roswell Park Institute treated with irradiation methods but with no radical surgery, report an absolute 5-year survival record in 17%; 19.2% for cases involving

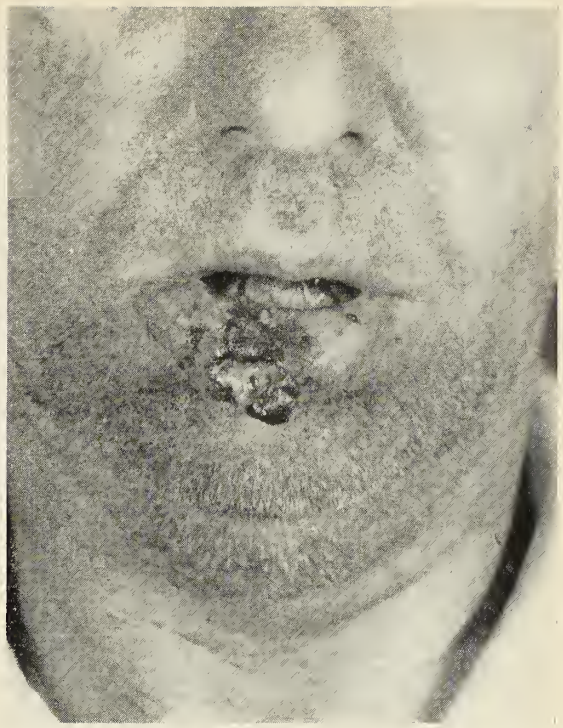


Fig. 6 Recurrent Cancer of Lip one year after radiation therapy; refused surgery at this time.

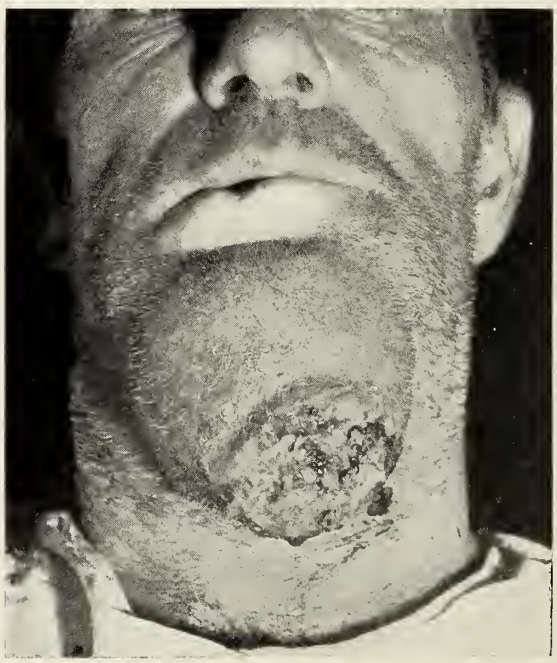
the oral portion of the tongue as opposed to 9.8% in cases involving the base of the tongue. In cases of the oral part of the tongue without lymph node involvement the survival rate was 29.3%. Of the 111 patients who had lymph nodes on admission only 3.7% lived 5 years. Baud reporting from the Currie Foundation cites the following figures for the anterior third of the tongue—15% alive and cured after 5 years; anterior two-thirds of the tongue—21% alive and apparently free of disease at the end of 5 years. Ash and Miller reporting on 394 cases of carcinoma of the tongue give an overall 5-year survival of 27.2% with irradiation methods. In 311 cases reported by Geschickter and Copeland treated by x-ray in combination with neck dissection, a 5-year survival rate of 16% was obtained.

It is probable that the above figures cannot be appreciably altered by substituting surgical treatment of the local lesion for radiation but surgical treatment does have several points to recommend its use. First, it is our feeling that a clean, surgical wound in the mouth will heal much more promptly and without the ulcerating septic mouth which is produced with radiation treatment, a more prompt attack on the neck nodes can be made after quicker healing of the

surgical wound. Second, if we agree with Slaughter that intra-oral cancer arises in pre-conditioned epithelium, then we must agree that the use of irradiation methods may be a means of producing a pre-conditioned or pre-cancerous type of epithelium which may at some later date undergo malignant degeneration. Third, the late side effects of irradiation therapy such as radio necrosis of mandible and soft tissues are avoided. Having decided on surgical treatment of the local lesion, the next problem is that of prophylactic versus therapeutic neck dissection. By prophylactic dissection is meant dissection of lymph nodes prior to the clinically evident cervical metastasis. Since it has been pointed out that such a high percentage of cases develop cervical metastasis at some time during the course of the disease and since it is known that cervical metastasis must be present for some time before they become clinically evident and since it is also known that the earlier the metastasis and the fewer number of lymph nodes involved the better the survival rates, it is my feeling that prophylactic neck dissection should be done in cancer of the tongue. Roux-Berger cited by Ackerman performed 105 therapeutic neck dissections in which lymph nodes were found to be invaded with a 5-year cure rate of 11%. He also performed 81 prophylactic neck dissections in which nodes were found to be invaded with a 5-year cure rate of 27%; this difference is considerably in favor of prophylactic neck dissection. Another fact which lends weight to the prophylactic neck dissection is that a number of patients would be lost through inoperability if they are not adequately followed. Certainly in patients in whom there is some question as to the feasibility of good follow-up, prophylactic dissection should be done rather than take a chance on waiting until metastases are too widespread to be amenable to therapy.

The last point of controversy in the treatment of cancer of the tongue is the role of combined jaw-neck dissections. Martin, Slaughter, Kremmen and others pioneering in this field report a definite improvement in 5-year survival figures. Slaughter reports a 5-year cure rate of 32% in 120 cases of combined operation and it must be remembered that this report includes many of his first cases in which the operation was used only for x-ray failures and for far advanced cases involving mandible. Modlin, in reporting 83 patient cases of combined operations for intra-oral cancer, reports 49% alive and apparently free of disease at the end of 5 years. Harrold reports that of 46 cases of intra-oral cancer treated by the combined operation 33.3% were alive at the end of 5 years without evidence of disease. Copeland reporting on a small series of 37 patients gives 5-year survival of 50%. While these figures are given for intra-oral cancers in general it is felt that tongue lesions closely ap-





Figs. 7 and 8 Same patient as in figure 6; 6 months later. Died few days later.

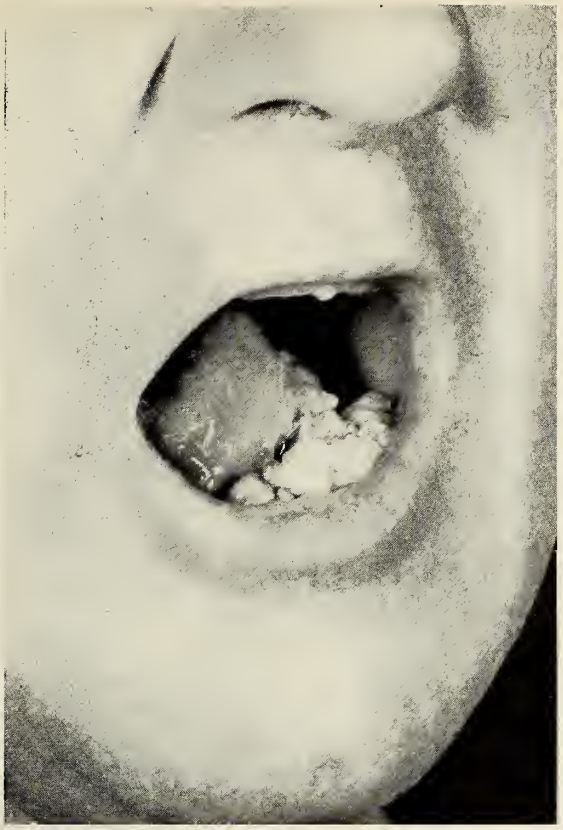


Fig. 9 Recurrent Cancer of floor of mouth.

proximate this same figure. To summarize, combined neck-jaw dissection is considered the treatment choice for operable lesions; surgical excision with prophylactic lymph node dissection would be a second preference, provided that the lesion was sufficiently small that it could be excised with a wide margin; or radiation therapy has its principal field of usefulness in the large bulky lesions of the tongue which are beyond the scope of local excision, followed by prophylactic neck dissection of the cervical lymph nodes. Recurrences following surgical treatment should be treated by irradiation methods in the same way that recurrences following irradiation can be only treated by surgical means. In addition to the above it is felt that radiation has no place where bone invasion has occurred; where there is also leukoplakia; in the very young; and in lesions known to be radio resistant.

Floor of the Mouth

In general carcinoma of the floor of the mouth presents the same general features which characterize carcinoma of the tongue. These include high-grade malignancy and early invasion of the adjacent structure including the tongue, gingiva and neck. Metastasis takes place early and frequently. Taylor and Nathanson reported that in 249 cases that are available for analysis, lymph node metastasis was present in 63% on admission. Martin and Surgarbaker reported metastasis in 34% on admission, while an additional 24% developed in metastasis while under observation. In the past, therapy for this type of lesion has been principally by radiation methods due to the fact that in order to perform more adequate surgery, radical excisions were necessary, resulting in very poor cosmetic result. The prognosis in patients treated by the combination of irradiation and the radical neck dissection is essentially the same as that of carcinoma of the tongue, perhaps slightly better. Some of the newer technics of radical excision either with unilateral or bilateral prophylactic lymph node dissections may increase the survival rate in this type of cancer. As yet sufficient numbers upon which to base any conclusions have not been done.

Buccal Mucosa and Upper Gingiva

These lesions are grouped together because of their generally similar characteristics which include late invasion of surrounding structures and metastasis which occurs in some 25 to 50% of the cases as opposed to the higher instance of metastastic disease in the more formidable types of cancer of the mouth such as tongue and floor of the mouth. The instance of metastasis in buccal mucosa is probably slightly greater than that in the gingival margins due to the greater mobility of the cheek in comparison with that of the gums. Where the lesion is still confined to the mouth and where bone is not involved, local excision and radiation therapy seem to be of equal benefit; however, if lymph node involvement is present in buccal lesions, radical excision of buccal mucosa and its adenopathy offers best chance of cure. Where definite mandibular involvement is present it should be resected along with the above *en bloc*. In the upper gingiva if the lesion is confined to one side of the face, radical excision of the maxilla with neck dissection if palpable nodes are present is the treatment of choice. If lymph nodes are not clinically involved an expectant attitude is justified, for here the number of cases which develop metastatic lymph nodes is somewhat smaller. Cer-

tainly irradiation therapy has little to offer in these cases.

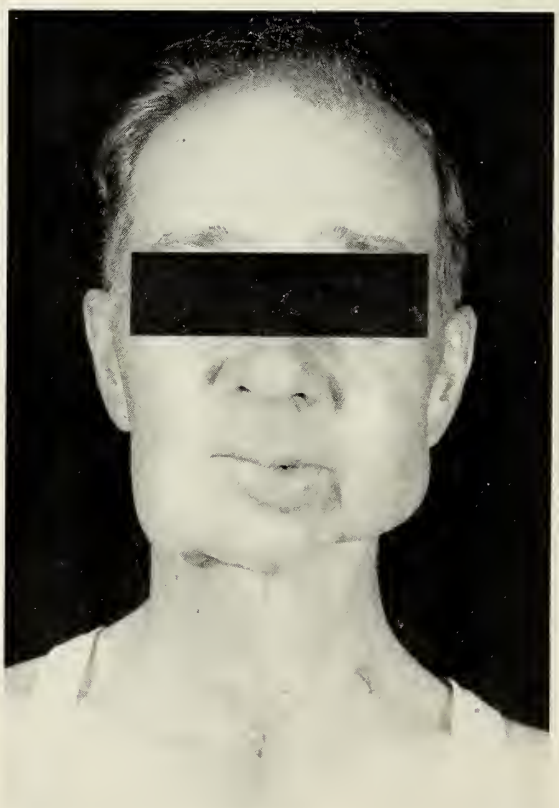
Lower Gingiva

This is another region which has carried a poor prognosis in the past. Some 65% of these cases have metastasis when first seen, with another 31% developing lymph nodes later. These awe-inspiring facts again point to a radical surgical approach. However, we do see occasional early lesions which are well differentiated and appear to be mere surface lesions. I am certain that either conservative surgery or radiation may be used in these with expectant treatment of lymph nodes, but if the lesion is very anaplastic, extensive, or if nodes are suspected, a radical approach must be adopted. Certainly wherever mandible is sacrificed, prophylactic node dissection should be done. That this approach is justified is proven by increase in survival rates from 25% with older methods to 45% with this approach. There are certain other areas such as palate, tonsil, pharynx, etc., which present individual problems.

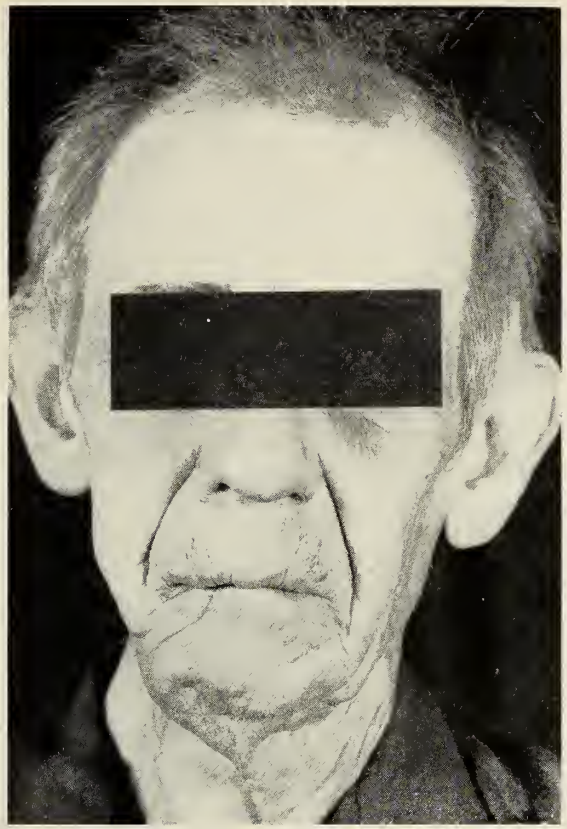
Conclusion

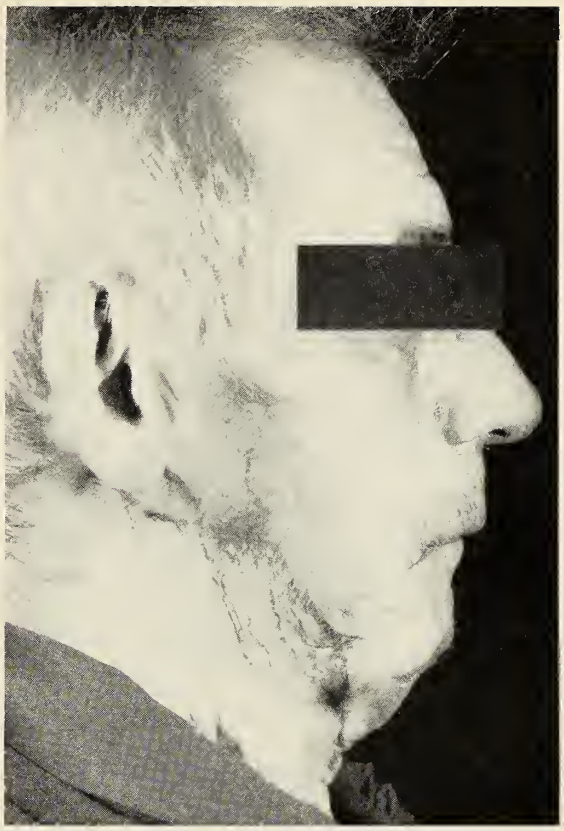
The authors do not present the matter of surgical treatment of cancer of head and neck as a panacea nor do they take lightly the splendid results of radiologic treatment in some cases by expert radio-therapists; but, it is felt that due to general dissatisfaction with survival figures over the country at large, more consideration must be given to this revised type of surgical treatment. Certainly all who embark on a course of extensive radical surgery in the treatment of cancer should approach their responsibilities with concern and caution. To do radical surgery, resulting in facial disfigurement on the people with tumors of high biologic activity with other factors which make a reasonable hope of cure questionable, is as bad as allowing the improper concern for cosmetic result to influence us to conservatism until a tumor has become inoperable. If these operations are done as palliative procedures, we should be certain that they will palliate. On the other side of the ledger, however, if one is fearful to apply these procedures in properly selected cases, let us point to the figures of Friedman and Ewing from Memorial Hospital in which 114 cases of combined neck-jaw dissections were done. Over 50% of these patients were in the seventh decade of life. The average operating time in these cases was from





Figs. 10 and 11 Same patient as in figure 9 after bilateral mandibulectomy and neck dissection.





Figs. 12 and 13 Post-op combined neck-jaw dissection for cancer of anterior pillar.

Percentage of Lymph Node Involvement in Patients With Head and Neck Cancer

Site	*On Admission*	*Later*
Lip	24% (16-25)	9% (8-10)
Buccal Mucosa	36% (30-50)	15% (14-20)
Lower Gingiva	65% (34.5)	31% (15.4)
Upper Gingiva	38% (6-27)	19% (16)
Hard Palate	28% (22.6)	12% (8)
Soft Palate	58% (41)	29% (23)
Antrum	61% (29)	(15)
Tongue	71%	11% (40)
F/M	63% (34)	(24)
Tonsil	80% (68-76)	7% (29)
Pharynx	75%	

3 to 6 hours; operative mortality .08%; 110 of these cases were ambulated on the first post-operative day; 94.7% who had pain were controlled with ASA, and their average hospital stay was 13 days. Another large series of cases reports an overall mortality rate of .6% and an operative mortality of 3% in patients over 60 years of age. So that even in the older age group these operations can be done, with reasonable mortality and with a good chance of increasing survival time or at least making patients more comfortable. With those who, on philosophic grounds, feel that a more conservative approach is in order, we will not argue; however, it is hoped that the foregoing statements help to clarify some of this apprehension concerning the surgical treatment of cancer of the head and neck.

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Modern Science and Civilization

"As an instrument, science can achieve either good or ill. That will depend upon the minds and spirits of those who use the instrument. Our natural and acquired capacity for extravagance, skillfully played upon by the sensationalists of the fleeting day, can too easily lead us to believe that the need for more scientists is such that all other higher studies should be subordinate; that the study of physical nature is the only thing that greatly matters; that if knowledge comes, wisdom will not linger. Believing as I do that science and wisdom have no necessary connection, and that scientific study and achievement are not ends but means, I am driven to the conclusion that what the scientists do or will do will put into our hands discoveries which can be the means of destruction or of a new and complicated form of technological slavery, but which, wisely used, can be the means of human salvation. The answer will depend upon our character, our broad intelligence, and our wise and understanding judgment."

R. G. Menzies,
in *The Medical Journal of Australia*
p. 516, Apr. 19, 1958
(Reprinted in *United States Armed Forces Medical Journal*)

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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THE AGED AND VOLUNTARY HEALTH INSURANCE

MEDICAL CARE for oldsters is the most important medical problem of today. Persons over 65 years of age require more medical care than those who are younger, and are apt to have less financial resources with which to provide it.

The older segment of the population is increasing rapidly. There are now about 15 million Americans over the age of 65. In 1975 it is expected that there will be at least 21 million.

The problem is real and urgent. The socialistic solution is outlined in the provisions of the Forand bill. The medical profession has and is insisting that the only proper solution is voluntary health insurance.

In view of these facts a recent government report is of especial interest.

A study by the U. S. Department of Health, Education and Welfare, made in June 1958, shows that the number of older people covered by health insurance is increasing even more rapidly than the group is increasing.

From March 1952 to September 1956 the number of senior citizens increased by 13%, those with insurance increased by 56%.

The growth trend holds true for all segments of the seniors. The number of persons in the 65-69 bracket increased by 7%, while the number of insured grew by 40%. In the 70-74 class, the

population went up 15%, those insured increased by 68%. Of those over 75 the figures were 18% and 87%.

The Health Insurance Institute reports that there are several means by which the older citizen may be provided with adequate insurance. One method is to allow workers to continue their coverage under group policies, or to convert to individual policies. Another plan is to issue new insurance to groups or individuals of advanced age.

Still another is the type of health insurance which becomes fully paid up for life at the age of 65. This enables the individual to pay for his protection while he is young and more productive.

So, it is apparent that voluntary health insurance is not only the best solution by far, but is also catching on at a phenomenal rate. Here is an opportunity for the medical profession to do everything within its power to accelerate the process to an even faster rate.

DEATH CERTIFICATES

USUALLY death certificates are completed at the proper time so that burial permits may be obtained and the services and interment may proceed as scheduled. However, there are occasions where the funeral director experiences considerable difficulty in obtaining a certificate from the attending physician. Instances have been cited in Indiana in which the funeral director was obliged to obtain his certificate from the health officer because of inability to secure it from the physician in the case.

Funeral directors have sometimes found it necessary to make several trips to the doctor's office, and occasionally are required to wait until all the patients are seen, before obtaining the certificate.

Although death certificates are important documents, the completion of one is not time-consuming. In the interest of good public relations it is wise to facilitate the legal steps involved whenever possible.

INCREASING HOSPITAL COSTS

"FORCES beyond the control of the hospital will continue to increase the community's hospital bill rapidly."

Higher hospital costs and some of the reasons therefor are the subject of discussion by Ray E. Brown, superintendent of the University of Chicago Clinics, in a recent issue of *Hospitals,* journal of the American Hospital Association.

Mr. Brown points out that there are many uncontrollable factors—cultural, economic and medical, coming into play to increase each community's total hospital bill. These factors are not only immune to the influence of the hospitals, but are also not subject to alteration by the medical profession nor by the public at large.

It is also pointed out that the factors under discussion are not amenable to state regulatory bodies, and will not be affected by changes in the basic laws.

One of these forces has been created by the increase in birth rate of recent years. The dependent child population is increasing at a much faster rate than is the population group between the ages of 25 and 64. Thus the number of dependents covered by a family certificate will be increasing at the rate of 33%, while the number of family certificates is increasing by 20%.

This change not only affects the utilization of the family certificate because of increased obstetrical service, which is rapidly approaching a 100% hospital procedure, but also increases the number of hospital admissions under a family certificate due to the greater size of the average family.

The rapid increase in the number of citizens over 65 years of age is also increasing the utilization of hospitals. Older people use the hospitals

more. The same trend is now observed in the age bracket between 55 and 64. In 1956 the Metropolitan Life Insurance Company found that the 55 to 64 age group used 193 hospital days per 100 individuals, whereas the 35 to 44 age group used but 64 hospital days.

The one decade bracket therefore utilized three times the hospital days as compared with the younger group. This ratio has, of course, probably always been approximately this large, but the differentially high rate of increase in the older groups places stress on the total hospital bill.

Mr. Brown pointed out that the "over 55 factor has seemingly been ignored in the free-swinging charges of over-use of hospitalization leveled at members of prepayment plans. There might be some connection between the increased utilization year-by-year and the increased number of individuals in the medically critical age group of those over 55."

The fact that Americans are shifting from rural to urban homes contributes to the increase in hospital usage. City dwellers use the hospital more than rural dwellers.

The growing nationwide accident rate and the fact that more and more married women are working and are, therefore, unable to care for sickness at home, are two other weighty factors.

New houses tend to be compact, the bedrooms tend to be smaller. Most new houses are more unsuitable for the care of illness than are the older homes. The more new homes are built, the more patients will be hospitalized.

All this together with the often observed fact that more people today are ready, willing and anxious to go to the hospital has slowly increased hospital utilization. It is an inescapable conclusion that as long as these factors are actively increasing the admissions per family, the hospital costs per family will also increase regardless of the basic hospital day cost. The cost of a hospital insurance certificate for family coverage must likewise increase in conjunction with its use.

LABORATORY FIRE HAZARD

A FIRE in a hospital laboratory is a catastrophe to be avoided at any cost. Loss of irreplaceable records and valuable equipment, injury to personnel and the loss of laboratory functions for considerable periods of time all add up to a high penalty for carelessness and failure to take proper precautions.

The National Fire Protection Association has published a 16-page bulletin which deals with the fire hazards and fire prevention for laboratories.

The use of much electrical equipment, and the presence of flammable liquids and open flames, necessitates the adoption of special preventive measures. Faulty construction, combustible interior finish and the lack of fire doors, fire walls and automatic sprinklers are cited as contributing causes.

Industrial and institutional laboratory fires have averaged one death or severe injury per fire during recent years.

The booklet contains an analysis of 50 fires, with comments to point out the most significant features of laboratory fire protection.

The bulletin may be obtained for fifty cents by addressing the NFPA at 60 Batterymarch St., Boston 10, Mass.

VENEREAL DISEASE IS INCREASING

ALMOST timely article, published in *G.P.* in April 1958 was excerpted in the fall issue of the bulletin of a large pharmaceutical laboratory.

It dealt especially with the problem of gonorrhea among adolescents. The gonococcus is becoming more resistant with time and the wider, greater use of our present antibiotic therapy. In spite of the spectacular success of antibiotics and sulfonamides, a million new cases occur annually in the United States, 20% in the 15 to 19 year age group. In our greater Indianapolis (city-county) area, 32.7% of the cases treated at the Indianapolis General Hospital alone were under 20 years of age.

Gelperin[1] suggests quite a few reasons. They are the seeming attitude not only among physicians, but among allied health professions, as well as the lay public, that our jokes and casual remarks are more important than public pronouncements. He asks, Are we, in reality, contemptuous of gonorrhea?

The higher incidence in the colored race is explained by the fact that more young white patients are treated by private physicians and are not reported, and that the clinic and the specialist no longer dominate the scene. "The much mentioned cooperation between practicing physicians and the health department must become a reality before effective control programs can be instituted and facts of the problem brought to light."

1. Gelperin, Abraham: The Continuing Problem of Gonorrhea Among the Teen-Age Group, G. P. 17, 93, 1958.

Gelperin also emphasized the importance of several causative factors. Among these are parents not knowing the whereabouts or associates and type of activities of their children, the lack of church attendance, and the lack of love and respect within the family. He states, "One might surmise that our youth is either misinformed or uninformed, willing to take a chance and also contemptuous of gonorrhea."

The last annual report for Indianapolis showed a sharp increase in rates from 172 per 100,000 population for gonorrhea in 1956 to 228.6 per 100,000 in 1957. Another alarming fact is that for the first nine months of this year, 1958, twice the number of cases of early infectious primary and secondary syphilis have been reported as were reported during the entire year 1957.

More careful initial and recheck examinations would prove that more of the so diagnosed "nonspecific urethritis," traumatic orchitis, Bartholinitis and pelvic inflammatory disease is actually gonococcal in origin.

An earnest plea is made for better and longer post-treatment follow-up, instead of the "treat and forget" attitude This would, we feel, help reduce the number of recrudescences and also many of the ping-pong infections in sexual partners.

GEORGE W. BOWMAN, M.D.,
Director, Division of Venereal Disease Control, City of Indianapolis.

What The Author Meant

Here is a sentence from a medical journal: "Experiments are described which demonstrate that in normal individuals the lowest concentration in which sucrose can be detected by means of gustation differs from the lowest concentration in which sucrose (in the amount employed) has to be ingested in order to produce a demonstrable decrease in olfactory acuity and a noteworthy conversion of sensations interpreted as a satiety associated with ingestion of food." All the author meant was: Experiments are described which show that normal people can taste sugar in water in quantities not strong enough to interfere with their sense of smell or take away their appetite.

RICHARD ASHER, M.D.
in *British Medical Journal*
p. 503, August 23, 1958

President's Page

As we start the new year, the cartoon showing the old man with a scythe, relinquishing his period of time to a baby representing a new year, brings to mind the problem of aging. This problem is becoming an important challenge to all people. The medical profession and allied sciences are mostly responsible for extending the length of life from 27 or 28 years in Caeser's time to nearly 70 years today. It is not enough that doctors be satisfied with prolonging life; we must maintain people's health, to permit self dignity, happiness, and a well functioning body and mind. We should not accept the idea that because a person has reached a certain chronological age he is old and should be set aside, so as not to interfere with younger, more active people running the business of living.

The physicians' scope of patient care has greatly broadened to include all the activities of the whole man. After a patient's illness has been cured or arrested, the physician must act as captain of a team of specially trained people to direct restoration of the patient to useful life in society. The physicians and medical societies should be the leaders in developing resources of allied groups of people in aiding rehabilitation. Every community should have systems or centers, or both, for restoration of the physically and mentally handicapped to enable these people to become taxpayers rather than welfare recipients. The senior citizen means more than just advanced age, for he may possess a mature mind, wisdom and skills that could benefit society. The housing of the senior citizen, with various degrees of illness, must be adequate and at a reduced cost that people can afford. In the less expensive facilities more time can be spent in rehabilitation with aid of paid and voluntary workers under the guidance of the family physician. The cost of medical care is of concern to all physicians, and we have always reduced fees or rendered no fees to those of lesser income. The AMA at the last interim session again urged all doctors to accept reduced fees from people of the retired older age group with reduced income.

Insurance companies should promote and offer a policy that will allow people to prepay their insurance before retirement, during their years of earning capacity, and then on retirement, the health and accident policy can be continued either by paying a low or no premium. Life insurance companies might consider converting proceeds of the paid up policy to paying premiums on a health and accident policy on retirement. All avenues of insurance should be explored for covering the older person for health and accident insurance.

We as doctors must assume more responsibility for improving the lot of the aging. It is better that we, rather than government officials, be the leaders and I urge our state medical association and every county medical society to work actively on the problems of the aging.

Happy New Year to all.

Kenneth L. Olson M.D.

Medical Panorama—

A. W. Cavins, M. D.

Terre Haute

LAMENT OF THE NORMAL CHILD

In Nov. 1956, the Florida Pediatric Society held a meeting at Clearwater and, among others, were fortunate to have Dr. Richard E. Wolf of Cincinnati, a pediatric psychiatrist, speak to them on behavior problems of childhood. The paper has now been published in the *Journal* of the Florida Medical Association, for October, 1958, and is worth anyone's time to read. Space forbids a long review, but at the end of the article is a quoted poem, said by Dr. Wolf to be anonymous, in which there is food for thought. It is entitled: "The Lament of the Normal Child."

I was strolling past a school house, when I spied a sobbing lad,
His little face was sorrowful and pale.
"Come tell me why you weep," I said, "and why you seem so sad,"
And thus the urchin lisped his tragic tale:
"My school you know is a modern school with numerous modern graces
And there they cling to the modern rule, 'Cherish the Problem Cases.'
From nine to three I develop me, I dance when I'm feeling dancy,
Or I lay on with my crayon the colors that suit my fancy,
But when the commoner tasks are done, deserted, ignored I stand,
For the others all complexes have, or a hyperactive gland.
Ah, how can I ever be reconciled to my hateful normal station?
Why couldn't I be a problem child, endowed with a small fixation?
Why wasn't I trained for a problem child, with an interesting fixation?
I dread the sound of the morning bell. The iron has entered my soul,
I'm a square little peg who fits too well in a square little normal hole.
For seven years in Mortimer Sears has the Oedipus angle flourished,
And Jessamire Gray, she cheats at play, because she is undernourished.
The teacher beams on Frederick Knipe with scientific gratitude.
For Fred, they claim is a perfect type of the antisocial attitude.
And Cuthbert Jones has his temper riled in a way professors mention.
I'm nothing at all but a Normal Child, so I don't get the least attention.
The others jeer as they pass me by. They titter without forbearance
He's perfectly normal they swiftly cry, With perfectly normal parents.
For I learned to read with normal speed; I answer when I am commanded.
Infected antrums don't give me tantrums, I don't even write left-handed
I build with blocks when they give me blocks; when it's busy hour, I labor
And I seldom delight in handing socks on the ear of my little neighbor.
So here, by luckier lads reviled, I sit on the steps alone.
Why couldn't I be a problem child with a case to call my own?
Why wasn't I born a Problem Child with a complex all my own?

Will all "do-gooders" in this field please notice?

The Physician's Role in the Social Security Disability Program

E. B. Haggard, M.D.* **

Indianapolis

† This article contains material prepared by Social Security Headquarters and distributed to the states for dissemination. Nearly every doctor in Indiana is involved in the processing of these cases; therefore, the author is issuing this material for the physicians of Indiana. Somewhere near the time of publication of this material, the Indianapolis Social Security office will mail to all members of the State Medical Association a pamphlet that will give in much greater detail facts and philosophy and background information about the evaluation of disability. It is suggested that this pamphlet be kept (as you probably kept the material on Back Disability that was issued by the AMA).

DOCTORS, hospitals, institutions and agencies who have contact with disabled people are frequently asked these days to fill out medical reports in connection with claims under the disability provisions of the social security law. These provisions protect severely disabled people in three ways:

1. Benefits are provided for insured workers age 50-65 who are no longer able to work because of an extended total disability. Beginning September, 1958, benefits may also be paid to certain of the disabled workers' dependents—namely, wives and dependent husbands who have reached retirement age, unmarried dependent children (including sons or daughters disabled in childhood), and wives, regardless of age, who have in their care children entitled to benefits.
2. Benefits can be paid to adult disabled sons and daughters of retired workers and of workers who have died. To be eligible for these benefits, the disabled son or daughter must have a disability which began before age 18 and has continued uninterruptedly.
3. Disabled workers, regardless of age, can "freeze" their social security records to protect their own and their families' future benefit rights.

To qualify under these disability provisions, a person must be unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration. A disabled worker must, in addition, have social security credits for work in at least five out of the 10 years before he became disabled and must be fully insured. The social security credits needed for a fully insured status vary from person to person, depending on age. Five years of work under the social security will be enough to meet the "fully insured" requirement through 1960. Anyone with 10 years of social security credits is fully insured for life.

Benefits are not payable for the first six months that a person is disabled. However, as in the case of the old-age insurance benefits, the law protects a person who delays filing his application for some time after he meets the requirements for payment (including the six-month waiting period), in that it permits back payments for as much as 12 months.

Workers with long-standing disabilities have until June 30, 1961, to apply to have their social security records frozen as of the time they actu-

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145 W. Washington St.

** See Disability Evaluation, J. Ind. State Med. Assn., p. 818, July 1957, E. B. Haggard, M.D.

Social Security

Continued

ally became disabled. In some cases this may be as far back as October, 1941, the first date when the work requirements could have been met.

Under the social security law the benefits payable to a child ordinarily stop at age 18. Where a disabled child was entitled to benefits before age 18, his benefits will be continued so long as he is disabled. Otherwise, his benefits begin when the parent on whom he is dependent becomes entitled to disability benefits (age 50-65) or to old-age, insurance benefits, or dies, regardless of the child's age at that time. In contrast to the applicant for disability insurance benefits or for a "freeze," the disabled child does not need a record of work under social security. The disabled child must, however, meet the same definition of disability as disabled workers. The mother of the person receiving this type of benefit may qualify for mother's benefits if she has the disabled son or daughter in her care.

All applicants, whether for benefits or for the freeze, are referred to their state vocational rehabilitation services. Payments to the disabled worker and his eligible dependents are suspended if the disabled worker refuses, without good cause, to accept available rehabilitation services. On the other hand, if the disabled worker accepts the rehabilitation services and performs work pursuant to an approved state vocational rehabilitation program, benefits may continue for as much as 12 months after he starts that work.

Applications under the social security disability provisions are taken by the 584 social security district offices, located in communities all over the nation. The social security district office gives the disabled applicant information about his rights, helps him to fill out his application and advises as to the proofs and documents he may need to support that application. **Under the law, the disabled person is responsible for furnishing, at his own expense, the evidence to show that he is "disabled" within the meaning of the social security law.**

His social security district office gives him one or more copies of a medical report form on which this evidence can be supplied. He is asked to take or mail this form to his attending physician or to a hospital, institution, public or private agency where he has been treated for his disabling condition. This report form, designed as a guide for the reporting physician, lists the kind of medical facts essential for the determination of "disability." However, the reporting doctor is not required to use it; if he prefers, he may make his report in the form of a narrative summarry or he may submit photocopies of the pertinent medical records. The completed reports are to be returned by mail to the social security district office (or to a state agency, if indicated).

By providing a full and objective clinical picture of his patient, the reporting doctor fulfills his responsibility to his patient, and incidentally, expedites the decision. To be of maximum use for the evaluation of a patient's capacity for work, the report should include a history of the impairment, the symptomatology, clinical findings and diagnosis. It should be noted that the attending physician is asked only to provide this type of objective medical data. He is not put in the position of having to decide the issue of "disability." The determination as to whether a patient is "disabled" must be made within the scope of the social security law; often it is based on evidence from more than one medical source. Also the determination must



take into account factors which are not purely medical—factors such as education, training and work experience.

After the applicant has filed his claim under the disability provisions, and furnished the supporting evidence, his case is forwarded by his social security district office to an agency of his state—usually the state vocational rehabilitation agency. Under agreements between the individual states and the Federal Government, these state agencies make the disability determinations for their own residents.

In the State of Indiana, the agreement with the Federal Government provides for the Division of Vocational Rehabilitation to make these disability determinations.

"Review Team"

The evaluation of disability is made by a "review team" in the state agency. There are at least two professional people on each team. One of the two is a doctor of medicine (often a practicing physician who serves with the state agency on a part-time basis) ; the other is trained in evaluating the personal and vocational aspects of disability. The team must decide whether the applicant is sufficiently disabled to prevent him from engaging in any substantial gainful activity within the foreseeable future.

In many cases it is necessary to write back to the reporting physician because the medical report does not contain enough clinical facts. As a rule, the kinds of medical facts that the attending physician needs in making his diagnosis and in treating his patient are the same as those required to evaluate the severity of impairments in disability programs. However, certain medical facts are more highly significant in disability evaluation than to medical management of the case. To evaluate the effect of the impairment on the individual's ability to work requires the kind of medical evidence that confirms the diagnosis and measures remaining functional capacities of mind and body. By furnishing complete and objective evidence, the reporting physician makes it unnecessary for the reviewing physician to "write back" for additional clinical or laboratory data.

Where the medical evidence initially submitted indicates a reasonable likelihood that the applicant is disabled, but more precise clinical or laboratory findings are needed to arrive at a

Continued on page 88

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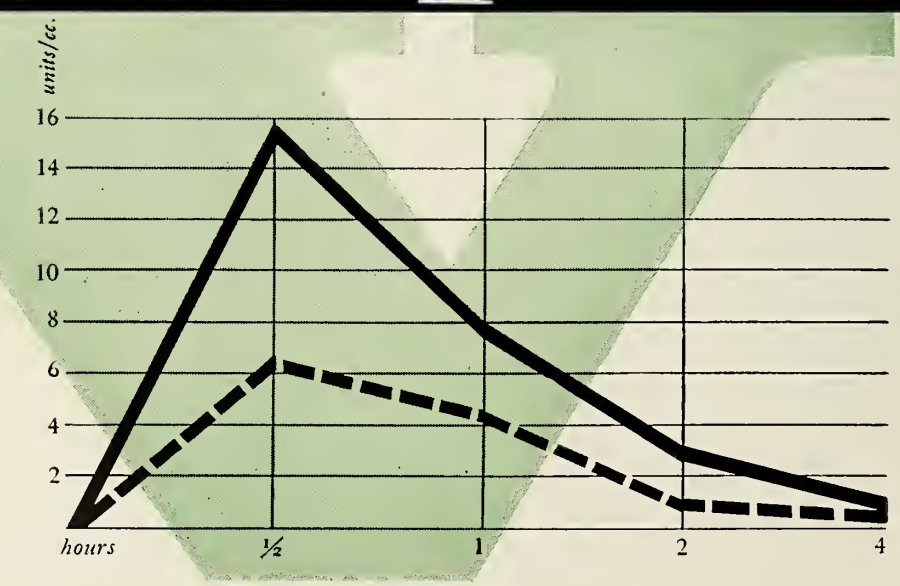
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Social Security

Continued from page 85

sound decision, or to resolve conflicts in the evidence, a consultative examination (usually at the specialist level) may be ordered to obtain additional information. Selection of consulting physicians and payment of fees are governed by state practices.

Some doctors feel that they should be reimbursed by the government for the cost of preparing the medical reports on their patients, and it is, of course, quite within their prerogative to charge the patient a fee for that service. However, under the law, the Social Security Administration cannot pay that fee; that is the individual's responsibility.

Other doctors are perturbed when asked to complete medical reports for individuals whom they may not have seen for years. In these cases, however, the physician is not expected to describe the present condition of the patient, but his medical condition as of the time he made his last examination.

Evaluation of Disability

The central purpose of disability evaluation is to determine remaining mental and physical capacities. To determine: (1) what the claimant has left, and (2) what he can do with what he has left.

A realistic evaluation of disability must be based on clinical and laboratory tests of the individual's ability to meet the metabolic demands of activity, to reason, to perceive and to perform certain basic activities such as sitting, standing, bending and walking. When incapacity results from severe impairment of one or more such functions, it is essential to establish not only the fact that functional impairment exists, but also its extent.

A brief discussion of disability from heart disease may serve to illustrate the kind of evidence needed to measure the patient's remaining functional capacity after appropriate therapy. Most frequently, impairments of the circulatory system produce loss of bodily function by reduction of cardiac reserve, or interference with peripheral vascular circulation. As a result the circulatory apparatus cannot meet effectively the metabolic demands placed upon it. The diagno-

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sis of the condition usually reflects whether the impairment is caused by valvular disease, myocardial damage or vascular pathology.

Cardiac size by X-ray or physical and EKG findings furnish objective proof of cardiac pathology. The amount of dyspnea or angina described in terms of the number of steps that can be mounted or distance in feet or blocks that the patient can walk is highly significant to evaluation of the degree of loss of function. The presence or absence of cardiac edema and response to therapy are also indicative of severity of cardiovascular impairments. The status of the pulse in the peripheral vessels may provide gross clinical evidence of impaired circulation of the extremities.

Impairments of the cardiovascular system may manifest themselves with dramatic suddenness; e.g., myocardial infarction, obstruction of vessels in peripheral or central nervous system circulation, lungs, and other visceral organs. The initial clinical manifestations are severe and the prognosis dubious. With survival from the acute stage, and appropriate therapy, substantial improvement can be expected over a period of time. A realistic evaluation of remaining function should be made after the convalescent period. Hence, the clinical and laboratory findings after maximum improvement from treatment are particularly valuable in making a determination of remaining cardiac, brain or other function. (Note that a "waiting period" is prescribed by law; i.e., the first monthly disability insurance benefit cannot be paid until the seventh month after the onset of the disability.) A description of the acute attack helps confirm the diagnosis and should therefore be included in the report.

Loss of function is evaluated on the basis of clinical and laboratory findings after maximum benefit from treatment. Clinical information concerning nature and response to treatment furnishes information on stability of functional capacity; i.e., a history of periodic decompensated heart disease, in spite of treatment, would indicate a comparatively severe condition.

More complicated tests of vascular function may be required in certain cases; e.g., arteriography. The reporting physician should not be concerned because he may not have equipment to perform these tests. A carefully performed exercise tolerance test (if not medically contraindicated) will almost always provide the clinical evidence needed to evaluate the degree of remaining function.

Conclusion

In developing evaluation guides for the use of state agency and its own technical and professional personnel, the Social Security Administration has had the continuing cooperation of a Medical Advisory Committee appointed by Commissioner Schottland in February, 1955. The committee is composed of recognized specialists associated with medical and allied professions in various fields outside government such as general practice, research, medical eduation, industry and labor.

The American Medical Association has cooperated with the Social Security Administration by informing its members about the medical aspects of the disability program, especially the preparation of medical reports. On June 1, 1957, the *Journal* of the American Medical Association carried a comprehensive report on the administration and organization of the disability provisions. Regulations on the meaning of disability appeared in the September 28, 1957 issue.

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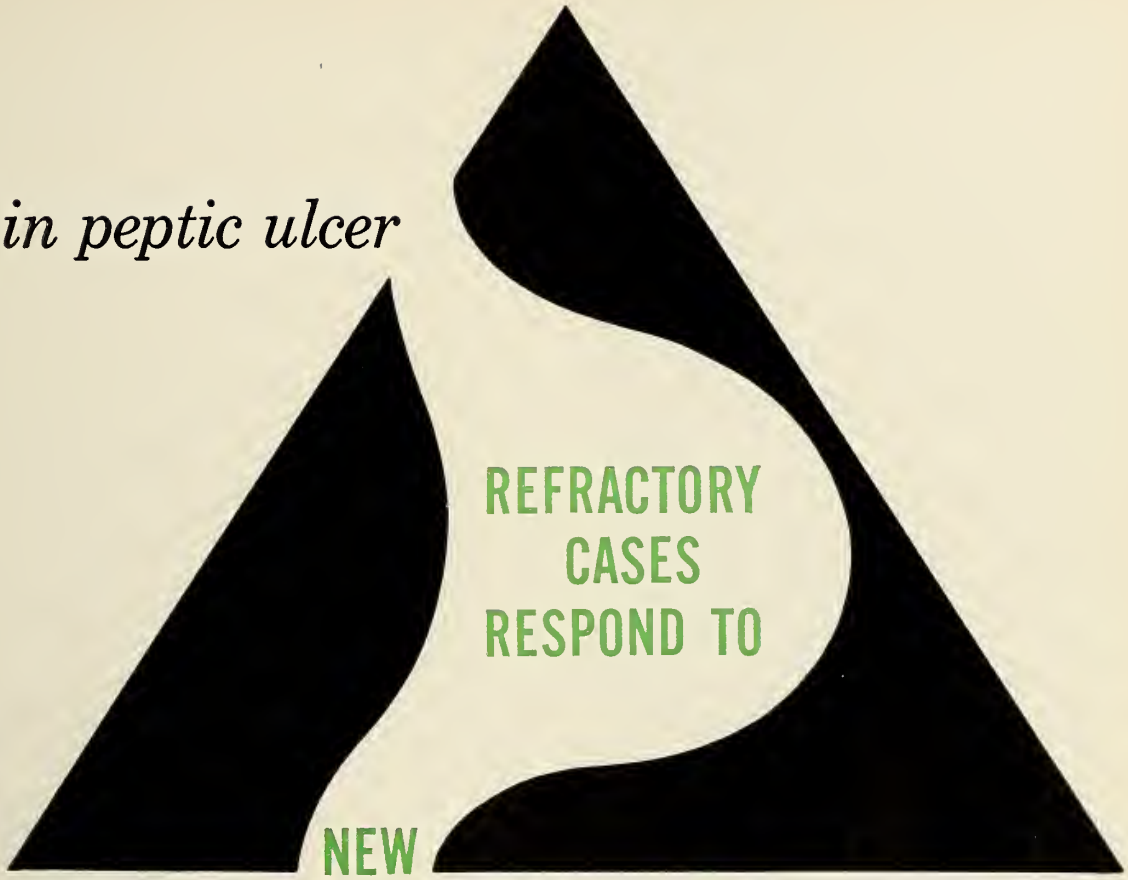
A. L. Marshall, Jr., M.D., *Director*

MONTHLY REPORT – NOVEMBER 1958

Disease	Nov. 1958	Oct. 1958	Sept. 1958	Nov. 1957	Nov. 1956
Animal Bites	326	784	448	205	226
Chickenpox	360	104	29	327	454
Conjunctivitis	40	41	37	30	17
Diphtheria	1	4	0	5	3
Dysentery, Unspecified	11	14	21	113	5
Impetigo	61	175	225	41	33
Infectious Hepatitis	11	17	11	18	13
Infectious Mononucleosis	7	19	6	1	0
Influenza	706	753	559	9186	55
Measles (Rubeola-Rubella)	270	171	89	48	208
Meningitis, Meningococcal	0	4	2	9	3
Meningitis, other	13	15	20	11	19
Mumps	147	87	45	357	115
Pertussis	91	147	155	35	22
Pneumonia	148	138	87	199	105
Poliomyelitis	22	39	33	14	48
Streptococcal Infections	232	372	250	159	189
Tinea Capitis	72	67	75	26	17
Vincent's Infection	3	7	1	3	5



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References: 1. Finkelstein, Murray: Journal of Pharmacology and Experimental Therapeutics, in press. 2. Winkelstein, Asher: Paper in preparation.

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Let's Keep It Simple†

LIEUTENANT COLONEL
SAMUEL McCLATCHIE, M.C.,
*U. S. Army**

FOR some time it has seemed to me that a euphoric fog permeates the American mind. We are, in spite of repeated warnings and occasional frights, in an astonishing state of complacency. Science moves ever outwards like the expanding universe and the progress has been feverish and fantastic in my lifetime. Where then lies this complacency? It lies in the assumption that our movement is always in the right direction, always an advance; that we do things better than our fathers did; that our present methods are best fitted to see us through whatever dangers may confront us. If atomic war does not come, these assumptions may not be challenged but if it does come, I, for one, am sure that our ways, based as they are on a highly technical and tightly integrated civilization, will have to undergo drastic changes if we are to survive.

That is why I have written this article. The viewpoint is admittedly controversial. To illustrate my points I have quoted medical articles and talked about procedures which are common practice and I have disagreed with many of them. No criticism of any person or institution is implied thereby. I merely present an opposed opinion in the forum of free speech. It is my hope that this will stimulate thought and discussion. If it does, some of that complacency of which I complain may well be dissipated, to our mutual advantage.

For the last half-century or so, the complexities of our civilization have increased in geometric progression, and with them the ultra-specialization of work. The Armed Forces have been seriously affected, partly due to competition for men trained in such specialties and partly to the inability of any one man to take over efficiently the job of another. Once upon a time the soldier had to fight, man to man, and almost any other soldier could replace him. Now the technological advances in supporting arms are so great that it is only under unusual circumstances that the infantryman, alone, can win battles. It is trite to say that the H-bomb confronts us with the end of this civilization. It is old stuff to say that after the H-bomb the only surviving fighting man will probably have to fight as an infantryman. But it may well be true . . . and what are we doing about it?

Knowing these things, we go on, thoughtlessly, becoming more and more dependent on our complicated machines and complex way of living. We seem to take pride in doing, by devious maneuvers, what used to be done simply. We love to do by machine what was done by hand. It was not done as efficiently, perhaps, or as often, but maybe it was done better. There is a law of diminishing returns in these matters . . . a law we tend to neglect in our routine-filled lives.

Let us suppose the H-bomb war does start. For the first time in a hundred years there will be devastated cities and dying civilians in the United States. The enemy, if he is smart, will

* Deputy Chief Medical Section, Army Section, Military Assistance Advisory Group, Taiwan, APO 63, San Francisco, Calif.

Lt. Col. S. McClatchie graduated from University of Toronto, Canada in 1939. Subsequently he served with the Royal Canadian Air Force, the Canadian Army and the Indian Army in World War II. In U.S.A. when the Korean War began, he joined the U. S. Army Medical Corps and served with the 27th Inf. Regt. in Korea. Subsequently among other assignments he was advisor to the Japanese Army, instructor at MFSS and Division Surgeon of the 82nd Airborn Div. He is now an advisor with the MAAG Taiwan.

† Reprinted from *Military Medicine*, official publication of the Association of Military Surgeons of the United States, Vol. 122, No. 4, pp. 247-255.

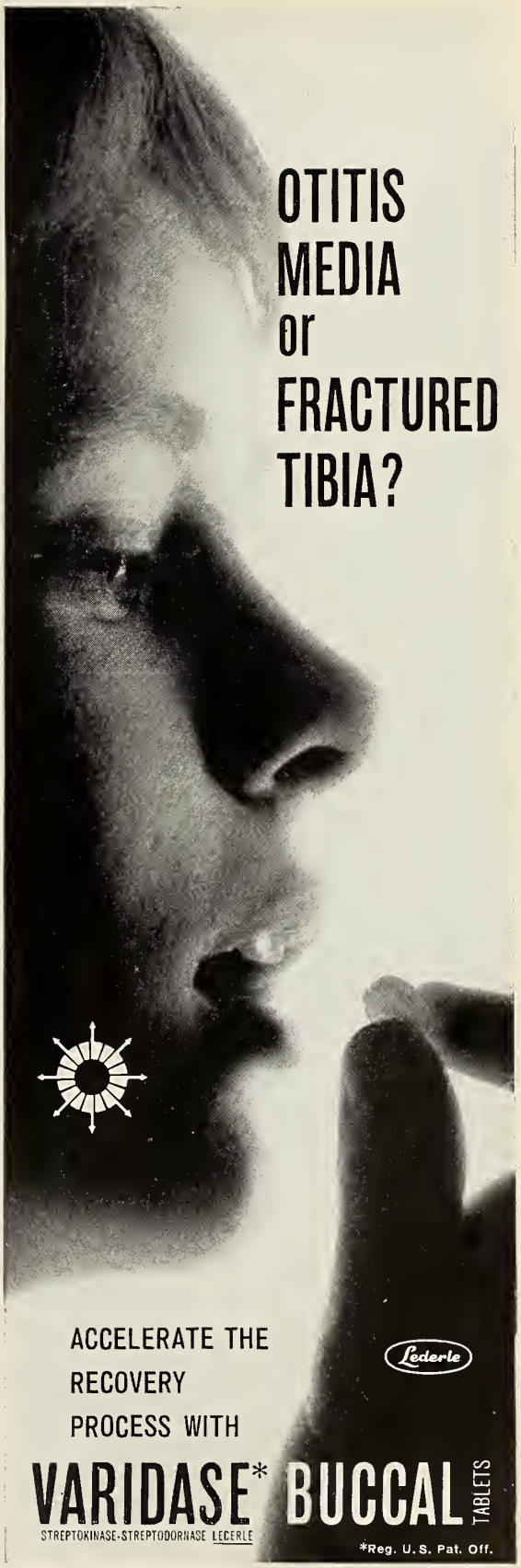
probably strike in winter, perhaps during the Christmas vacation when we are relaxed and disorganized and the cities are packed with people. We have read of the probable consequences but have we really visualized them? Of course we haven't because, even after two recent wars, very few of us have seen mass slaughter and destruction. And memory dies, even in man. The antelope walks past the lion who is eating his brother. We quickly ignore relatively minor horrors such as the Hungarian revolt and jive with Elvis Presley.

But we are talking about problems engendered by our complexity. Let me give some examples.

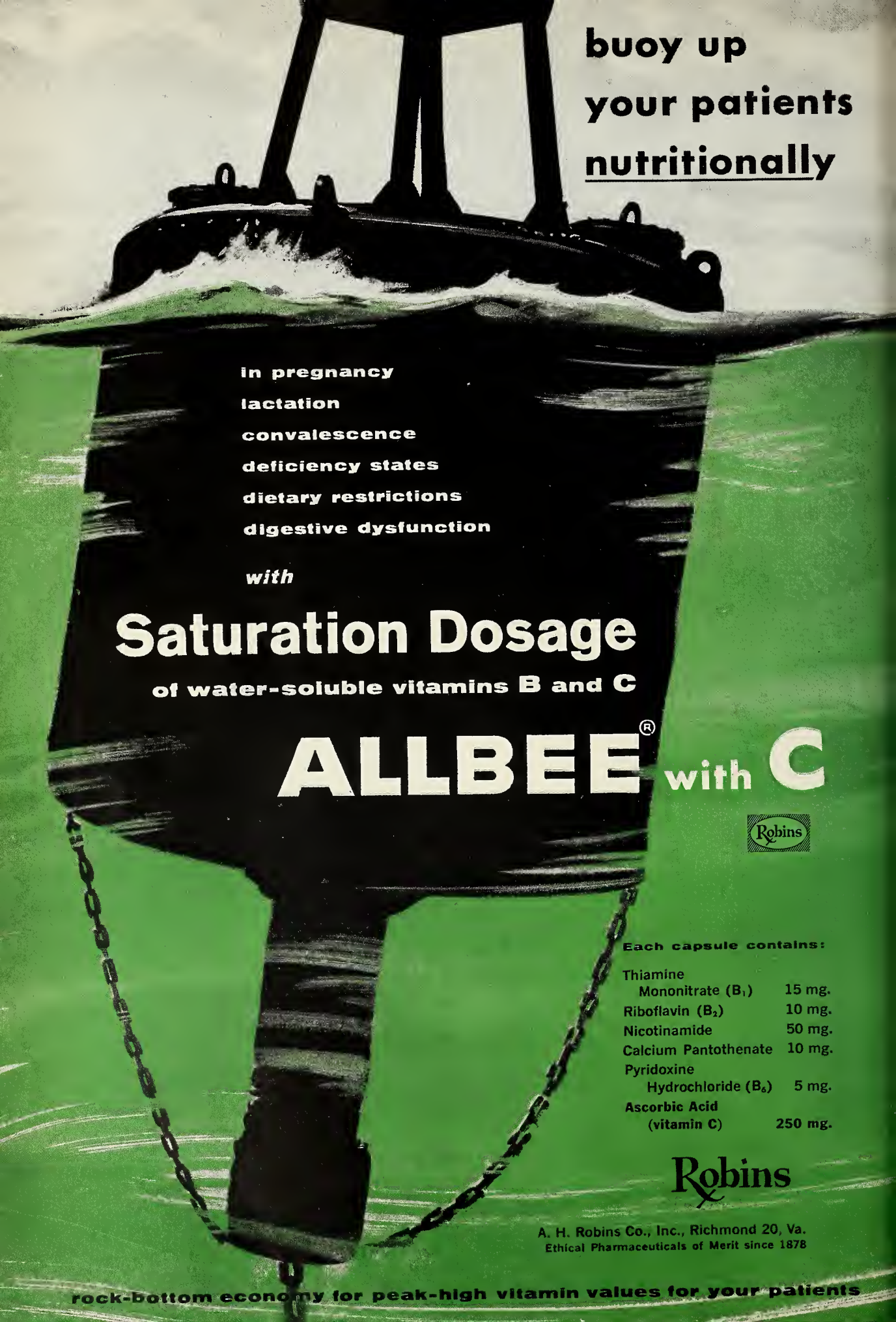
In the city of Vancouver, Canada, in the winter of 1956, a transformer in a key power station broke down in rush hour. It was dark. Traffic lights went out and, downtown, the worst jam in history defied police efforts for hours. Electric buses stalled in the streets made the problem worse. With the power off, furnace blowers stopped; houses got cold; dinners congealed in the ovens; housewives groped in the dark, trying desperately to remember where the Christmas candles were stored. Fortunately in the Northwest many homes have fireplaces, so they were not quite helpless. Outside the homes there was chaos. Gasoline pumps wouldn't work and cars ran out of fuel; bread production stopped in bakeries; milk bottles stood unfilled in the assembly line; meat warmed up in the refrigerators and bacteria stirred from their sleep and began to proliferate. The whole machinery of life halted. It was hours later, after power was restored, that life as we know it, returned to normal. And that was only a temporary block in our civilization's nervous system; one minute peripheral ganglion out of action!

Now let us go to Korea, early in 1951, to the Wolfhound Regiment on the line. There is a battle in progress and the casualties are coming in. The lights in the Collecting Station flicker as the generator, used all day to power the dentist's drill, and all night to light the treatment area, finally coughs and stops, worn out by overwork and lack of replacements. There are no old fashioned wick-type hurricane lamps in the modern U. S. Army Medical Company. Mantles and globes for gasoline pressure lamps are fragile and generators, supposed to take leaded gas, still plug up. All are slow to be replaced. We work, using electric torches, and

Continued on page 95



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Keep It Simple

Continued

the doctor, without a head lamp, does his best by the spot of light directed by a G.I. who should be busy somewhere else. (Nowadays the Aid Station probably would have a battery-power operating lamp, a big one of course, since he has a truck, but batteries "conk" out quickly in zero weather and the thing is impossible to carry unless you can use motor transport). The casualties are attended eventually using the torches, but the strain has been great and much time lost. Our complicated machinery, once it breaks down, leaves us far worse off than those who rely on simpler methods.

Up front the fight continues and the weather is bad. Supplies are desperately needed but the roads, churned to a pudding by countless wheels, are almost impassable. From the road's end there is still a long way to go. Weary soldiers and Korean porters (will we always have native porters?) struggle through the night along narrow mountain trails to bring up the ammunition and carry back the wounded. There certainly are not enough American litter bearers for the job and though the Koreans are worth any two Americans for carrying purposes, even they are exhausted.

Where are the mules? They are back in the Z.I. fighting a rearguard action against the internal combustion enthusiasts who, apparently never having heard of Italy or Korea, managed their expulsion from the Army some five years later. What about the helicopters? Well, it's a steep mountain, it's dark, it's sleeting and it's generally a hellish night, a not unusual thing in winter mountain warfare. So these overly praised, extremely expensive and definitely limited machines are grounded back at the MASH where the pilots, first class men by the way, can do nothing but play rummy and wait.

I understand something called an Airphibious Unit replaces "them ornery mules." But can this unit eat grass and keep going day after day? Can it fly regardless of weather and terrain? Will we risk such expensive machinery in a rain of shellfire like that we felt in Italy? Can the machines be replaced for a few hundred dollars? Can their pilots be converted from ordinary G.I.'s by the hundreds in a few weeks, without expensive training? Will we want such expensively trained and highly skilled men wasted in trying to save a couple of ordinary dog faces? We did it in Korea without enemy air opposition and with relatively little enemy shellfire. Will we do it where he has at least equality in the air and on the ground? These are rhetorical questions. To me the answer is an obvious "No." If for no other reason, we couldn't afford it, either in dollars or in men, in an all-out war. Then somebody will ask me . . . "Can you find the mules"? Unless we do something about it that answer will soon be "No" too. Incidentally, after the Suez canal was blocked, the price of horses in France rose astronomically. Tractors sat uselessly in the fields. Fortunately for the French they still had enough horses to get the ploughing done. What would we do here if our oil fields were blown up or sown with radioactive dust so we couldn't get at the oil?

It is still 1951, but summertime. A young keen medical officer comes to see me. He needs help from someone who once lived in a simpler way and fought a simpler war. His unit has pushed forward into the hills where roads cannot follow. The route back to the Aid Station gets longer and rougher. At last the Station

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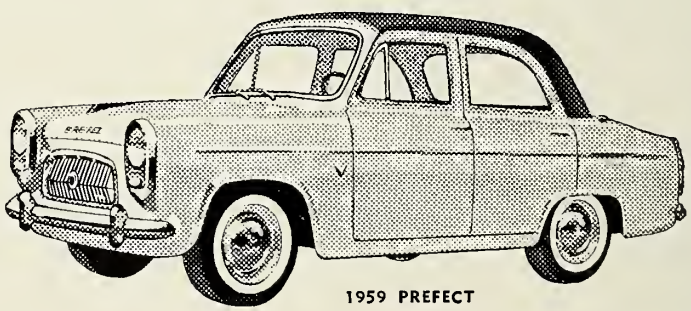
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must follow if it is to save life. But we are mechanized. Our equipment is packed in steel boxes designed to be dropped from aircraft, to be carried by jeep, to float in water but not upon the back of a poor medic. How many Americans today can pack 100 pounds over steep hill trails day after day? The French-Canadian voyageurs did it. The Chinese and Koreans can still do it, but legs used to being wrapped around a soda fountain stool will not endure such torture. So we scurry about and improvise light loads using borrowed infantry packs and away he goes. I tell him something about how to cross rivers without benefit of engineers and how to rappel down cliffs when there are no mountaineers to help. He has read about that a little. He has never done it because he was trained in San Antonio, where, since the drought, you can jump across the river, and the biggest cliff is a bank building. Our evacuation system depends too much on machinery; too much on getting mechanical transportation. We are not really trained for anything else.

We do carry a lot of equipment into battle. And we leave it there. Anyone who has ever followed an American force in war will no longer wonder why the natives are soon looking like soldiers. The countryside is strewn with excess equipment. We have equipment for hot weather; for cold; for dry cold; for wet cold; desert; jungle; dry heat; wet heat and so on. When we fight in territory where many of these climatic conditions may be present, the soldier, moving up to the Replacement Company, looks like Santa Claus staggering out for his first visits on Christmas Eve. It is true that other armies are never as comfortable as we are under any one set of conditions. We stay cooler, or warmer, or drier as the case may be, PROVIDED that we all have our gear; but once the fight starts and the infantryman must use his feet and carry his pack he starts to suffer. His field coat, so wonderful in the foxhole, is too heavy and he throws it away only to freeze when he stops to rest. His vapour barrier boots were warm and snug when he stood still. Now, after a long forced march his soft feet are bathed in sweat and the skin, if it hasn't peeled, looks like a washerwoman's hands. He hasn't a change of socks . . . why bother when the trucks constantly bring up fresh laundry? But the trucks

Continued on page 97

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Keep It Simple

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can't come today and the NCO forgot the routine foot inspection.

The emergency rations are a miracle of condensation but they get tiresome very soon. Our lovely field kitchens can't easily be manpacked into the hills. The marmite cans keep food warm only so long and the kitchen truck with the K.P.'s is still miles behind. Yes, the elaborate equipment is great, back in B Echelon, where the quick frozen turkey is now browning nicely in the ovens. But the doughboy who risked sneaking across the snow and mud at Cassino to trade cigarettes, lemonade powder and chocolate bars with the "Limeys" for a pan of poor but hot meat and vegetable stew and a steaming mug of tea, prepared right on top of the mountain under shell fire with the help of a portable blowtorch gadget, will never forget it. His young brother in Korea, alternately living like a king on steak, chicken, ham or turkey one week in reserve or on greasy cold hamburger patties, sausage or ham and lima beans, congealing almost as fast as they warmed over the little "canned heat" tablets, and washed down with lukewarm coffee powder . . . I'll not call it coffee . . . would probably agree. It is better to eat simple fare, hot and comforting, up front where it is really needed, than to feast in the rear echelon. Morale and hot food go together; both are needed in sight of the enemy.

What about our medical equipment and its use? One of the simplest items we have is the field dressing . . . the old Carlisle bandage . . . in various sizes. It takes a beating in its strong packet, it provides sterile dressing pad and bandage all in one. Yet I remember a Division Surgeon from Korea telling me it was no good. His units wouldn't use it because in our wealth of equipment, four-by-fours of gauze (in flimsy packets of doubtful sterility), cotton and roller bandages were also available. Three separate items were preferred to one! Why? Because these items were familiar in civilian life and nowhere, not even today, is there an adequate manual of instruction showing the multiple uses of this ingenious dressing. So, we still go on with hours of instruction on fancy spicas, spiral reverse bandages, etc., which, after years of soldiering, I still can't remember and almost

Continued

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Keep It Simple

Continued

never use. After I showed this Surgeon how versatile the Carlisle is, in its simplicity, he admitted he had neglected a very useful tool. Now, with ten million casualties lying around, wouldn't it be better to stockpile one item in its three sizes which we could load into open trucks with a steam shovel if we had to, rather than dozens of different sized packets of gauze, cotton and bandage?

The Army Leg Splint is another example. Simple to use, if used properly it is lifesaving, as World War I proved. Today, the young doctors, learnedly discussing Kirschner wires, Kuntscher nails, Smith-Petersen pins, pegs, plates, nuts, bolts and screws, have never used it and must be taught to regard it with proper respect. Judging by official reports from Korea and what I have seen, some of them never did learn, to the detriment of the casualty. The wire ladder splint is another simple gadget, almost as good in its way, and equally neglected. Many a patient was still being sent to the Receiving Section of the Army Hospital, where I last worked in the United States, with no splints on his fracture, when the dispensaries from which they came were supposed to have adequate supplies of this item. I cannot believe it was callousness and neglect. It must have been forgetfulness of the simple old rule "Splint them where they lie," plus a civilian tendency to send everything to the hospital in a panic, without thinking. When the hospital isn't just a few minutes away, what will they do? The old country doctor, knowing it would be a long time and a rough journey, carefully splinted the patient. Now, with the motor and smooth roads, the tendency is to skip the splinting.

I could go on enumerating examples gathered from two wars and some years as a general practitioner, but I believe my trend of thought is clear enough. My thesis is this. In a war which may disrupt our country so as to make highly integrated procedures and processes unworkable, victory is likely to go to the side which can most quickly and successfully revert to simpler, even to primitive methods; and further, the time to start using such methods, at least in practice, is NOW.

There are those, bound to our comfortable way of life, who will insist that "Science will find a way." To them that thought has almost religious significance. Perhaps they are right. But can we afford to be wrong?

When I say revert I do not necessarily mean retreat. I mean return in the sense of using older, simpler and still effective methods, but also I mean to use our science not to devise more complicated machines, but to simplify deliberately, in all possible ways, the new methods of doing things. We have already done this in many instances. Defense against tanks used to be limited to towed artillery which got bigger and heavier along with the tank. The bazooka, an essentially simpler device, changed the picture drastically. The recoilless rifles are doing the same in artillery circles. The jet engine, aside from metallurgical problems, is a much simpler engine than the piston-driven plane, and the ram jet is practically a flying stovepipe. Here we have simplicity made possible only by an advanced technology. Now the Air Force could fly its jets above me and I could use

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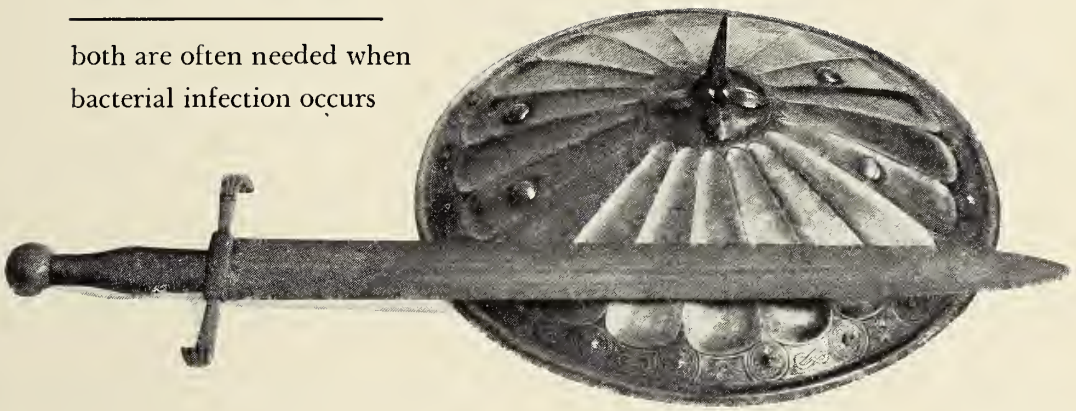
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Keep It Simple

Continued

that old hurricane lamp on top of the mountain, and we both would use the same fuel.

There are many other examples . . . printed circuits on ceramics in radio, plastic bottles for medicine and blood, antibiotics in disposable syringes and so on. Unfortunately some inventions tend the other way. The complicated modern truck is not as easy to patch up and keep running after minor breakdowns and the system of replacement is vulnerable to bad roads, shelling on roads and so on. Signal communication systems require experts to work them. I wonder if there is a set of flags or a heliograph outside of a museum and yet, if our cities were blasted, our radio batteries would be difficult to replace and telephone wire might become a priority item if power shortages halted our manufacturing plants for long periods. Radar, guided missiles, electronic computers and such items are terribly complex; their usefulness is undeniable. It is improbable that they will ever be simple but that should not stop us from trying. The American frequently links the words, "Bigger and better," as the core of his philosophy of life. It is not necessarily so. "Simpler and sounder" pleases me more. Certainly if we are to use the new atomic divisional groups to fight widely dispersed actions, we will have to consider, very seriously, the validity of these mottoes.

In addition to simplification of machinery, I believe we must simplify in other ways. One of these is planning. Not long ago an article on the U.S.S. Bennington disaster appeared in *Military Medicine*.[1] The procedures used in evacuation and treatment were admirably described, but I take issue on one major point. The author presented the article as "an object lesson for the management of possible disasters in the future." He also stated, "Duty sections consisting of six medical officers, four nurses and twelve hospital corpsmen were established on eight-hour watches for each of the four wards." This apparently was continued for 10 days. Yet the total number of patients hospitalized was 82. Unless I misunderstand him, this means a total of 72 doctors on duty or on call in one day for 82 men. I didn't count the nurses and corpsmen.

Now, I ask you, when the mass casualties amount to ten million, where are we to get the more than eight million doctors this sort of planning would require? And will we have time and facilities to work eight-hour shifts in well prepared hospitals? The experiences of recent tornadoes, explosions and so on will soon bring us to realize how impractical this all is. The article is an object lesson, all right. A lesson in how we will not be able to handle anything but minor tragedies! For two years during the Italian campaign I commanded an Indian Field Ambulance Company. Out of 50 men, I had two British medical NCO's and two Nursing Sepoys. The rest were tribesmen trained only in the most elementary first aid. They were stretcher bearers, cooks, sweepers, etc. Yet, in one night at Cassino, I evacuated about 100 men, Americans, British, Indians, French and Arabs. Now in battle there is room to attend to only a few men at a time because they have to be carried

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Keep It Simple

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about, given food or fluid, be documented, have medical treatment, be loaded on transport and so on. Most of the medical corps personnel, therefore, are not doing medical work beyond possible emergency first aid that all soldiers should know. To put it bluntly, there's room around the pot for only a few cooks. The rest might as well be helpers. In Korea, in the Aid Station of 1st Battalion Wolfhounds, I did much the same thing under rather similar circumstances. I had one officer (MSC) and 24 men in the section but, although in theory they were all well trained aidmen, in fact 16 of them were infantry recruits who had no medical instruction beyond what we gave them on the line because at that time aidmen were in short supply. The same situation held in the rest of the regiment.

As far as I can tell, our work with the Indians at Cassino and the infantry retreads at Kumwha was as good as at any time subsequently when, as Regimental Surgeon, I had so many medical NCO's I couldn't get privates for details. I honestly do not believe that we need as many highly trained men as our T/O calls for. What we do need is tough, experienced soldiers who can get the casualties out for treatment. In a war of movement and isolated actions this may be even more important than it has ever been before. The simpler the organism, the harder it is to kill. The same goes for organizations.

Another way of simplification is most unpopular but may well become necessary. I refer to austerity. I understand that in England, under strict rationing, the health of the people improved. It would be almost impossible, at least in peacetime, to deprive our boys of their soft drinks, ice cream, candy bars and such items as excessive food in the mess halls, in units where little hard physical work is done but the caloric allowance is the same as for active field soldiers. It would be possible, except for the national aversion to violent exercise, after graduation from high-school, to see that all of us got more physical training. These are questions of discipline and policy. I believe there is no doubt, medically speaking, that we would be in better health if such austerity were improved. I do not say I would like it. Football teams do not become fit by eating cream puffs and playing tiddley-winks, yet many medical corps units, knowing these things, still do not emphasize physical fitness, or, if they do, set a sorry example to their patients. Too many commanders take great pride in their football squads or other teams while neglecting the fitness both of themselves and their men. Sitting on the bench rooting for the team hardens nothing but the arteries and the tail end.

Are there other ways to simplify? Of course there are, and one of these is administration. A very detailed article on tracking down epidemics of diarrhea appeared this year in *Military Medicine*.[2] There is no doubt that, if the measures advised are taken, the epidemic should be traced. It refers to peacetime investigations of course and is intended for the use of dispensary, i.e. unit surgeons. Among other recommendations the authors suggest the printing of detailed questionnaires—preferably in large numbers, apparently so that the statistician gets enough for the "Chi-square" Test. There are numerous charts to be made out, groups of interviewers resembling the recent election pollsters, analysis of numbers and stool specimens and a great deal of telephoning, writing, calculating and so on. The crowning statement to my mind is "This system is characterized by the use of untrained personnel . . . and by statistical analyses so simple that they can be carried out successfully by medical officers . . ." and again, "Only a few hours time is required for interviewing an entire company and because the men are brought to the interview in increments, no man need be kept from his duties for more than an hour." That, to me, is the essence of peacetime garrison-type thinking! Except perhaps for units in reserve, it has no more applicability to a war or disaster situation than a station wagon has to troop transport. In the units in which I served in combat, such an investigation would have been impossible both because of time and space dispersion of troops, and because of a lack of personnel and equipment able to be spared from other essential activities of war. I cannot imagine myself trying to figure out a Chi-Square rule in a frontline medical company even if I could find the space for books or locate a statistician among the aidmen.

Why do we not get away from this peacetime complexity and use our brains instead to figure out what to do in war or chaotic situations? That's what we have an army for! And

Continued

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Keep It Simple

Continued

that's when the real epidemics break out too. I remember a typhoid epidemic among the refugees in San Marino after that tiny republic was overrun by the Germans. We did not have time to track down the source. We assumed that all the wells were contaminated and all civilian food sources suspect. We also had had our immunizations and we checked these as best we could at company level. It took only verbal orders to reiterate well known army principles such as "Drink only treated water; stay away from civilian food and drink." Then it was up to our disciplinary people—the corporals, sergeants and so on. We moved fast as the battle went on and none of my men got sick. Perhaps the statisticians following us had a field day with the case histories. In a real disaster they wouldn't have the time even if they could find the paper.

There are other examples of administrative complexity. On a recent overseas move I had so many copies of orders, amendments, etc., I could have written a book on the backs of them. Here is a fertile field for someone to save wood pulp. I travelled all over the world during the war with one little letter which I showed as I went along. Why can't we do it now? Medical records could be spruced up, I'm sure. We write letters to "get it on the record" so we can prove later that we said what we did. My foreign friends tell me we are a nation of paper shufflers. Having had to do things their way, for some years, I am inclined to agree. Perhaps the price of paper in their countries has something to do with it. But we may be lucky. The first H-bomb may knock out a paper warehouse or two. If it does, I shall expect to return to verbal orders. There may be more misunderstandings but I believe things will be done faster with no semantic double-talk in five copies.

Our MOS system also is very elaborate and looks good on paper, but my experience over the last few years is that, for every officer or man I get who really has the MOS I need, I probably get at least one other replacement who has never worked in the MOS slot he is sent to fill. I myself have had command, staff, parachute, pathology, internist and obstetrician MOS's in the past six years, and yet the only formal military or medical training I ever had, aside from internship and some pathology, was three weeks at the airborne school. Recently, with the loss of trained men, the situation has become worse. Why keep kidding ourselves? Let's have a few basic MOS's and simplify the whole business. We can't go back to the concept of the soldier doing everything, I agree, but we need not complicate our system unnecessarily.

One fertile area for simplification is in training. I refer, in the medical service, especially to the young doctors who "volunteer" for their two-year tour of service. Now these men are not interested in the Army or they would really volunteer for the Regular Army. We have to use them to our best mutual advantage. Therefore, it would seem logical that one should get as much WORK as possible from them and then let them go home, rather than to send them to school for training in organizational matters. Remember, nowadays most of them have just finished their internship. So where do they go? To military hospitals and dispensaries for the most part where they spend the rest of their tour doing what their M.D. and internship trained them for. Or some go to field units. Why don't we just assign these young men, as I and many others were assigned in wartime, to their units, and let the experienced officers and NCO's there tell them what they need to know. It would be just as good and a lot simpler.

The same holds true for the enlisted man after infantry basic or its equivalent, aside from some specialty courses, and I even wonder about many of these. In these budget-conscious days there is no place for all this "schooling," if indeed there ever was. The career soldier is a different case entirely. I have no objection at all to spending some time and money on him.

There is another way to simplify. This time I mean a reversion to older ways. In the medical field this could mean cutting out the multiplicity of drugs and equipment. If the A-bomb hits, generators will be needed badly back in the big hospitals where the power is cut off. I can do first aid by coaloil lamp, I'm sure, on most occasions, and certainly in such a disaster (but I've got to have the lamp on my T/E, not in some catalog). We could limit the variety of drugs and antibiotics. Those who want the latest model 1957 antibiotics should pay for them and the others, including me, get along with just three or four which are of maximum useful-

Continued to page 106

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every  antibiotic 



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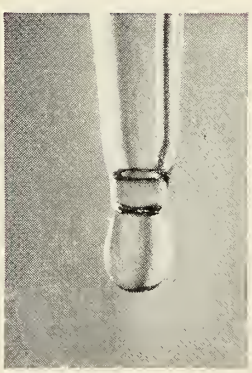
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Keep It Simple

Continued from page 104

ness, with a few others available only in real need, such as a demonstrated sensitivity or resistant organisms in serious disease. Nowadays in our military hospitals the choice of drug is not noticeably limited and some very expensive items are used unnecessarily. Simplifying labels and colours, shapes and sizes of pills would be a great help. In an emergency I haven't time to find out if X-mycin, a little blue pill, is the same as y-micen, in a green capsule, or Z-MIZIN, which is a red lozenge. It would be comforting in a disaster to say to the layman helping me, "Give these 50 patients Q-mycin" and know that he would find all the bottles the same, clearly labelled and with the adult dose on them.

The same idea holds in other departments. Let me tell you the tale of the shirt. The other day I went to buy a new summer shirt to go with shorts. They are undoubtedly cooler than slacks and long sleeves, so after laughing at our allies' knobby knees for the last 30 years or so, we have finally decided they aren't so stupid. But what do we do? We design a new shirt with the sleeves cut off and a different shape of collar, of the same color and material as the khakis. Why couldn't we just roll up our sleeves, and roll them down against the mosquitoes at night? It would immediately reduce by half the types of shirts needed. Now this cloth is heavy and hot . . . for durability, I suppose . . . of shirt, not of wearer. What's wrong with poplin? Our allies use lighter materials and think it worth while for comfort's sake . . . and they can't afford to waste money either. Using a lighter shirt for all three purposes would cut one more type from my wardrobe. One shirt, one shade, four uniforms! That would be simplicity. It may be good for a soldier's morale to have a varied wardrobe, but considering the cost in money, space and trouble I believe we are well into the curve of diminishing returns of which I spoke earlier.

Now all this talk of simplification is really just the preamble to the crux of the problem. Unless our philosophy of life is simple it is doubtful if we will ever turn from our present pre-occupations to another way. The old frontiersman, it seems to me, had an essentially basic hardiness of mind, what you might call a "down to earth philosophy" shorn of much of the rationalization which makes most of us reluctant to abandon our comfortable materialism. His life was a dangerous and lonely one. It might be said that he was constantly at war . . . with natural forces, with the savage Indians, the civilized British and French, and his own weaknesses, to which he could not pander and survive. Today our enemies are partly visible, in the Communist philosophy, but partly hidden, in the fallacies of our technological civilization. Being the more insidious they are the harder to fight. And we aren't as good fighters as that old-timer was.

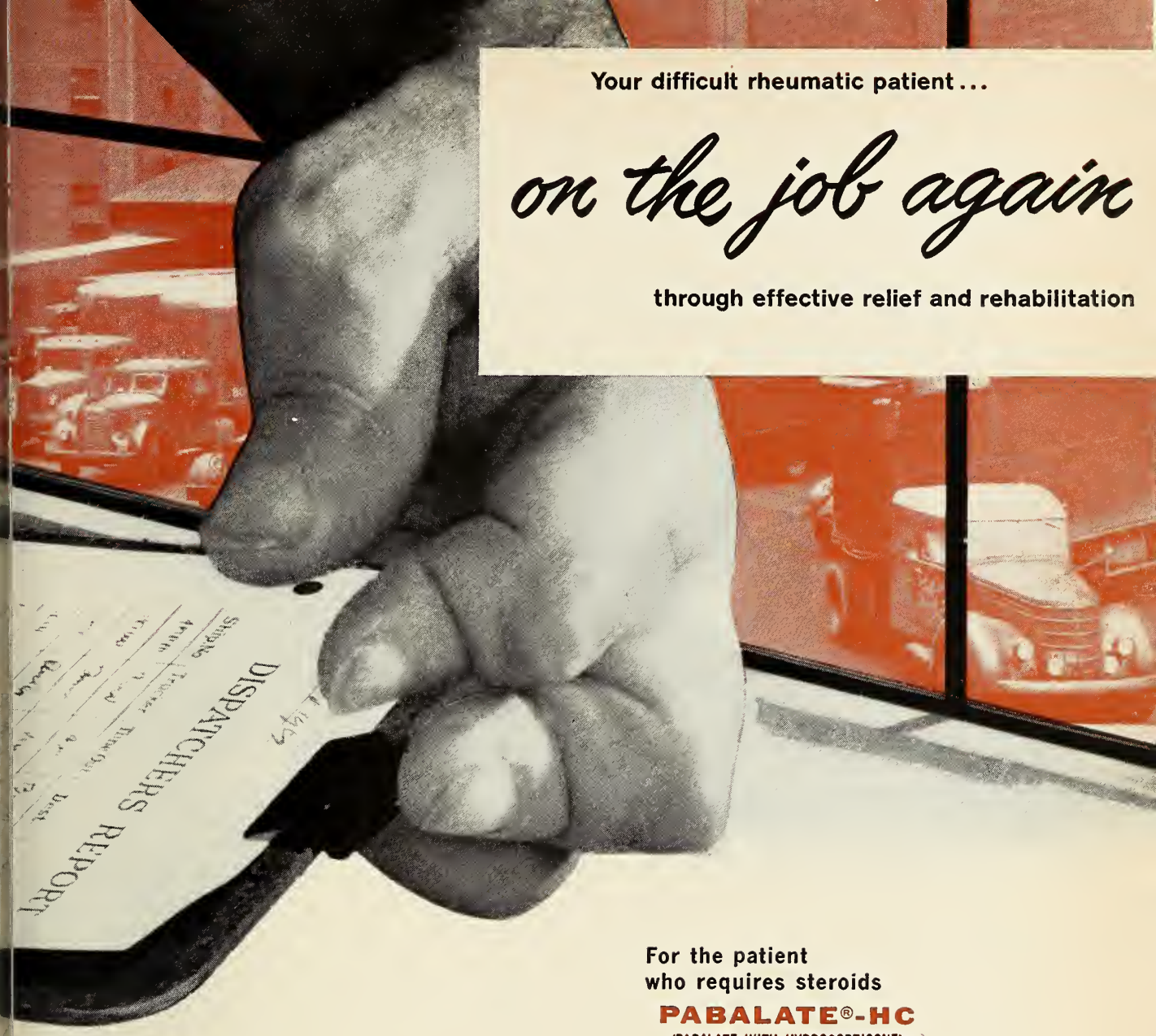
In conclusion, to comfort myself somewhat on this exposed perch that I have taken, I would like to quote an excerpt from a speech given recently by A. Whitney Griswold, President of Yale University, speaking on "The Liberal Arts and Democracy," at Hartford, Connecticut:

"This country began as a political and moral philosophy. Some day we materialistic Americans will rediscover the importance of these things which lie much closer to the source of motive in civilization than the mechanical marvels of its technology. When we do, when some miraculous power, which, let us hope, may not present itself in the form of atomic catastrophe, arouses us from our childish infatuation with toys and gadgets, we may discover how to supply the things we need to save our minds and our souls."

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1 The U.S.S. *Bennington Disaster.* Military Medicine, 116:278 (Apr. 1955).

2 Epidemiological Investigation of Diarrhea Outbreaks. Military Medicine, 119:11 (July 1956).



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NEWS NOTES—from State and Nation

Second SAMA Scientific Assembly Planned

Medical students, interns and residents are being urged to participate in the second annual national Scientific Exhibit Assembly of the Student American Medical Association to be held in Chicago next April.

The program was inaugurated in 1958 and is dedicated both to the contributions of medical students to research and to the advancement of the scientific exhibit as a primary medium of communication in the profession. It is hoped that new physicians will contribute to their colleagues' knowledge through exhibits and papers throughout their medical careers.

Arrangements have been made for more space to hold a total of 40 scientific exhibits, the best work presented in this medium of professional communication by the country's outstanding students, interns and residents. Of these, 20 will be by students and 20 by interns and residents.

The SAMA-Lakeside Laboratories Awards will again be given, with the special honor of free all-expense trips to the American Medical Association convention and the privilege of exhibiting in the AMA's own world-famed scientific assembly, for the top student and the top intern or resident.

Cash Prizes

Cash prizes and plaques will be given, with $500, $250 and $100 for award-winning exhibits by students; and $500, $250 and $100 for those by interns and residents. Lakeside Laboratories supports the awards and the trips to the AMA.

A distinguished group of judges will again make the decisions.

SAMA believes this program is a real opportunity for all medical colleges and teaching hospitals—students, faculty and hospital staff alike—to report on their work nationally and to be recognized for their contributions to new medical knowledge.

Applications must be obtained from SAMA (address Mr. Russell Staudacher, Executive Secretary, Student American Medical Association, 430 North Michigan Avenue, Chicago 11, Illinois) and returned no later than February 1, 1959. On February 14, the 40 chosen exhibitors will be announced. These must complete their exhibits and ship them to Chicago at their own expense, for inclusion in the SAMA scientific assembly, April 30-May 2.

Space and basic materials such as backdrop, table, chairs and lighting will be provided free by SAMA.

Last year, SAMA was particularly pleased that the top award-winning exhibit by a student, Quinton Callies of Wisconsin, was also exhibited at the American Trudeau Society, as well as at SAMA and AMA, and the study was published in the *Journal of the AMA.*

I.U. Gains Hi-Speed X-Ray Processing

Automatic processing of X-ray films, speeding interpretation and diagnosis, has been inaugurated at the Indiana University Medical Center through the installation of an X-Omat Processor in the Department of Radiology.

Major advantage of the new equipment is that processing and drying of the film is accomplished in six minutes, one-tenth of the time required under former hand methods. The new equipment, developed by Eastman Kodak Company, will be particularly valuable in surgical procedures and in emergency cases where rapid diagnosis is essential.

Members of a survey team from the National Institutes of Health spent several days at the Indiana University School of Medicine during December as a part of a study of 20 medical schools to determine the effect of U. S. research and other grants upon medical schools throughout the nation.

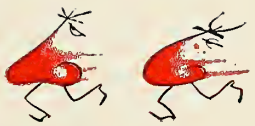
Allergy Course Planned

American College of Allergists Graduate Instructional Course and Annual Congress has been planned for March 15-20 in San Francisco. It will be held at the Mark Hopkins Hotel. For information, contact John D. Gillaspie, M.D., Treasurer, 2049 Broadway, Boulder, Colo.

Continued



running noses



and open stuffed noses orally

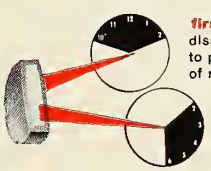
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News Notes

Continued

Ob-Gyn, Part II, Exams Scheduled

The next scheduled examinations for oral and clinical candidates (Part II), American Board of Obstetrics and Gynecology, will be conducted at Edgewater Beach Hotel, Chicago, by the entire board May 8-19. Formal notice of the exact time of each candidate's examination will be sent him in advance of examination dates.

Candidates who participated in Part I exams will be notified of their eligibility for Part II as soon as possible.

Current bulletins of the American Board of Obstetrics and Gynecology, outlining requirements for application, may be obtained by writing the secretary, Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

Appointment of Dr. Michael H. Travers, manager of the V. A. Hospital at Fort Wayne, as director of domiciliary homes for V. A. in Washington, D. C., has recently been announced by the Veterans Administration.

Mayo Program Planned Again

Staff members of Mayo Clinic and Mayo Foundation for Medical Education and Research will again present a 3-day program of lectures and discussions on problems of current interest in general medicine and surgery. Dates for the program have been set for April 13-15.

Up to 21 hours of Category I credit may be obtained by American Academy of General Practice members who attend. There are no fees for attending.

Number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with the Clinical Reviews Committee, Mayo Clinic, Rochester, Minn.

I.U. Postgrad Courses Listed

Forthcoming postgraduate courses in medicine, cardiology, anesthesiology and orthopedics at the Indiana University Medical Center during February are:

Heart Symposium (8th Annual)—Weds., February 11.

Anesthesia for General Practitioners and Part-Time Specialists—Weds. and Thurs., February 18, 19.

Backache—Weds., February 25.

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News From Indiana Medical Assistants

AAMA Gets Chicago Headquarters

Twenty-eight medical assistants from Indiana attended the American Association of Medical Assistants Convention in Chicago at the Palmer House, Oct. 31, Nov. 1-2, 1958.

Chicago was chosen for the National A.A.M.A. headquarters and members also approved the appointment of an executive secretary. The headquarters will be located in the Boyce Building, 510 North Dearborn Street, and the office space was offered rent-free to the A.A.M.A. by the Medical Dental Hospital Service Bureaus of America until larger quarters may be needed.

Indiana was honored by the appointment of Dr. Robert Allyn Royster, Evansville, as a national medical advisor of the A.A.M.A., and Miss J. Marie Theobald, Indianapolis, was elected to a 2-year term on the Board of Directors.

In 1959 the A.A.M.A. Convention will be held at the Benjamin Franklin Hotel, Philadelphia, October 16-18. In 1960, Dallas, Texas, will be host to the A.A.M.A. Convention.

Speakers at the banquets were Dr. Morris Fishbein, Chicago, on Friday evening, and Dr. Robert J. Samp, Madison, Wisc., on Saturday evening.

Following the dinner Saturday newly elected officers were installed in a candlelight service by Miss Barbara Wade, Los Angeles. Officers for 1958-1959 are Mrs. Lucille Swearingen, Oklahoma, president; Mrs. Marian Little, Iowa, president-elect; Mrs. Virginia Dougherty, Pennsylvania, vice-president; Miss Lois Pluckhan, Wisconsin, recording secretary, and Mrs. Juanita Ainsworth, Texas, treasurer.

Members attending the workshops found them interesting and educational and were enthusiastic with their praise. The workshops were on various phases of the Business, Medical and Technical techniques.

Educational Program Planned

An educational program for the Indiana State Medical Assistants is in the making. Dr. Harry Pandolfo, Chairman of the State Medical Public Relations Committee, and past president of the Marion County Medical Society; Miss Jeanne Woods, ISAMA president; Miss J. Marie Theobald, ISAMA secretary; Mrs. Zenna McCance, Crossroads Chapter of the National Secretaries Society, and Mr. Virgil Hunt, director of the Indianapolis Extension Center of Indiana University, have met on several occasions and made a study of various educational programs. The program will be similar to the Michigan State Medical Assistants Association training program.

In February the Indianapolis Center plans to offer to the medical assistants an "In-Service" Training Program starting with two courses; each course to be 2-hour sessions for 16 weeks. The first courses to be offered will be "Medical Information for Medical Assistants," and "Psychology and Dynamics of Human Behavior." Courses to be offered at following semesters will be "Medical Office Management," "Nursing Information for Medical Assistants," and "Law and Economics in Medical Office Administration." The sixth course has not been chosen at this time. Further information regarding this course will be sent each doctor for them to study and then give to their medical assistant for her consideration. It is felt this educational program will be of great benefit to both the medical assistant and her doctor.

By September, 1959, it is hoped the course will be given in other extension centers throughout the state; thereby, giving all medical assistants an opportunity to participate in the educational program.

Athletic Injury Symposium Held

Hendricks County Medical Society held a symposium on Athletic Injuries September 23 at the Danville School Building. Local coaching staffs were invited to attend.

Jim Morris, Indianapolis physiotherapist and former Butler University trainer, was guest speaker, discussing injury prevention and therapy.

As of September, 47 new projects have been approved for Indiana in Hill-Burton grants, but were not yet under construction. Twenty-four projects were under construction. Two had been completed supplying 38 additional beds.

Continued on page 114

Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

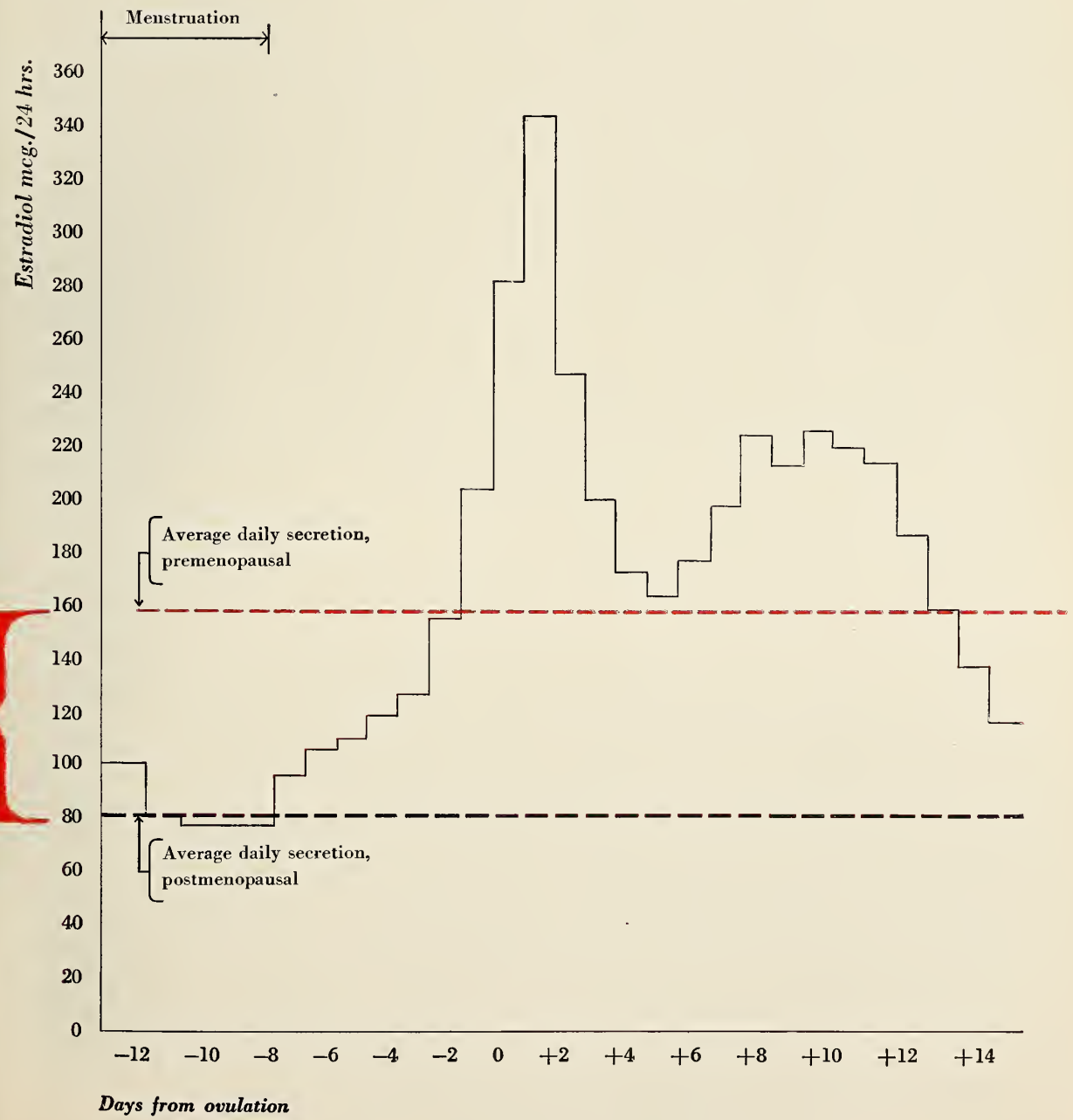
Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

Upjohn

*TRADEMARK, REG. U.S. PAT. OFF.

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Endogenous estrogen secretion (mcg./24 hours)
(calculated from average 24-hour urinary excretion
of estradiol, estrone, and estriol)



News Notes

Continued from page 111

Ophthalmologists Hold Annual Clinical Conference

The Chicago Ophthalmological Society will hold its Annual Clinical Conference on Feb. 13 and 14, 1959, Drake Hotel, Chicago.

Guest speakers will include Dr. Paul A. Chandler, Boston; Dr. Charles E. Iliff, Baltimore, Md.; Dr. Samuel J. Kimura, San Francisco; Dr. John Harry King, Washington, D.C.; Dr. J. V. Cassady, South Bend, Ind.; Dr. J. Robert Fitzgerald, Chicago; Drs. Wm. F. Hughes, Gilbert Iser, Bertha Klien, and Frank W. Newell, all of Chicago; Dr. R. Charles Oldfield, Oak Park, Ill.; Dr. John H. Olwin, Chicago; Dr. Frank Pirrucello, Evanston, Ill., and Dr. Theodore Zekman, Chicago.

Subjects will include a symposium on the management of surgical conditions of lids and lacrimal apparatus, management of uveitis, prophylaxis and treatment of vascular occlusions, plastic surgical principles, clinical value of electro-retinography, management of cardiac arrest and glaucoma management, and present status of preserved eye tissue for transplantation.

Registration fee for the entire course including round table luncheons and buffet supper is $45.00 and may be payable to the Registrar: Mrs. Mary E. Ryan, 1150 North Lorel Avenue, Chicago 51, Illinois.

The Fifteenth Annual Sanford R. Gifford Memorial Lecture will be delivered by Dr. Paul A. Chandler of Boston, Friday, February 13, at the Drake Hotel, 5:15 p.m. All ophthalmologists are invited to attend this lecture and a buffet supper which follows.

Dr. Nafe to National Post

Dr. Cleon Nafe has accepted appointment to the Federal Hospital Council. The Council consists of 8 members appointed by the Secretary of Health, Education, and Welfare, and serves as an advisory agency to the Surgeon General of the Public Health Service. It serves primarily to advise on the administration of the federal hospital and medical facilities survey and construction program (Hill-Burton program), and also to render opinions on proposed regulations for the program. The term of appointment is for 4 years.

AMA Medicolegal Meetings Planned

The American Medical Association has announced another series of 3 regional medicolegal conferences to be held in March and April as part of a continuing effort to create a better working relationship between lawyers and doctors.

The meetings will be held in Washington, D.C., Cleveland and Salt Lake City. Indiana will be represented at the Cleveland conference which will be held at the Hotel Cleveland on April 4 and 5.

The AMA Law Division is sponsoring the meetings in cooperation with state and local medical societies. Doctors and lawyers from the midwestern states will be in attendance at Cleveland.

While the program for each meeting will not be completed until after the first of the year, it has already been decided that the following subjects will be covered in speeches and question-and-answer periods: narcotic addiction, traumatic neurosis, Res Ipsa Loquitur and medical professional liability, contingent fees and impartial medical testimony.

The session will be presented for a half day on Friday and a full day on Saturday. Luncheon will be served on Saturday with no planned program on Friday night.

Advance registrations should be mailed to the Law Division, American Medical Association, 535 N. Dearborn St., Chicago 10. The registration fee is $5.00 to cover the cost of the luncheon and a copy of the proceedings.

New York State Society Appoints Hoosier

Dr. Herbert T. Wagner, graduate of Indiana University School of Medicine and former resident of Indianapolis, has been appointed as executive director of the Medical Society of the State of New York. He will administer the Society's staff of 70 employees and the functions of its numerous bureaus.

The New York State Society is largest in the United States and is third largest organized medical group in the world. Dr. Wagner, in the past, has served as assistant director of Roosevelt Hospital, New York City, and as director of Stuart Circle Hospital, Richmond, Va., and Meriden Hospital, Meriden, Conn. He has recently been regional consultant for the National Foundation for Infantile Paralysis.

Army Clarifies Billing Regs. For Military Personnel Care

To clarify procedures involved in submitting bills for medical care rendered to military personnel, the following release has been made by Hqs., Fifth U. S. Army:

As a general rule, civilian medical agencies are aware of the appropriate channels for submission of their charges for care furnished Army military personnel. They are informed of the correct procedure, either by prior arrangement with the appropriate military authority for routine medical care of personnel under their jurisdiction, or through notification to the patient's Commanding Officer, or the Surgeon of the Army area in which emergency type of service is rendered.

In situations where the above does not apply or when the civilian medical agency is in doubt concerning the normal procedure, bills may be submitted directly to Headquarters Fifth US Army, Office of Army Surgeon, 1660 East Hyde Park Boulevard, Chicago 15, Illinois, with a request that they be placed in appropriate channels for settlement.

Such bills should show name, rank, service number, organization and duty station of the patient, disease or disability treated, inclusive dates and nature of the services and a brief statement of the incident leading to the treatment.

The above pertains **only** *to care of military personnel, and should* **not** *be confused with the established procedures for the processing of claims for care of eligible military dependents under MEDICARE.*

Child Guidance Clinic Expands

Remodeling is being started in former residence quarters on the third floor at Riley Hospital to adapt this area for expansion of the Child Guidance Clinic. The remodeling is being financed by a grant by the Riley Memorial Association from gift funds. The Child Guidance Clinic has outgrown its former quarters on the third floor of the Rotary Building. The third floor at Riley already houses the pediatric, psychiatric and neurology department offices, Epilepsy Clinic and the nursing and psychological service offices.

Continued

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News Notes

Continued

Nurses, Specialists Invited To Attend Surgeons' Meeting

The American College of Surgeons has invited surgical specialists and nurses to attend special sessions to be conducted for them at Kiel Auditorium and many St. Louis teaching hospitals during the 4-day Sectional Meeting to be held March 9-12.

Nurses' program will include morning sessions at Kiel Auditorium, afternoon visits and demonstrations at hospitals, and opportunities to attend all surgical specialty sessions and exhibits.

Attractions for surgeons will feature hospital clinics and separate programs in general surgery, gynecology and obstetrics, ophthalmic surgery, orthopedic surgery, thoracic surgery and urology. No program is being scheduled for otolaryngologists at this meeting because of a conflict in meeting dates with one of their specialty societies. However, all otolaryngologists have been invited to attend sessions prepared for them at the college Sectional Meeting at Shamrock Hilton, Houston, February 2-3.

Ladies' Hospitality committee will conduct a registration and information desk where visitors will be advised concerning entertainment, shopping opportunities and other city attractions. Ladies are cordially invited to the dinner at Hotel Statler, March 11, where an attractive program has been arranged for them.

Hotel reservation forms and other information may be obtained by writing Department of Organization and Assembly, American College of Surgeons, 40 East Erie St., Chicago 11.

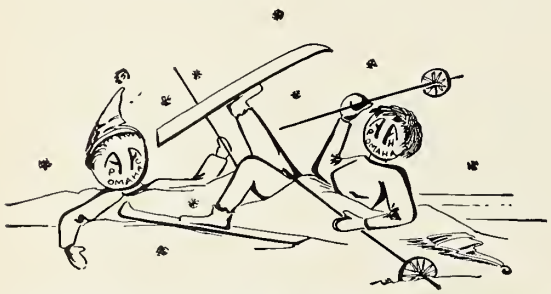
Dr. Simon S. Rubin, Gary, presented a paper entitled, "Corticotrophin and Corticosteroids in the Treatment of System Lupus Erythematosus," at the 3rd Congress of International Allergology, Oct. 21, 1958, at Paris, France.

Heart Course Scheduled

A 2-day post-graduate course in cardio-respiratory resuscitation will be held at Indianapolis General Hospital January 24-25. The course will be sponsored by the hospital and supported in part by its Robert M. Moore Heart Clinic.

Presenting the course will be Dr. Paluel J. Flagg, president of the National Resuscitation Society and consulting pneumatologist at Manhattan General Hospital, and Dr. Robert M. Hosler, associate director of the Cleveland Heart Society's Course in Cardiac Resuscitation.

Both didactic instruction and clinical practice will be included in the course.



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AS PROVED BY extensive clinical trials—an over-all success rate of more than 94% was achieved in a total of 3,280 cases.†

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AS PROVED BY excellent safety record—extremely well tolerated; discontinuance of medication was necessary in only 11 of 3,280 patients.†

A significant number of the above cases had not responded to other antibiotics.

Cosa-Signemycin is particularly valuable in home and office, where susceptibility testing is difficult or impractical.

SUPPLY: *Capsules* (green and white), 250 mg. and 125 mg.
New Oral Suspension (raspberry-flavored), 2 oz. bottle, 125 mg. per teaspoonful (5 cc.).
New Pediatric Drops (raspberry-flavored), 10cc. bottle, 5 mg. per drop, plastic calibrated dropper.

Average dosage: For adults, 1-2 Gm. daily in divided doses; proportionately less for children, depending on age, weight, and severity of infection.

†Literature and bibliography available on request.

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Add 1

by corki

It seems appropriate for a January column to mention something about cleaning up the mess of wrinkled tinsel and torn Christmas wrappings; and trees shedding needles, looking forlorn and alone in the backyard ashcan. But at this writing, most of my gifts aren't even wrapped yet, much less unwrapped! It's hard to envision the sparkling, brightly lit trees now decorating most living rooms and shedding their multi-colored lights across vivid, assorted packages, as being cast out and stripped of all their warmth and color. It's really quite a sad thought so close to Christmas.

So let's just say, a Happy 1959 to you all! We'll just have to leave the Christmas afterthoughts and New Years Resolutions to February.

Looks like I eat my words about "does it snow any more in Hoosierland?" a question asked in the December column! Right after that one was set, too late to change it, came, upon a Thanskgiving night, that REAL snow! I can tell one and all it was really lovely to the eyes of one who hadn't seen snow in many a year. (But you can keep the sub-zero temps!) Anyhow, now I know Indiana still has snow; and in abundance!

Signs of Modern Times: Didja' ever stop to think that advertising can be construed as a sign of our time? Not too many years ago (or so it seems), advertising stressed the fattening value of products. Today it stresses nutrition without weight-inducing qualities. We're evidently too fat and too weak!

Shades of our forefathers! An "AMA News Release" recently came out with a story about a "Modern-Day Tomahawk Wound Treatment" which described the removal of liquid from a man's skull which had been caused by a tomahawk wound! Called trephination, the article also described this same treatment as being used by prehistoric South American Indians; and added that "American Indians also performed the operation, evidently to treat tomahawk wounds."

Payoff was the last paragraph: "As it is, sometime in the distant future an archeologist may come across a skull showing signs of a tomahawk wound and trephination and speculate upon the anachronism of tomahawk injuries in the 20th century." The quote was attributed to Dr. Thomas B. Summers who wrote the article.

(The man, an Iowan, evidently received the wound when he stopped a resident of his trailer camp from beating his wife!)

Relax and enjoy it! I like the article written by M. E. Pickett, M.D., in the Fort Wayne (Allen County) Medical Society *Bulletin*. Titled "Wise Use of Leisure Time in Medicine," Dr. Pickett points out that many Americans still shun the use of leisure time as a period of unabashed relaxation. The modern trend is toward "do-it-yourself," and hobbies, sports, etc., become something to work at rather than time to relax and enjoy.

Dr. Pickett gives some guides on the correct use of leisure as follows:

"1. Hobbies should be regarded as hobbies, not as means of enhancing one's ego or social status.

"2. Exercise or sport should be considered an adjunct to individual health, not a compulsory activity which requires competitiveness.

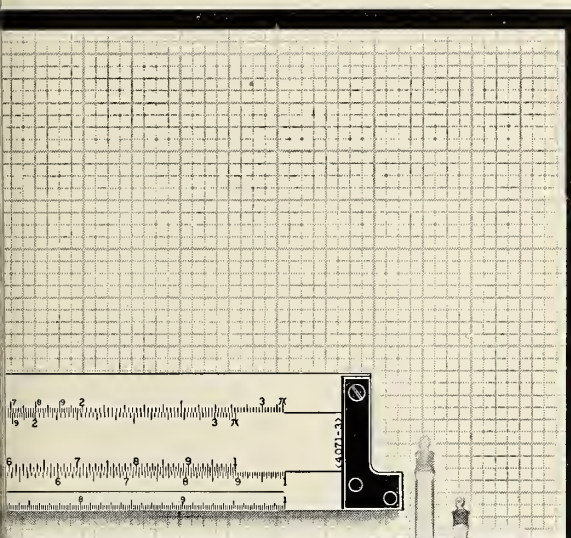
"3. Forego regular recreation periods, i.e., the 'must-have-fun' compulsion."

"Summing up," the doctor advises, "the wise and correct use of leisure time should be in doing the thing that one actually enjoys doing and does not tax him physically or mentally. We are certainly living in a rapidly moving world and too much cannot be said about taking things easy when we have a chance."

I'm all for it, doctor! Watching TV Westerns and who-dunits seems about the only leisure activity left today that doesn't tax mind or body! Seriously, if more of us would take Doctor Pickett's advice, the psychiatrists might not be so overworked and mental health would be a diminishing rather than growing health problem.

Belated column orchids to Dr. A. C. Yoder,

Continued to page 122

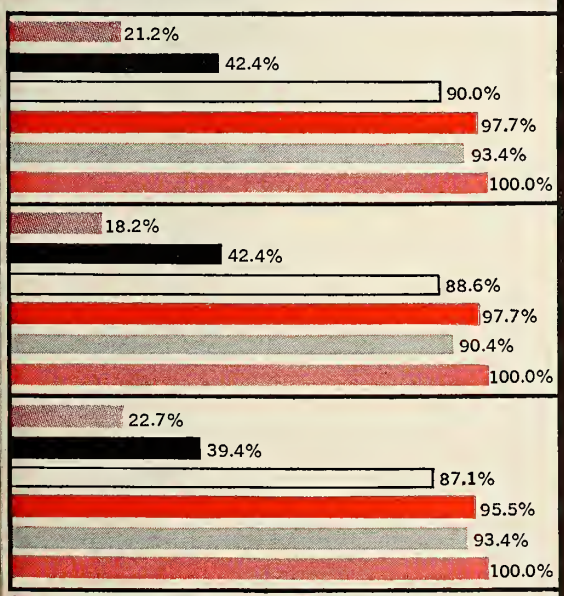


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Highly palatable—"practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

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Supplied: TAO Capsules—250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension—1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

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Continued from page 118

Goshen, who celebrated his 91st birthday Nov. 11. Dr. Yoder was in the center of the picture of technical exhibits in the December *Journal.*

From the Bulletin of the Ind. State Assoc. of Medical Assistants:

"A brain is as strong as its weakest think!"

Another sign of modern hectivity: From the Indianapolis *News,* "Faced with the problem of staying abreast with medical literature, Dr. Aaron L. Arnold has a device in his car on which he plays tape recordings of papers, lectures and panel discussions while driving on his medical rounds." (My apologies to the columnist who wrote the note, but the clip service didn't include the whole column.)

More mythical orchids to Dr. James McFadden, Lafayette, who presented White County Memorial Hospital with a binocular microscope. Dr. McFadden is a staff pathologist at the hospital.

Also same to the Grant County Medical Society auxiliary for donating a Bennett intermittent positive pressure breathing machine to a hospital, evidently in Marion. (Article failed to give name of hospital and that's one of the few times I've seen a veteran newspaper failing to give the "who, why, what, when and where" in a news story. Granted, there's only one accredited hospital in Marion, but outsiders getting hold of the story — like me — might not know that.)

Happy hard work to Dr. Don E. Wood, Indianapolis, recently named to the State Chamber of Commerce Board of Directors. Since Dr. Wood also holds a number of active positions in ISMA, including chairman of the executive committee, he should have a real busy 1959!

A good laugh cures many ills Dept.:

The girl who knows all the answers has very often misunderstood the questions—*Femina & Woman's Life,* Johannesburg, So. Africa.

Edward Newman, editor of Britain's *Ideal Home Magazine,* has come up with a novel suggestion. It is his contention that customers at furniture stores should be permitted to change into pajamas or nightgowns in order to test bedroom products properly. "You cannot," says Newman, "test a bed properly if you are wearing day clothes and carrying a handbag or umbrella."—*Quote.*

(So can't the clerk hold the umbrella?)

Education is the process of transforming an impulsive, self-centered little animal into a civilized adult who can think with the symbols of language and can thereby develope the ability to subordinate his animal impulses, habits and immediate ends to long-range personal and social ends.—Eugene H. Sloane, "Will Power," *Wisdom,* 27th issue.

(Meet Arab, my kitten. Shame she can't assimilate those language symbols; my life would be much easier!)

A psychiatrist is a man who doesn't have to worry, so long as others do.—*AMA Jnl.*

Juvenile delinquency is the result of parents trying to train children without starting at the bottom.—G. G. Kinvin, *Tid-Bits,* London.

(And, please, I'm not trying to get into the arguments, many and varied, on this problem! Just quoting a funny with a serious "undertone!")

An optimist is a grown man who decides to take up ice skating again, with a bottle on his hip.—*Scripps-Howard Newspapers.*

And with that, to all a good night!

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Deaths . . .

Charles M. DuPuy, M.D., 91, a senior ISMA member, died November 18 at his Riley residence.

He had practiced medicine in Vigo County for 63 years. During WWI he had been a member of the selective service board until he enlisted in the Medical Corps. He was discharged with the rank of captain.

Dr. DuPuy graduated from Louisville Medical College in 1917 and first practiced medicine in Terre Haute. He was a 50-year Club member of ISMA, member of the Vigo County Medical Society, AMA, 50-year member of the Masonic Lodge and member of Elks Club, Riley IOOF. At one time Dr. DuPuy was a breeder and owner of race horses.

Harry L. Foreman, M.D., 75, ISMA senior member, died December 3 at his Indianapolis home. He was a former superintendent of General Hospital, Indianapolis.

He was from Blackford County, earned his B.A. degree at I.U. and B.S. degree at Marion Normal College.

Dr. Foreman taught school, and later served as a principal in a county and a city school in Bloomington. He obtained his M.D. at I.U. School of Medicine in 1917 and interned at Robert W. Long Hospital, Indianapolis.

His specialty was internal medicine. He was a member of the county, state and national medical societies, of Phi Delta Kappa and Alpha Omega Alpha Fraternities.

David H. Forsyth, M.D., 81, ISMA senior member, died October 29 at St. Anthony Hospital, Terre Haute. He had been a member of that hospital staff for 40 years.

Dr. Forsyth graduated from I.U. School of Medicine in 1909. He was a member of Vigo Medical Society, ISMA, AMA, Central Christian Church, Terre Haute, Social Masonic Lodge No. 86, Scottish Rite, Valley of Terre Haute, Kerman Grotto and the Aesculapian Society.

Maurice S. Fox, M.D., 57, died November 21 at Good Samaritan Hospital, Vincennes.

A Freelandville native, he graduated from I.U. Medical School in 1930. He served in WWII as a Medical Corps captain as chief of an evacuation hospital x-ray section. He had been on the staff of the Good Samaritan Hospital where he passed away and of the Memorial Hospital, Lawrenceville, Ill. His specialty was allergy.

Dr. Fox was a member of the American Academy of Allergy, the Academy of International Medicine, county, state and national med-

Continued on page 130

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SURGERY—
Surgical Technic, Two Weeks, February 16, March 2
Surgery of the Colon & Rectum, One Week, March 2, April 6
Fractures & Traumatic Surgery, Two Weeks, March 9
Treatment of Varicose Veins, Two Oays, March 2, April 6
American Board Review Course (Part I), Two Weeks, April 6
Blood Vessel Surgery, One Week, February 16
General Surgery, One Week, February 9

GYNECOLOGY & OBSTETRICS—
Office & Operative Gynecology, Two Weeks, February 9, March 16
Vaginal Approach to Pelvic Surgery, One Week, February 2, March 9
General & Surgical Obstetrics, Two Weeks, February 23, March 30

MEOICINE—
Electrocardiography, Two-Week Basic Course, March 16
Gastroscopy & Gastroenterology, Two Weeks, March 2
American Board Review Course (Part II), to be announced

UROLOGY—
Two-Week Intensive Course, April 27
Ten-Oay Practical Course in Cystoscopy, by appointment

RAOIOLOGY—
Oiagnostic X-Ray, Two Weeks, March 2, April 27
Clinical Uses of Radioisotopes, Two Weeks, May 4

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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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Deaths

Continued from page 126

ical societies, and was a graduate of the College of Allergists.

In addition, he was an officer in the U. S. Coast Guard Auxiliary and commandant of a flotille, member of the Masonic Lodge No. 1, Scottish Rite and Shrine, Elks Lodge and Harmony Society of Vincennes. He was a member of the First Methodist Church.

Floyd M. Freeman, M.D., 75, a senior member, died November 25 at Goshen hospital where he had been a member of the hospital staff.

From Middleville, Mich., Dr. Freeman graduated from the University of Michigan in 1908 and interned at St. Vincent's Hospital, Toledo. He took a postgraduate course in pediatrics in 1925. He practiced medicine in Goshen for 48 years, giving his attention to internal medicine.

Dr. Freeman was a past president of the Elkhart County Medical Society, member of ISMA and AMA, of the Presbyterian Church and 50-year member of both ISMA and the Masonic Lodge.

Carl Henning, M.D., 79, senior member and 50-Year Club member of ISMA, died November 24 at King's Daughters Hospital, Madison.

From Lexington, he attended Hanover academy and graduated from Hanover College in 1902, then received his M.D. from Indiana Medical College in 1906, graduating with high honors and as a member of Phi Beta Kappa honorary fraternity. He had served as county coroner, county health officer and county physician in Jefferson County.

During WWI he was a medical officer. He was a charter member of Jefferson Post American Legion, past commander and member of the former drum and bugle corps, county, state and national medical societies, Hanover Masonic Lodge, Presbyterian Church (where he served on a board of trustees for 30 years), president of both Hanover school building corporations and member and past president of the Jefferson County Historical Society.

Fred Langsdon, M.D., 65, former chief of staff of Ball Hospital, died November 2 at his Gaston home.

He obtained his M.D. from Indiana University in 1922. He was a member of Delaware-Blackford Medical Society, ISMA, AMA, Masonic Lodge 650, New Corner Lodge 425, American Legion and Gaston Methodist Church. He was a veteran of WWI.

Thomas B. Noble, M.D., 62, died of a heart attack December 9 while on a vacation at Laguna Beach, Calif.

A Marion County surgeon, he had practiced medicine since graduating from Washington University School of Medicine in 1918. He also had attended Wabash College, University of Wisconsin and University of Pennsylvania.

As an Army captain, he participated in research which developed protective and preventive measures against gas in warfare. He was involved in the first mustard gas attack at Passchedale, Germany.

Dr. Noble was most extensively known for his fight against peritonitis. He is credited with initiating and refining a technique known as the "Noble plication," in performing operations on intestinal obstructions.

He was an avid anthropologist, well known for his work with the Navaho and Hopi Indians.

Dr. Noble was a former member of the boards of directors of Flanner House, Marion County Red Cross, Torch International and was a Regent of the International of the College of Surgeons. He was a member of the Indianapolis Literary Club, Phi Delta Theta, American Legion, American Anthropological Association, Indiana Academy of Science and New Mexico Historical Society, as well as the local and national medical societies.

Thomas F. Reitz, M.D., 62, Evansville heart specialist, died October 24 at St. Mary's Hospital, Evansville.

He graduated from Washington University School of Medicine in 1921 and interned at University Hospital, Madison, Wisc., practiced a year in Chicago and then moved his practice to Evansville.

As well as being a heart specialist, he was active in industrial medicine. He was a past president of Vanderburgh County Medical Society, and on the staff of St. Mary's Hospital.

Dr. Reitz was a member of the Country Club,

Elks, Central Turners and Kennel Club. He belonged to Holy Trinity Church.

Professionally he belonged to the local and national medical societies, American College of Cardiologists, Catholic Physicians Guild, Fellows Academy International of Medicine and American Heart Association.

In addition, he was a staff member at Deaconess and Welburn Baptist Hospitals and member of Local 936, Traveler's Protective Association and Sigma Alpha Epsilon Fraternity.

Wilbur H. Shortridge, M.D., 52, died suddenly of a heart attack at his home in Seymour October 28. He had been a prominent Seymour surgeon for 20 years.

A native of Bedford, he attended Franklin College and obtained his M.D. from I.U. School of Medicine in 1935, interning at Henry Ford Hospital, Detroit, where he also took his surgery residency.

During WWII he served as a lieutenant commander in the Navy, part of his tour extending to duty in the Far East with the aircraft carrier Ajax as a medical officer.

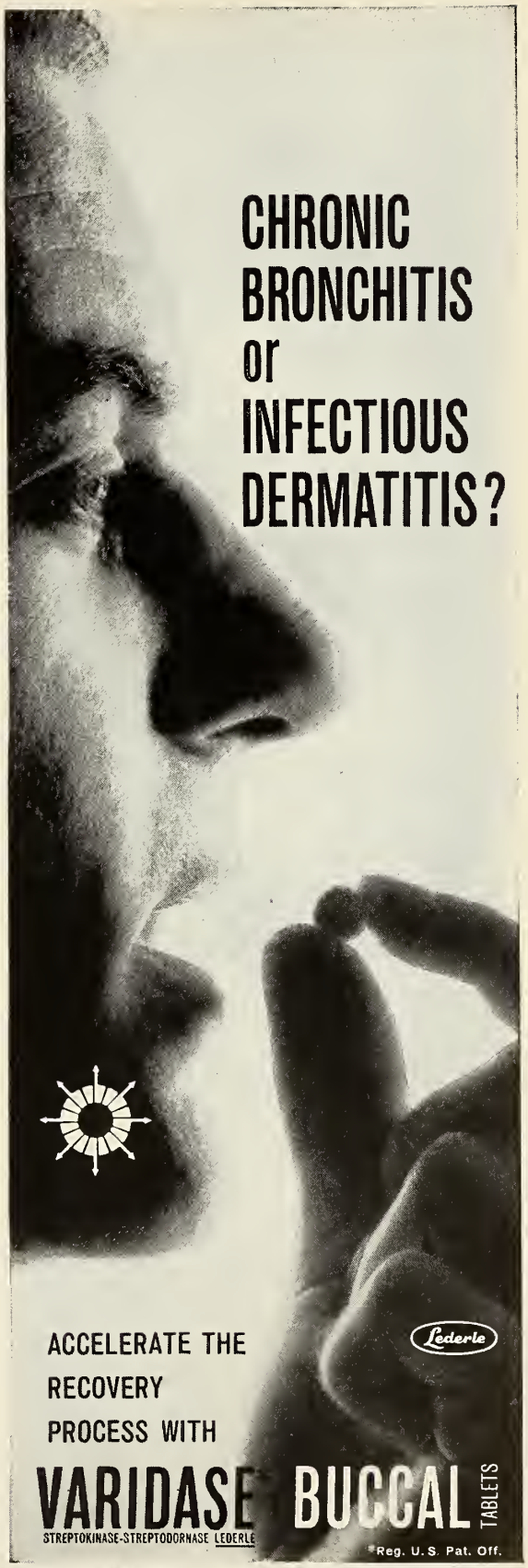
He was a Phi Beta Kappa and member of Alpha Omega Alpha, honorary fraternity. He was made chief of staff at Schneck Memorial Hospital in 1949. Dr. Shortridge was a member of First Methodist Church, Seymour Rotary Club, Medora Lodge No. 328, Free and Accepted Masons; Lodge No. 462, B.P.O. Elks, Seymour Country Club and the local and national medical societies.

John E. Yarling, M.D., 89, Peru city health officer and former mayor, died November 8 of a heart attack at Dukes Hospital.

A native of Shelby County, he taught school in his youth and received his M.D. from the Medical College of Ohio in 1897. He has been a Peru physician since that time.

He served as Peru mayor for five years beginning in 1930, was Miami County coroner from 1899 to 1905 and county health officer from 1914 to 1922. He has been city health officer since 1943.

Dr. Yarling was a past president of Miami County Medical Society, senior member and 50-year Club member of ISMA, member of AMA, Masonic and Elks Lodges, receiving 50-year pins in both of the latter.



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County Societies and District Reports

Seventh District

Meeting of the Seventh District Medical Society was held November 19 at the Public Service Company, Plainfield, with Dr. Malcolm O. Scamahorn, president, presiding.

New officers elected consisted of Dr. Arthur W. Records, president-elect; Dr. Herbert L. Egbert as secretary-treasurer and Dr. Jones as alternate councilor.

Dr. Earl W. Mericle, ISMA president-elect, extended greetings from Dr. Kenneth L. Olson, ISMA president.

Guest speaker was Charles G. Werner, editorial cartoonist for the *Indianapolis Star*.

Fort Wayne (Allen)

The Sixth Annual Road Show produced by The Indiana Academy of General Practice in cooperation with the Allen County Medical Society comprised that society's December 2 meeting at the Shrine Club, Fort Wayne.

A. D. Dennison Jr. M.D., Indianapolis, presented two papers, "Pre-operative Cardiac Evaluation" and "Common Errors in Cardiac Diagnosis." J. Edward Berk, M.D., Detroit, presented "Diagnosis and Management of Acute Pancreatitis" and "Medical Management of Uncomplicated Duodenal Ulcer."

Next meeting scheduled was for January 6, same place.

Carroll

Mr. Alfred Shell, administrative director of the Regional Blood Center of Fort Wayne presented an examination of the blood program in Carroll County at the Carroll County Medical Society program November 19.

Next scheduled meeting was for December 17.

Clark

Clark County Medical Society's monthly meeting for November was held the 18th at the Point Inn where Field Representative Robert Amick was the speaker.

Clay

Nine members were present at the November 25 meeting of Clay County Medical Society held at the Elks Club in Brazil.

New officers included J. F. Maurer, M.D., Brazil, president; J. R. Glosson, M.D., Clay City, vice-president; R. K. Webster, M.D., Brazil, Secretary-treasurer; C. E. Moon, M.D., Centerpoint, delegate to the state convention, and J. R. Glosson, M.D., Clay City, alternate delegate.

Regular meetings will be held the third Tuesday of each month.

Fountain-Warren

Election of officers was held by Fountain-Warren County Medical Society at its December 4th meeting with 9 members and 12 guests present. It was held at the home of Dr. and Mrs. Tom Sazukis, Covington.

Next scheduled meeting was for January 8.

Kosciusko

New officers of Kosciusko County Medical Society include Wymond B. Wilson, M.D., Mentone, president; John J. Johnson, Warsaw, vice-president, and Carl E. Shrader, M.D., Warsaw, secretary-treasurer.

Orange

Election of officers was held at the December 2 meeting of Orange County Medical Society at French Lick Hotel with nine members present.

Next scheduled meeting was for January 6.

Randolph

Election of officers was held at the Elks Club, Union City, by Randolph County Medical Society December 3. Thirteen members were present.

Next scheduled meeting was for January 12.

Shelby

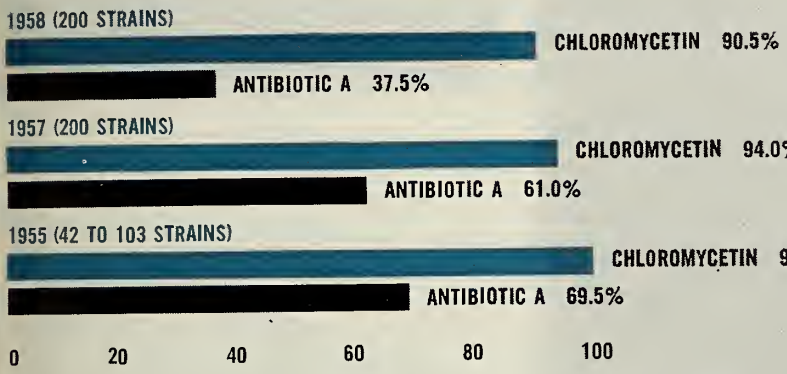
Arthur Roberts, D.D.S., presented the subject "Common Medical-Dental Problems" at the December 3 meeting of Shelby County Medical Society. Nineteen members were present at the W. S. Major Hospital, Inlow Clinic, to hear Dr. Roberts.

Whitley

H. L. Brenton, M.D., showed a film entitled, "Three Key Operations of Coronary Artery Disease," at the December 9 meeting of Whitley County Medical Society before 13 members present.

Next scheduled meeting was for January 13.

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The Journal

February 1959

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OUR COVER

This month our cover was specially worked out by Mrs. Rosebud Lane Preddy (whose painting of the hands appeared on our November 1958 cover) for the heart issue and the "month of hearts." Mrs. Preddy is a medical artist at Letterman Army Hospital, San Francisco. The bouquet is composed of actual heart conditions as shown on a graph which are transposed into musical notes, materials she has used in her medical art. Further explanation may be found on page 197 in Mrs. Preddy's own words.

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4	Joseph E. Dudding, Hope	Oct. 1959
5	Robert K. Webster, Brazil	Oct. 1960
6	Harry P. Ross, Richmond	Oct. 1962
7	Ralph V. Everly, Indianapolis	Oct. 1959
8	Guy Owsley, (Chairman), Hartford City	Oct. 1960
9	K. O. Neumann, Lafayette	Oct. 1962
10	J. P. Vye, Gary	Oct. 1959
11	Max R. Adams, Flora	Oct. 1960
12	Maurice E. Glock, Fort Wayne	Oct. 1962
13	G. O. Larson, LaPorte	Oct. 1959

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2.	Fred M. Dukes, M.D., Dugger	J. S. Brown, M.D., Carlisle	May 7, 1959
3.	Robert LaFollette, M.D., New Albany	Daniel H. Cannon, M.D., New Albany	New Albany, May 6, 1959
4.	Robert O. Zink, M.D., Madison	Frank W. Hare, M.D., Madison	Madison, May 6, 1959
5.	James Richart, M.D., Terre Haute	Roy Pearce, M.D., Terre Haute	Terre Haute 1959
6.	Frank Lewis, M.D., Liberty	John H. Smith, M.D., Greenfield	New Castle, May 7, 1959
7.	Leon Gray, M.D., Martinsville	Herbert L. Egbert, M.D.	1959
8.	Forrest Keeling, Portland	Guy Owsley, M.D., Hartford City	Portland, June 10, 1959
9.	S. E. McClure, M.D., Monon	David C. Beck, M.D., Monticello	Monticello, May 21, 1959
10.	Ralph T. Hartsough, M.D., Remington	Kenneth Ockerman, M.D., Rensselaer	1959
11.	Eugene Cook, M.D., North Manchester	C. L. Wise, M.D., Delphi	Logansport, May 20, 1959
12.	F. B. Kantzer, M.D., Garrett	Max M. Gitlin, M.D., Bluffton	Fort Wayne, May 20, 1959
13.	R. L. Bender, M.D., Elkhart	James M. Wilson, M.D., South Bend	Michigan City, Nov. 18, 1959



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References: 1. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 2. Eisenberg, B. C., Clinical Medicine *5*:897-904 (July) 1958. 3. Robinson, H. M., et al.: J.A.M.A. *161*:604-606 (June 16) 1958. 4. Robinson, H. H., et al.: So. Med. J. *50*:1282 (Oct.) 1957.

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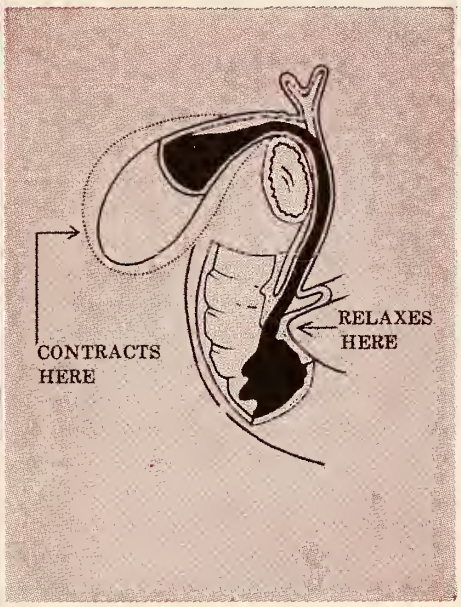
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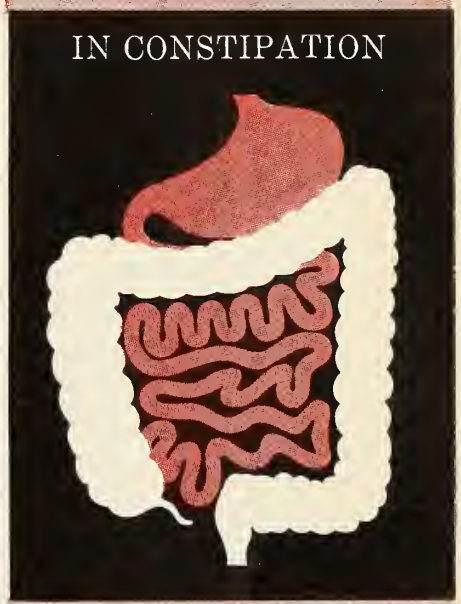
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1. Herland, A. L., Lowenstein, A.: Quart. Rev. Surg. Obst. & Gynec. 14:196 (Dec.) 1957

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THE MONTH IN WASHINGTON

Washington, D.C. — Since the release last summer of the much-discussed Bayne-Jones report on medical education and research, the administration has been reviewing the situation and the possible need for Congressional action on federal aid to the country's medical schools.

Just how strong is its case is likely to be determined in the session of the 86th Congress now underway. In the closing phases of the 85th Congress, a health subcommittee of the House took up the subject amid a feeling at that time that proponents had failed to achieve a sense of urgency.

Another year has rolled around and the climate may be different. The Bayne-Jones report revived the medical school aid issue. Not since the 6-year-old report from the Magnuson Commission has a medical report been quoted so extensively. The Bayne-Jones report calls for a doubling of medical research spending by 1970 and the immediate start on at least 14 new medical schools.

Secretary Flemming of Health, Education, and Welfare let it be known soon after taking office last summer that he was not going to allow the report to be "put on the shelf to gather dust."

In an address to the American College of Surgeons, Surgeon General Leroy Burney sketched briefly a plan for another consultants' group not unlike the Bayne-Jones committee. It is now looking into the question of need for more physicians in the next decade. No date has been set for the final report. At its first meeting in December, the committee authorized 2 staff studies to get underway: on construction costs of newer schools and on the financing of present-day medical school operations.

Chairman of the group is Frank Bane, former executive secretary of the Council of State Governments and active in public affairs for more than 30 years. Other members include Dr. Edward L. Turner, American Medical Association's council on medical education and hospitals; Dr. Ward Darley, Association of American Medical Colleges; Dr. Julian Price, AMA trustee; Dr. Edwin L. Crosby, American Hospital Association; Dr. Vernon Lippard, Yale medical school dean; John McK. Mitchell, Pennsylvania medical school dean; Dr. Isador S. Ravdin, Pennsylvania medical affairs vice president; Dr. Clayton G. Loosli, Southern California medical school dean; Dr. Charles E. Smith, University of California public health school dean; Morris Thompson, president, Kirksville College of Osteopathy and Surgery; Harold Hillenbrand, DDS, American Dental Association; Miss Marion Sheahan, National League for Nursing; Dr. Harold L. Enarson, Western Interstate Commission for Higher Education; Emory Morris, DDS, president, Kellogg Foundation; Douglas E. H. Williams, Dunbar Community Association; Fred C. Cole, Ph.D., Tulane; Robert C. Anderson, Ph.D., director, South-

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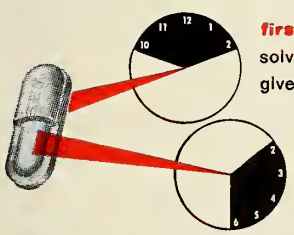
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†Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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Dormethan (brand of dextromethorphan HBr)	30 mg.
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APAP (N-acetyl-p-aminophenol)	325 mg.

Dosage: One tablet in the morning, midafternoon and in the evening, if needed.

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ern Regional Education Board; Alvin C. Eurich, Ph.D., vice president, Fund for the Advancement of Education; John G. Searle, president, G. D. Searle & Co.; and the Very Rev. Robert J. Slavin, president, Providence College.

Its final report in all likelihood will have a strong influence on the course of legislation.

NOTES

The Office for Dependents Medical Care has decided that this year's contracts for Medicare between the Defense Department and state medical societies and other groups will be negotiated by mail. ODMC felt that the whole field had been pretty thoroughly gone over last year and furthermore that administrative costs are no longer an issue. States will be supplied copies of proposed department changes in contracts 45 to 60 days prior to expiration dates, according to Brig. Gen. Floyd L. Wergeland, head of Medicare.

The National Air Pollution Conference held in Washington is beginning to produce results. HEW and the auto industry have worked out an agreement on research into devices for controlling auto exhausts. Exhaust experiments are underway at the Robert A. Taft Sanitary Engineering Center on animals, plants and bacteria.

Federal workers contributory health insurance proposal has taken a new lease on life. The AFL-CIO Government Employees Council which speaks for half a million civilan employees is suggesting the following: (1) the U.S. would pay for two-thirds of basic insurance up to a maximum contribution of $14 a month; the worker would pay the balance and could also broaden coverage for himself and family by paying the extra cost himself, (2) there would be a choice of basic insurance such as commercial Blue Cross, Blue Shield, employee union plans, (3) the government would pay the full cost of major medical insurance but the worker would have to have basic coverage; catastrophic coverage would meet 75% of costs.

Congress has failed in the past years to enact legislation. Among the reasons has been failure of the various interested groups to get together on a single bill.



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The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

From Other Editors:

The 10-Year Miracle
(Miami Herald)

This is the time of year for stocktaking.

Looking back over recent developments that contributed to the welfare of mankind, we would like to nominate medical science for any awards that may be available in this field.

It is astonishing to consider that in a brief decade, medicine has added five years to the average American's life span and has reduced deaths due to common infections by 80 percent, from influenza by 91 percent, and appendicitis by 76 percent.

In that same ten years medicine developed broad spectrum antibiotics which can track almost any infection to its lair; the Salk vaccine which has just about conquered paralytic polio (if we would but take advantage of it), and the great family of tranquilizers which guarantee peace of mind not only for humans but for dogs.

Physicians now have steroids to help the body produce hormones, radioisotopes to fight cancer, and a pill instead of an injection for diabetics. Surgeons transplant arteries, skin and bone, as well as corneas for blurring eyes, and can operate directly on the heart.

It sounds miraculous. It is just that. The American people took advantage of these medical wonders by visiting their doctors 890 million times in 1958.

In the face of such achievements, unmatched since man first began to cast spells and brew potions against the devils of illness, medicine is not at rest but has drawn bead on the remaining killers—heart disease and cancer—and on the painful, chronic ailments of old age.

It is in this area that the medical history of the next ten years will be written. Since the results of research tend to increase in geometric progression, one discovery leading to two others, that future seems full of promise for human kind.

—Kokomo Tribune
Jan. 7, 1959

Kokomo Clergy to Evaluate Results of Project To Arrest Mental Illness in Community

By HORTENSE MYERS
United Press International

A unique experiment, aimed at bettering the mental health of an entire city through its religious leaders, marks the end of its first six months next week.

Some 25 ministers, priests and rabbis who have taken part in the "Kokomo project" will meet Jan. 12-15 at the University of Chicago to evaluate the results of those six months. Expansion of the same plan to other cities also will be considered.

But this much of an evaluation has been made by Prof. Granger E. Westberg, one of the university's staff members taking part in the "Kokomo project."

Dr. Westberg, associate professor of religion and health for the school of medicine and federated theological faculty at the University of Chicago, said, "Our evaluation of the project at this moment convinces us more than ever that the minister is in a strategic position to deal with problems which lead to emotional stress and often eventually to mental breakdown."

The plan originated in Kokomo in September, 1957, when Dr. Carl Wennerstrom, chaplain of Chicago's University Hospital, addressed a joint meeting of the Howard County Ministerial Association and Kokomo mental-health leaders. The chaplain proposed a study of the relationship between the parish ministry and mental health on a city-wide basis.

The Lilly Endowment financed this first project which began with 25 clergymen enrolling for a week of intensive study last June at Chicago. Then followed monthly visits to Kokomo

Continued on page 162

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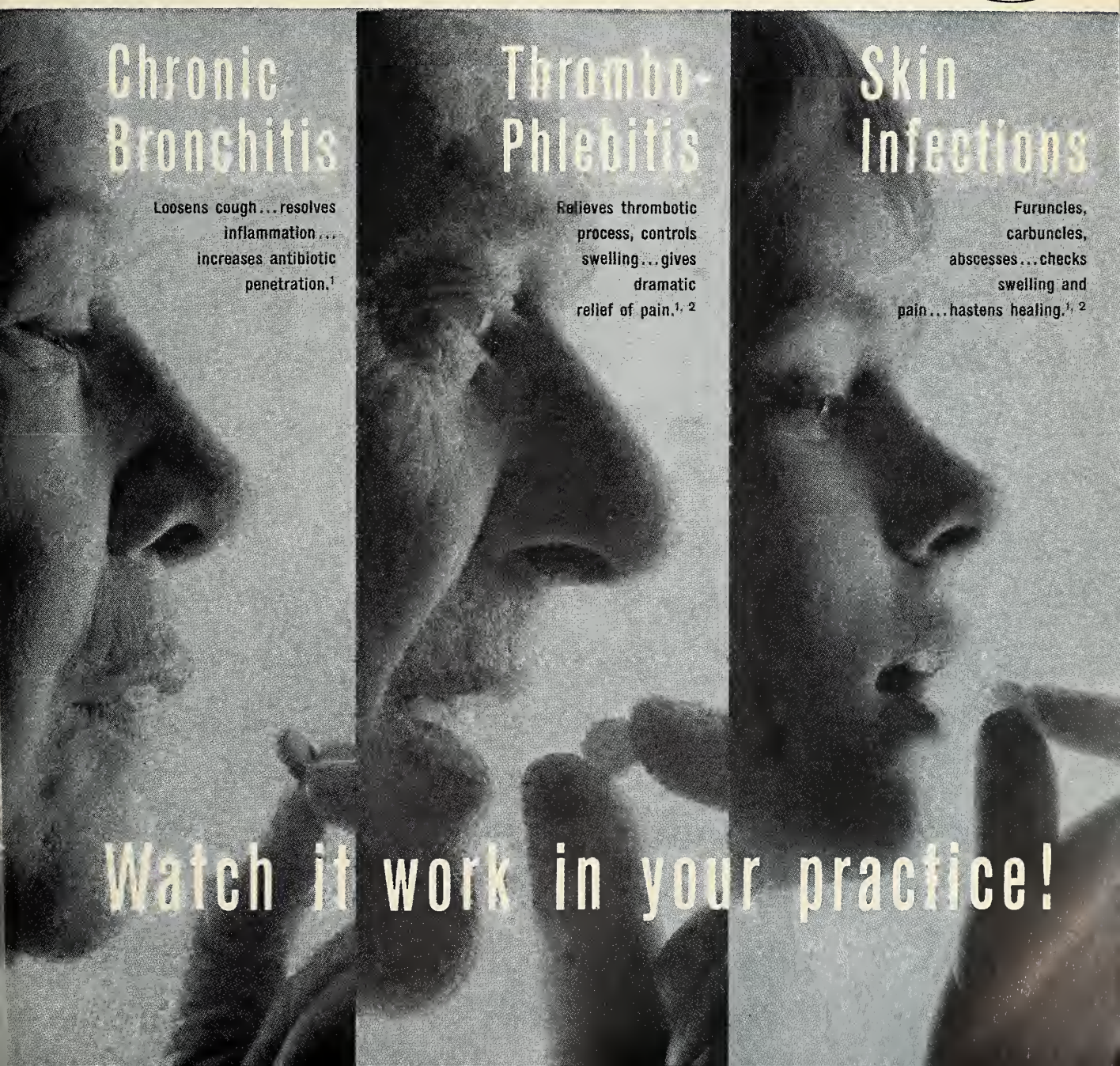
Administration: VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption patient should delay swallowing saliva.

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Continued from page 158

by a team of psychiatrists, psychologists and others to consult on handling of mental-health problems encountered by the ministers, priests and rabbis.

The university staff undertook to train the clergymen to recognize danger signs pointing to mental illness, using the plan of an opening week in residence on the campus, interim consultations in Kokomo and a final return to the University of Chicago campus at the close of the six months.

The Rev. Donald E. Bailey, who headed the Kokomo ministers participating in the plan, said, "This apparently is the first time a partially controlled group has taken such training and later submitted to a checkback to determine stages of progress."

Although original plans called for the Kokomo project to end with the January review course, the University of Chicago experts have decided to meet three or four more times with certain civic groups of the city to orient them "to the growing role of the minister in the area of mental health."

—*Indianapolis Times*
Jan. 8, 1959

Mental Illness

A bill pending in the British parliament proposes to revise that country's arrangements for dealing with mental illness. The new measure would set up review tribunals with power to discharge patients who do not require further retention in institutions. Two medical recommendations would be necessary for commitment, instead of one, as at present. And the words "suffering from mental illness" would replace "of unsound mind" in some existing legislation.

All three of these suggestions are relevant to the American scene as well as to the British. Few, if any, would deny that numbers of persons now in "mental hospitals" neither require nor receive what is generally meant by "hospital care." Professionally competent tribunals, independent of the overtaxed hospital staffs, might well at one and the same time reduce hospital populations and restore to normal life a number of individuals better outside than in.

The requirement of two medical recommendations for commitment, instead of one, obviously would lower the number of mistakes. And "suffering from mental illness" expresses, as "of unsound mind" does not, the fact that mental health is not something one has or lacks once and for all. The new wording will, it is hoped, encourage people who need treatment to seek it more promptly than before.

Not only medical and welfare officials in this country, but the general public also should follow with interest the subsequent history of the measure just introduced in the British parliament.

—*Chicago Tribune*
Jan. 12, 1959

Meetings Can Kill Us

People are killing themselves with too many meetings.

So said a man we know at a dinner recently. We think he had something.

This man said he was not suggesting that meetings are bad. Many of them are good; many are the only means of getting something constructive done.

He explained that he wasn't intending to stop supporting the worthwhile causes and projects that meetings produce. He just isn't going to wear himself into an early grave trying to attend so many of them.

He's going to continue attending some meetings, but, he declared, he'll be selective.

Everybody would be in better health if he cut out 50 percent of the meetings he tries to go to, the man reflected.

Attending meetings for this or that purpose has become a frenzied life for a lot of people. They go at a pounding pace and their physical stamina suffers more than they realize.

Too frequently, too, it is the busiest man who is pressed to participate in the most activities outside his own work. He is overworked, and the organizations that seek his services are too selfish about it, forgetting that he can endure only so much.

Someone has to take the leadership, someone has to do the work in the many fine and necessary welfare, volunteer health, charitable and other organizations. But the average man and woman probably would live longer if he or she limited the number of causes to which he gave extra time.

Continued on page 164

re-evaluating tranquilizers?

READ WHAT CLINICIANS ARE NOW SAYING ABOUT ATARAX®

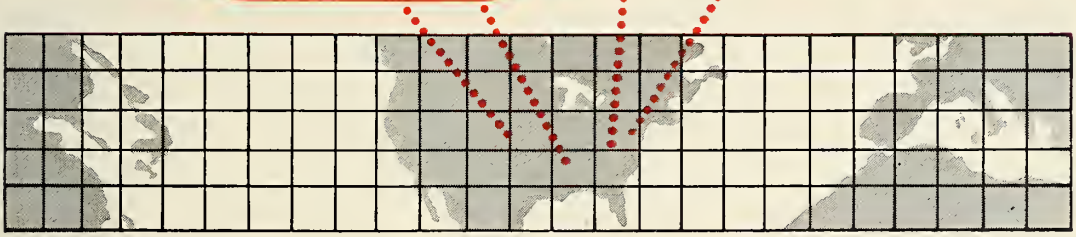
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IN WORKING ADULTS
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"ATARAX appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...."[2]

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ATARAX is "effective in controlling tension and anxiety.... Its safety makes it an excellent drug for out-patient use in office practice."[4]



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For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
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Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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Fourth Estate

Continued

The man we heard talking at dinner said America would be a healthier nation if more of its people would go to fewer meetings and would conserve their strength. Could be that he is very, very bright.

—*Kokomo Tribune*
Dec. 30, 1958

Food Additive Laws Helpful

The new food additive amendment to pure food and drug laws presents the chemical and food processing industries with a new public relations problem. It is to make housewives understand what certain chemicals added to prepared foods are all about—good and bad.

When the first pure food law was passed in 1906 the basic philosophy was that any chemicals added to foods—principally to preserve or adulterate them—were bad.

Fifty years of advancing food chemistry have changed that concept considerably. Now it is appreciated that some food additives may be beneficial. Like vitamins.

Discovery and use of vitamins is one of the great all-time advances in food technology. Vitamin additives prevent nutritional deficiency diseases like pellagra, which used to take 3,000 lives a year.

Addition to salt of micro-amounts of iodine —itself a poison—and wider use of sea foods have all but eliminated goiter.

Calcium and sodium propionate additives in bread prevent mold. In small amounts, these are harmless chemicals found in natural foods like Swiss cheese.

Other chemicals may be added safely to prepared mixes to keep ingredients in good condition. Many processed foods now sold in supermarkets would be impossible without additives. Still, they are distrusted by many housewives.

The long chemical names on the packages are confusing. Housewives can't buy them and they are not in the cookbooks.

Sensational magazines have overplayed the dangers of food additives. These have created scares that all additives are dangerous. The public relations job is to kill this fear.

At first the food and chemical industries opposed all moves to bring additives under government regulation. Then the light began to penetrate. Food processors realized that their industry would be operating under a handicap unless some system was devised to clear beneficial additives.

In 1957 Congress, Food and Drug Administration and the food industry all began to give a little. The resulting legislation isn't as stiff as some of the early drafts. But Food and Drug Administrator George Larrick considers it adequate for what it's supposed to do. The problem is to make it work.

Several classes of additives have been put under government regulations by previous legislation. They're exempted from the new food additives amendment.

For instance, additives used in meat products have already been tested and approved by the Department of Agriculture.

Pesticides—over 100 chemical bug killers which are sprayed or dusted on growing food crops were brought under regulation in 1954. Tolerance limits have been established for the amount of pesticide that may remain on the marketed fruits or vegetables without impairing their safety for human consumption.

Coal tar derivative food dyes were brought under legal control in 1938 after nearly 50 years of voluntary testing.

Silbesterol products—hormone-like chemicals used in fattening chickens and speeding the growth of beef cattle—were brought under control in the 1954 pretesting law. Any chemicals added to livestock feeds are considered drugs. The safety test is that only harmless amounts of the chemicals may be found in the flesh as it reaches the butcher's counter or the kitchen.

The new law covers both additives put directly in food products and indirect additives like fats and oils used in greasing cooking utensils or chemicals used in cleaning cooking vats and pipelines in canneries.

The new irradiated foods are also brought under the additive amendment. Tests must show that the amount of radiation needed to preserve food and the process for applying it do not make the products unsafe for humans. This is one of the big new developments in a long-time food storage.

All of which reminds us that the Food and

Continued



Medicine's priceless past is but prologue to its brilliant present and future. To help provide a better public understanding and awareness of Medicine's proud traditions, Parke-Davis will launch a unique and informative new institutional advertising campaign this month. GREAT MOMENTS IN MEDICINE will depict historically accurate scenes of advancements in Medicine through the centuries. This very colorful and interesting Parke-Davis campaign will appear regularly during 1959 in LIFE, SATURDAY EVENING POST, TIME, READER'S DIGEST, and TODAY'S HEALTH. As a preview to the medical profession, the first ad in this series is reprinted above. Within a few weeks millions of people throughout the United States—and the world—will also see it.

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Drug Administration is one government department that is giving us our money's worth.

—*Kokomo Tribune*
Dec. 23, 1958

Driving Criteria Held Duty of MDs

By World Wide Medical News Service
Washington Bureau

Washington, D. C.—The entire medical profession must share the responsibility of recommending medical criteria that can be used to limit driving privileges of high-risk cases, Dr. A. L. Chapman, chief of the U.S. Public Health Service Division of Special Health Services, told the Association of State and Territorial Health Officers meeting here.

Dr. Chapman did not recommend compulsory case reports by physicians to motor vehicle licensing agencies on applicants for driver's licenses. Such a recommendation, he said, might invade the physician-patient relationship.

His report, based on a survey of the relationships of State Health Departments and State Motor Vehicle Administrators, showed the wide variations among the states in reporting of medical conditions to driver-licensing agencies. The survey was conducted by the PHS Accident Prevention Program.

Dr. Chapman urged state health officers to attempt to reach agreement among the private physicians in their areas on limiting or disqualifying medical criteria. In addition, he urged state health departments to conduct epidemiologic studies on accident susceptibility of some drivers, to direct public education campaigns on effects of drugs, alcohol, and fatigue on driving, and to establish closer liaison with State Motor Vehicle Administrators through Governors' Traffic Safety Committees.

The PHS survey, which grew out of a meeting of PHS and the American Association of Motor Vehicle Administrators, produced these findings:

1. Case reports on diabetes and epilepsy among applicants for driver licenses or renewals are submitted directly by private physicians to motor vehicle departments in seven states (Rhode Island, New York, Pennsylvania, Wisconsin, Iowa, Oklahoma, Wyoming) and from physicians to health departments in four (Connecticut, Indiana, California, Oregon).

Some Report Mental Patients

2. In only one state, New Hampshire, is there a system of reporting hospitalized mental patients to the health department, but in 10 states hospitalized mental patients who are applicants for drivers' licenses are reported directly to the licensing agency by physicians and hospital administrators.

3. Cooperative accident research studies among state health departments and motor vehicle agencies are conducted in 17 states, 12 of them through the Cornell University Automotive Crash Injury Research project.

4. Death certificates or lists of deaths are regularly sent by health departments to motor vehicle departments in 15 states.

5. Governors' committees on traffic safety exist in 42 states, but the state health department is a member in only 23. In no state do representatives of the health department conduct regular meetings with the motor vehicle agencies, but there was a regular exchange of statistical reports in 18 states.

The report acknowledged that the question of reporting possibly disqualifying medical conditions was controversial and quoted several health officers in opposition to a compulsory system of reporting on grounds that the patient might avoid consulting a physician for fear of being reported an unfit driver.

—*Scope Weekly*
Jan 1, 1959

Slower County Speed Limit

The Indiana Traffic Safety Foundation, Inc., favors legislation to reduce the state speed limit of 65 miles per hour on county roads.

It's a good idea.

It is not a suggestion that the 65 mph limit on major highways be changed, but that a slower speed be authorized on lesser roads.

Most of the county roads in Indiana were not designed or built for high speed traffic. Yet traffic is permitted to travel over them at 65 miles an hour except in places where other speeds are posted.

Authority to post limits which are suitable for the type of road and amount of traffic it carries rests with county officials. But not all roads that fall in this category are posted.

Continued

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in Rheumatoid Arthritis

*Using combined drug therapy with **PLAQUENIL®** or Aralen® as maintenance therapy. With Plaquenil or Aralen alone 62% grade I and II improvement. (Scherbel, A.L.; Harrison, J.W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958. Report on 805 patients with rheumatoid arthritis or related diseases.)

Reasons for Failure:

1. Treatment discontinued too soon (percentage of patients improved increases substantially after first six months).
2. Patients in relapse after prolonged steroid therapy are resistant to Plaquenil or Aralen treatment for several months.

Plaquenil sulfate is supplied in tablets of 200 mg., bottles of 100.

Dose: Initial — 400 to 600 mg. (2 or 3 tablets) daily.
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Fourth Estate

Continued

Hazards of driving on these narrow secondary roads create a problem which the legislature might well try to solve. It is the suggestion of the Traffic Safety Foundation (an independent organization) that a speed limit of 45 miles an hour be established, with county authorities retaining the power to zone certain roads either up or down from this limit to conform with the need.

The proposal for a 45 mph limit is reasonable. If it should be established, traffic probably would move at 50 miles an hour, for motorists usually drive a little over the speed limit whatever it is. At 50 miles an hour, traffic over county roads would be safer than it is at 65.

The foundation's proposal seems to us to be a step in the direction of sensible safety measures. If a bill calling for enactment of the suggested limit is introduced, we hope that Howard County legislators will support it.

—*Kokomo Tribune*
Nov. 24, 1958

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE

INTENSIVE POSTGRADUATE COURSES
STARTING DATES — EARLY 1959

SURGERY—
Surgical Technic, Two Weeks, March 2, March 16
Surgery of the Colon & Rectum, One Week, March 2, April 6
Basic Principles in General Surgery, Two Weeks, April 13
Gallbladder Surgery, Three Days, April 6
Surgery of Hernia, Three Days, April 9
General Surgery, Two Weeks, April 27
Board of Surgery Review Course, Part II, Two Weeks, May 11
Fractures & Traumatic Surgery, Two Weeks, April 6
Treatment of Varicose Veins, Two Days, March 2, April 6

GYNECOLOGY & OBSTETRICS—
Office & Operative Gynecology, Two Weeks, March 16
Vaginal Approach to Pelvic Surgery, One Week, March 9
General & Surgical Obstetrics, Two Weeks, March 30

MEDICINE—
Electrocardiography, Two-Week Basic Course, March 16
Gastroscopy & Gastroenterology, Two Weeks, March 2
American Board Review Course (Part II), to be announced

UROLOGY—
Two-Week Intensive Course, April 27
Ten-Day Practical Course in Cystoscopy, by appointment

RADIOLOGY—
Diagnostic X-Ray, Two Weeks, March 2, April 27
Clinical Uses of Radioisotopes, Two Weeks, May 4

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Tougher Driver Policy
(Marion Chronicle)

Fewer driver license suspensions and more jail sentences for drunken drivers will be recommended to the 1959 session of the Indiana Legislature.

The recommendation will come from the Governor's Traffic Study Commission as one of several ideas to improve the state's record for automobile accidents and fatalities.

Actually, the chairman to the traffic commission has called its recommendation a "horse trade" with the Indiana State Bar Assn., which contends that the present license suspension law is too strict.

Indiana's statutes now call for suspension of a driver's license for a year on first conviction of drunk driving. The suspension is for two years on additional convictions.

The traffic commission wants this law repealed and replaced with a law handing out jail sentences. A drunk driver who was at fault in a crash that injured someone would automatically go to jail for at least 90 days and possibly as long as five years. There would be a fine ranging from $250 to $5,000.

First conviction of a drunk driver in a property damage case would bring a fine of $250 to $500, and a jail term ranging from five days to a year could be handed down on a second conviction and the court would not be allowed to suspend the sentence.

Suspension of drivers' license would be left up to the judge.

It will be a hot potato for the legislators when they convene in Indianapolis.

The Legislature also will be asked to pass a law requiring everyone under 18 to pass a driver training course before being issued a license.

The traffic commission favors establishment of a special state police detail to make sure motorists are not driving after their licenses have been suspended.

Only recently a Marion judge noted the laxity in keeping track of motorists who have had their drivers' licenses suspended. This correction certainly is in order.

The traffic commission's jail sentence recommendation is severe. It needs serious study by the Legislature before taking action.

—*Kokomo Tribune*
Dec. 12, 1958

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provides fast, high blood and tissue concentrations

Because ERYTHROCIN Stearate is rapidly absorbed, patients get therapeutic blood and tissue levels within 30 minutes. High, peak levels occur between one and two hours—and effective concentrations are maintained for at least six hours. Always at hand, then, against more critical infections is ERYTHROCIN-I.M.—the only intramuscular form of erythromycin available.

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Actually, every prescription you write for ERYTHROCIN is backed by more than six years of clinical effectiveness against coccal infections. And, with the problem of antibiotic resistance becoming more important daily, the value of ERYTHROCIN as a day-to-day anticoccal agent is dramatically underlined.

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During all the years ERYTHROCIN has been prescribed, serious reactions have been practically nonexistent. Unlike penicillin, allergy is no problem. And, in contrast to "broad-spectrum" action, the normal flora of the intestinal tract is virtually unaltered with ERYTHROCIN therapy.

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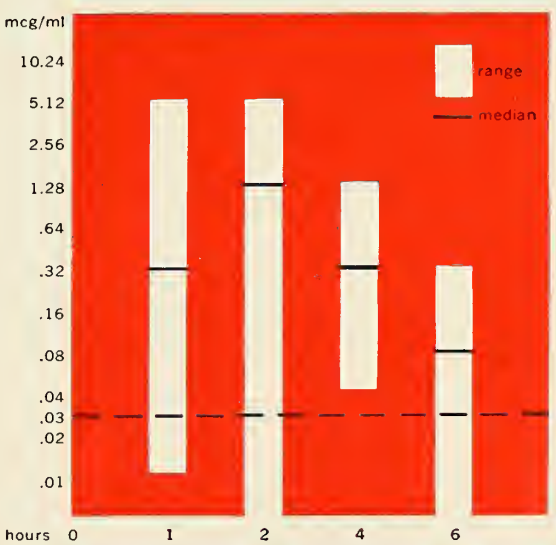
Unlike broad-spectrum antibiotics, ERYTHROCIN is classed as a bactericidal antibiotic. It offers lethal action against common coccic invaders—resulting in prompt clinical response.

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Usual adult dose is 250 mg. four times daily. Children's dosage is reduced in proportion to body weight. ERYTHROCIN comes in Filmtabs® (100 and 250 mg.), bottles of 25 and 100. Also in oral suspension and for intramuscular use. Won't you prescribe ERYTHROCIN doctor? Abbott

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Dotted line shows actual inhibitory concentrations against most organisms. Note the high ranges and medians of ERYTHROCIN Stearate at one, two, four and six hours. Data represents three studies with adults. Each was given one 250-mg. Filmtab.



And where you need a consistent uniform response that only an injectable form can provide, remember—**ERYTHROCIN-I.M.**(Erythromycin Ethyl Succinate, Abbott) and **ERYTHROCIN LACTOBIONATE.**

®Filmtab—Film-sealed tablets, Abbott; pat. applied for.

Indiana's Health Care Bill

A true solution to the problem of financing health care can be based only upon accurate and comprehensive information. Since they were organized, the Blue Cross-Blue Shield plans have accepted the community responsibility of accumulating such data on a continuing basis. This article is the first of a series prepared by Blue Cross-Blue Shield to detail changes in the cost of health care and trends in the financing of health care.

Blue Cross-Blue Shield experience indicates that most people want to prepay most of their health care bill. The Plans believe that the time is not far off when most of the health care bill will be prepaid. That is the trend.

What is the size of the bill we are talking about? According to the U. S. Department of Commerce, in 1957 Hoosiers spent an estimated $368,000,000 for this purpose. Of this amount, approximately $220,000,000 was spent for hospital bills and physicians services—which is the area covered by Blue Cross-Blue Shield.

During 1957 Indiana Blue Cross (with membership totaling one-third of the population) paid one-third of the total hospital bill—$34,000,000. On the average, 95% of our member's total hospital charges were covered. The remaining 5%, which was paid by the members themselves, was made up largely by the private room differential and blood or blood plasma charges.

Blue Cross fees increased during the year as service benefits expanded to absorb increased hospital costs resulting from more people entering hospitals and staying longer at increased cost per day. Other factors affecting costs included rising wages, the increased use of new and expensive procedures, drugs and equipment, and services.

During the year Indiana Blue Shield payments totaled more than $11,500,000 — about 10% of the total bill paid by Hoosiers for surgical, obstetrical and other physicians services.

The total surgical bill was $34,000,000; obstetrical, $18,000,000; and other physicians services, $66,000,000. In the surgical and obstetrical areas, Blue Shield is doing a good job with the Preferred Schedule, and a fair job (60% of total charges) with the Standard Schedule.

In the area of other physicians services, 90% of the Blue Shield membership is covered for in-hospital medical care, but many doctors say the coverage is not adequate. Blue Shield currently is pushing its diagnostic program, and at this time covers about 20% of its members with the protection.

Any expansion of Blue Shield benefits will probably include the following: (1) increased allowances for in-hospital medical care, (2) consultants' fees, (3) home and office calls, and (4) other physicians services.

Most people believe that the time will come when all of these areas will be covered by some form of health care financing: Blue Cross-Blue Shield, commercial insurance or government.

Today high quality health care is available to all Hoosiers. The problem has been changing from one of availability to one of financing.

The next step is to find a way to provide the needed health care benefits at a price the people can afford. Blue Cross-Blue Shield believes that doctors, hospitals, the Plans themselves and other constructive elements of the population can work out the solution on a cooperative basis.

WARREN HUDDLESTON,
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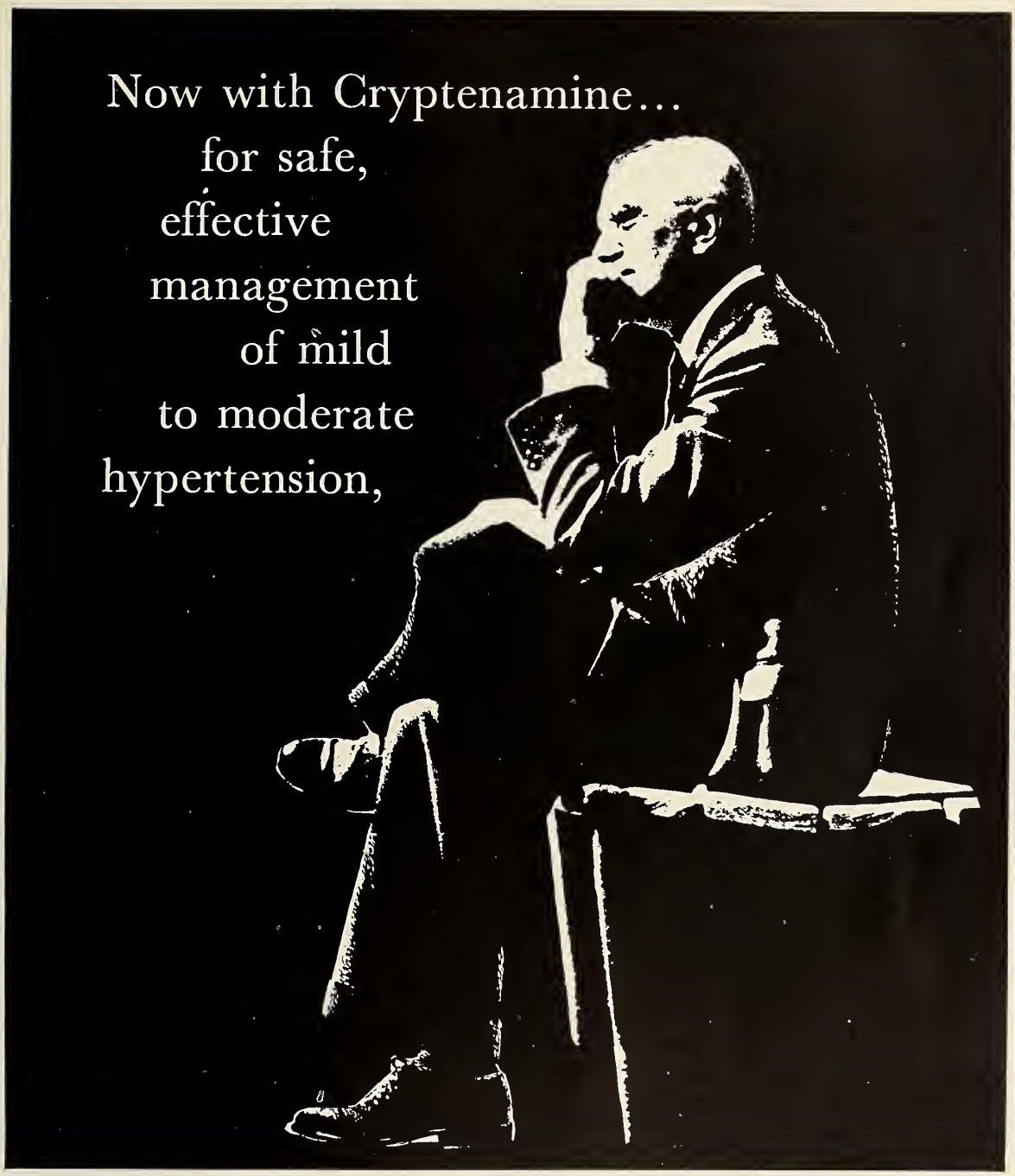
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Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health. strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol. in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

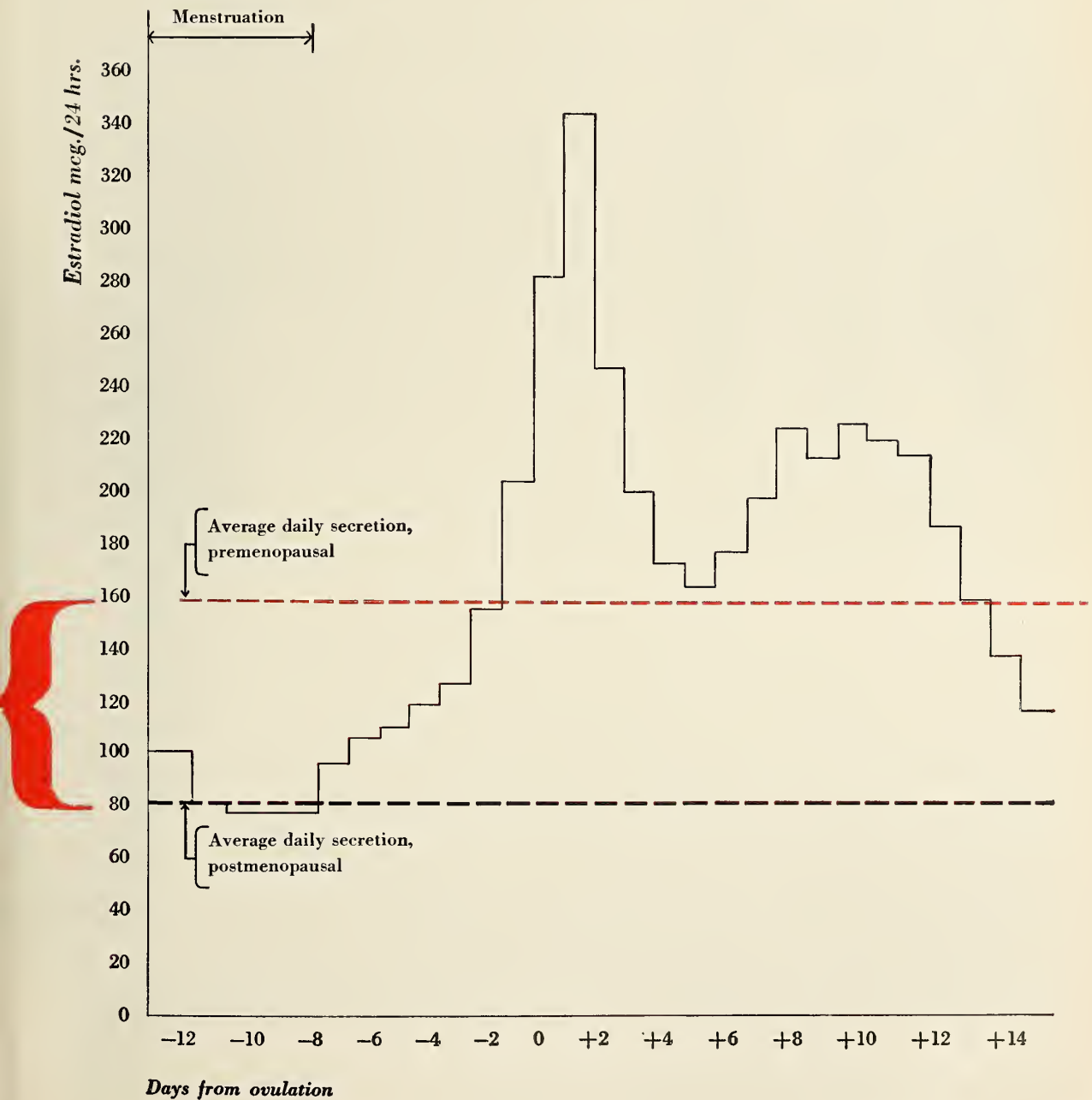
Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

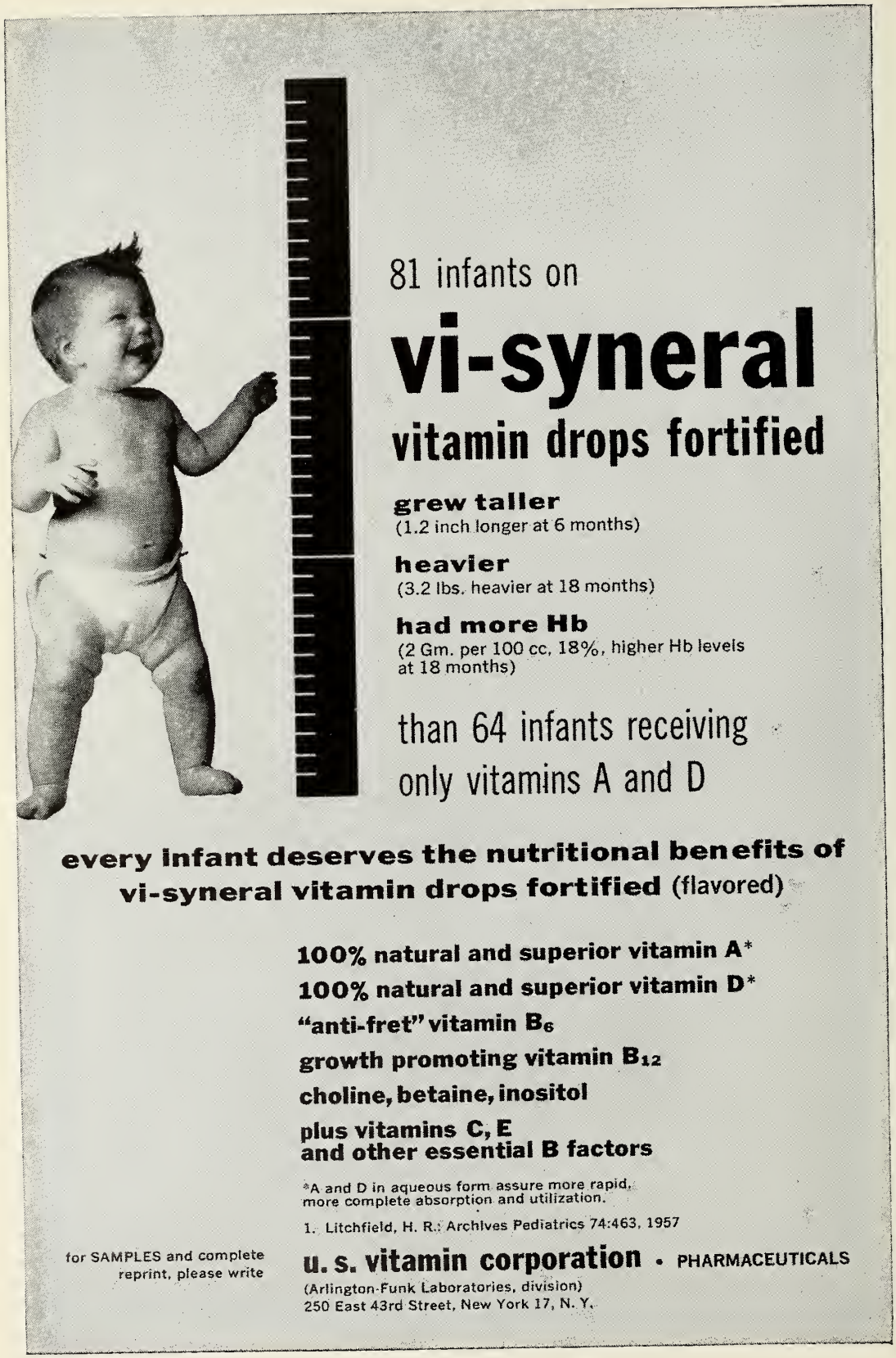
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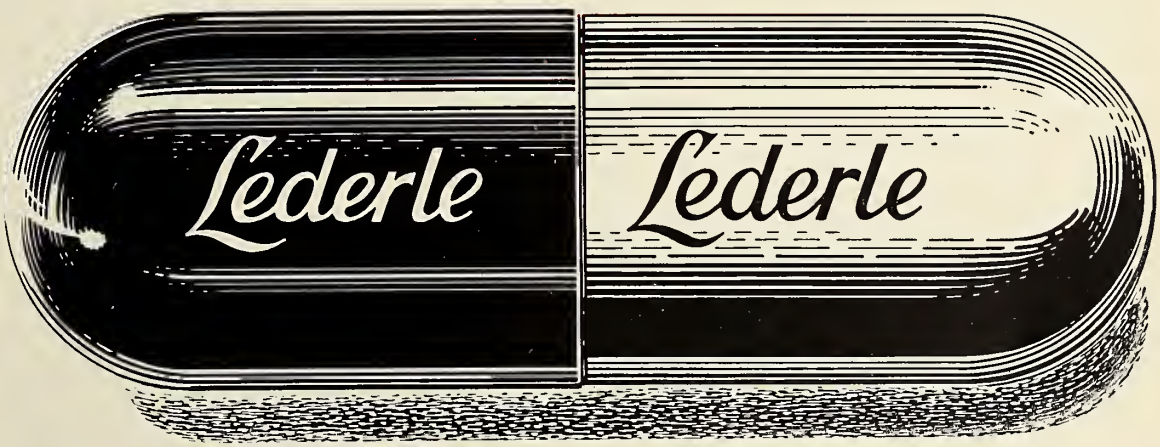
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1. Litchfield, H. R.: Archives Pediatrics 74:463, 1957
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What Labor Said at 1958 National Conference on Labor Health Services*

E. T. EDWARDS, M.D., Chairman
Commission on Medical Economics and Insurance

THE AMERICAN LABOR Health Association sponsored a meeting in Washington, D. C. on June 16, 17 of leaders and administrators of health and medical programs from all segments of labor for the following purposes:

1. To discuss the major health needs of the American worker and his family. 2. To review the obstacles encountered in meeting these needs. 3. To discuss methods of achieving labor health goals.

This meeting was important to all physicians in private practice for it outlined the direction that labor intended to follow to accomplish the above purposes. Many of the statements made are in agreement with our own ideals, some are distortions of fact or erroneous conclusions, while others are in direct opposition to the majority of physicians.

Last year we were concerned with "freedom of choice" in regard to third party payers designating physicians. This concept is rapidly going the way of the Model T Ford, for at the conference it was frequently stated that group practice, salaried physicians with no "private" (fee for service) patients, was the only inexpensive way that top quality medical care could be rendered, not only to union members but to entire communities.

Most of the speakers were physicians! That is important. True, they were employees of union operated group practices, but some were medical administrators and public health leaders, and medical educators. All condemned "solo" practice and this would include partnerships in the same speciality. We recognize that some physicians prefer salaried positions with regular hours such as they find in clinic or group practice, in the V.A. hospitals, in the Armed Services. The important point to most of us in medical practice is that the labor aim is to force all of us into such organization. Individual professional integrity was discounted, yet the speakers are looking to these same individual physicians for medical manpower.

The contradictions are obvious throughout the printed "Papers and Proceedings." Quality of medical care was implied as being the exclusive desire of union health centers. The Blue Plans were criticized for not having built-in quality controls. In discussing professional quality controls, Milton Terris, M.D., assistant dean of postgraduate school of medicine, University of Buffalo, listed these familiar methods of "solo-AMA" origin; Joint Commission on Accreditation of Hospitals, the regional organization of hospitals, e.g., Rochester, N. Y., Reg. Hosp. Council, medical and surgical audit committees, postgraduate programs (IAGP "Road Shows") specialty boards.

Dual plan coverage in which health service centers with group practice and/or insurance coverage with a choice for the union member between the two types of practice revealed some interesting statistics.

District 65 Security Plan, NYC—60% stay with HIP, 40% indemnity plan
10% switch back and forth yearly

ILGWU Dress Joint Board—66% comprehensive, service plan
33% fee-for-service plan

Kaiser Foundation Plan, Oakland, Calif.—

Continued

* Written to provide background information for commission members. Published for information of all ISMA members.

In the Treatment of Rheumatic Disorders Greater stability of maintenance dosage minimizes risks of hormonal imbalance

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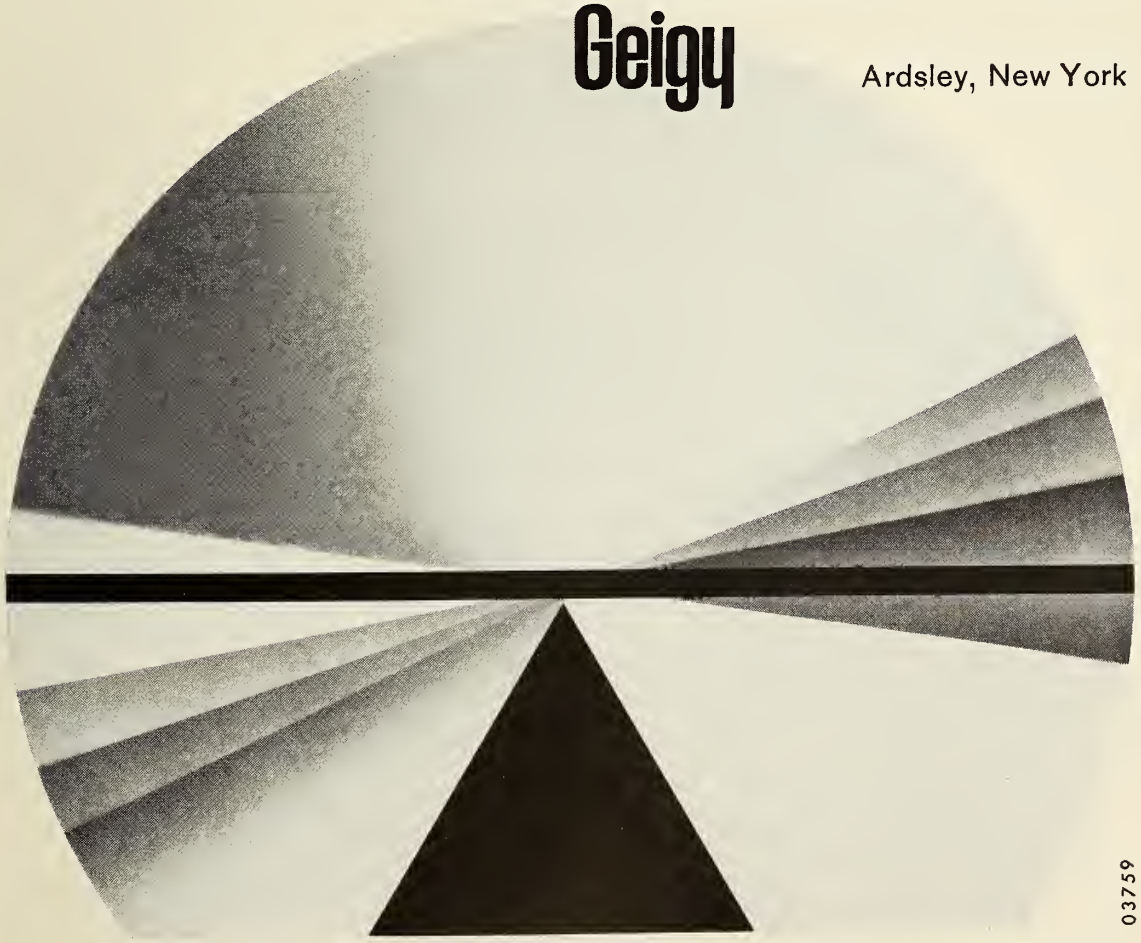
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What Labor Said

Continued

70% Kaiser, 30% indemnity plan
3-5% switch yearly

The above was explained on the basis that "patients shop around among solo M.D.s too." It was also pointed out that with both H.I.P. and Kaiser plans that the longer a particular union was affiliated with a service plan, the fewer members who changed to indemnity, being 10% after 10 years. A contributing factor was thought to be the attitude of the part-time physician toward group patients implying that he was more interested in his "private-fee for service" patient; hence, the desire to have only full time M.D. Costs: The Medical Institute Local 88, St. Louis has an average cost of $29.70 per employee and family per month or $356.40 per year. The AMA was quoted as saying that $450.00 per family per year was minimum to do an adequate job on fee-for-service.

What does this mean to us in Indiana? There are two answers depending upon location-urban or rural-and on time—now or later. Apparently the Steel Unions in Northern Indiana are toying with the service medical center idea this year; if successful there and if the U.A.W. is successful with their community wide program in Detroit, this concept of medical care can spread over our urban areas rapidly. It might take longer to reach the rural counties, but the co-op movement among farmers is big business and the Farm Bureau is already in the health insurance field.

Likewise there are two ways of appraising the success of such plans in obtaining medical manpower. Some doctors with light practices, for various reasons, might jump on the band wagon. The others with large practices and financially solvent with good patient rapport and/or loyalty can resist. The latter group are the physicians most desired by the unions . . . if they are sincere in speaking of "quality care" and if they want member support. Herein lies our strength, in my opinion, and we must use it to the fullest extent. Going to the Courts and Legislatures has proven to be a mistake in Colorado and Kentucky, but individual physicians can refuse to work for a particular employer just as any other civilian worker.

Traditionally, the county medical societies have been the watch dog of professional ethics. Should they assume an auditing function over the quality of medical practice in our offices and on our house visits as do the Joint Commission for our hospital practice? If so, how?

Rural Health Conference Planned

The AMA Conference on Rural Health will be held this year at Wichita, Kansas, March 5-7. Theme of the meeting will be "Horizons in Rural Health." Dr. F. S. Crockett of Lafayette, AMA Council chairman, will speak on this subject and outline the objectives of the conference.

The keynote speaker will be Earl L. Butz, dean of Agriculture and director of agricultural extension services at Purdue University. Dr. Louis M. Orr, AMA president-elect, and Governor George Docking of Kansas will address the meeting.

About 700 physicians, farm leaders and representatives of government and other lay groups will be in attendance for the three-day session.

Subjects of mental health, aging, nutrition, dental health, costs of medical care and health insurance will be discussed.

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 52 — February 1959 — Number 2

The Robert M. Moore Heart Clinic at Indianapolis General Hospital in 1958

KENNETH G. KOHLSTAEDT, M.D.*

EACH YEAR the activities of the Robert Moore Heart Clinic have expanded. During 1958 there were 6,500 visits to this clinic. Dr. Fisch and his associates gave the in-patient services at General Hospital 430 consultations. The catheter team performed 62 examinations and 6,500 electrocardiograms were made and interpreted. In addition to the care of patients, the staff has taken a very active part in the medical education of both the house staff and the medical students.

The Krannert Fellows for 1958-59 are Dr. Edward F. Steinmetz and Dr. Alfred F. Fasola.

In 1958, Dr. Fisch became full-time staff member of Inidanapolis General Hospital. This has enabled us to increase both the teaching and research programs in cardiology. The chief interest has been in the relation of potassium to digitalis intoxication and a study of cardiac output in cirrhosis of the liver.

The articles in this issue of *The Journal* have been prepared by the Department of Cardiology at the Indianapolis General Hospital.

The generous financial support of Mr. and Mrs. H. C. Krannert is acknowledged. We wish also to express our appreciation for the fine cooperation of the Indiana State Board of Health and to Dr. Wendell C. Anderson.

Although the diagnostic facilities available to us in 1959 represent a vast improvement over those in the days when Dr. R. M. Moore and Dr. C. J. Clark first began to hold a Saturday morning heart clinic at the City Hospital, nevertheless we must continue to strive for the skill and perfection in physical diagnosis of these, our teachers, Dr. Bob Moore and Dr. Cy Clark.

* Director, Clinical Research Division, Eli Lilly and Company; professor of medicine, Indiana University School of Medicine; chief, Department of Cardiology, Indianapolis General Hospital.

Potassium, Digitalis and the Heart†

CHARLES FISCH, M.D.*
EDWARD F. STEINMETZ, M.D.**
ALFRED F. FASOLA, Ph.D., M.D.**
B. L. MARTZ, M.D.***

THE ROLE OF potassium in normal metabolism and in patients with heart disease has been the subject of intensive study. It is the purpose of this paper to review briefly (1) the normal metabolism of potassium, (2) the role of this cation in the healthy and diseased heart, (3) its use in the treatment of cardiac arrhythmias purportedly due to digitalis toxicity and (4) to present the results of our studies of the relation of digitalis and potassium.

The major effects of oral or intravenous infusion of potassium on the electrocardiogram are well known. The T wave assumes a peaked, "tented" appearance when the concentration of serum potassium reaches 5.5 mEq/liter, and this elevation is independent of the heart rate or duration of the QRS. Progressive depression of the P wave becomes evident at a serum concentration of 9.4 mEq and the wave becomes isoelectric at a concentration of 11.0 mEq. The disappearance of P wave may take place at lower concentrations if the rate of rise of plasma level exceeds 0.33 mEq per minute. In some cases depression of the RS-T or inversion of the T is seen at concentrations of 8.0-11.0 mEq/liter The PR interval becomes prolonged at high serum levels with appearance of partial or complete heart block. Depression of intraventricular conduction is evidenced by widening of QRS with ventricular standstill at a concentration of 14.0-16.0 mEq/liter. Rapid intravenous administration of potassium on the other hand often results in ventricular fibrillation.[1] In the presence of normal renal function a human cannot ingest sufficient amounts of potassium to produce significant electrocardiographic changes because of gastric irritation. However, studies in animals show that acute loading with 1.0 mEq per Kg of body weight by the oral route may elevate serum potassium to toxic levels. The kidney can easily excrete potassium in amounts up to 0.5 mEq per Kg of body weight but doses of 1.0 mEq per Kg elevate the serum level by 1.0 mEq/L and doses of 2.0-2.5 mEq per Kg can elevate serum levels up to 6.0-8.0 mEq/L. It has been shown in rats that the tolerance to potassium can be increased markedly by chronic sublethal loading with this cation.[2] The excretion of potassium after acute loading has been investigated under various states of renal function. In congestive heart failure a negative potassium balance usually exists and measurement of exchangeable potassium using radioactive isotope dilution technic discloses a reduction in total body potassium.[3] The ability of an individual to handle large amounts of orally administered potassium was studied in the normal patients with

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Supported by the Herman C. Krannert Fund of the Indiana Heart Foundation and the Indiana State Board of Health.

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** Krannert Fellow in Cardiology, Indianapolis General Hospital, Indianapolis,

*** Director, Lilly Laboratory for Clinical Research, and Visiting Physician, Indianapolis General Hospital; Assistant Professor of Medicine, Indiana University School of Medicine, Indianapolis.

compensated heart disease and individuals with heart disease with congestive failure. Those with heart failure showed poorest tolerance for potassium with the highest rise of plasma level and a parallel low renal excretion of the cation. On the other hand plasma levels were lowest in the normals and in these individuals most of the injected ion was excreted within 3 hours.[4]

Experimental studies showed that prolonged work results in the loss of muscle potassium and that this can be prevented by adding potassium to the perfusing solutions. Analysis of myocardium in congestive failure revealed an absolute diminution of intracellular potassium with a concommitant rise in intracellular sodium. Differential analysis of right and left ventricles showed that this decrease is more pronounced in the chamber "primarily" responsible for the congestive failure. Digitalis tends to reverse this process and tends to reestablish the normal intra- to extracellular ratio of potassium.[5, 6, 7] This drug maintains the intra- to extracellular ratio of potassium by aiding in the transport of potassium into the cell, or preventing the egress of the cation from the cell. Digitalis given to the normal animals in therapeutic doses has been reported by some to cause an increase in the intracellular content but the great bulk of evidence fails to disclose any demonstrable shift. On the other hand it is pretty well agreed that toxic doses of digitalis result in egress of potassium from the cell.[5,8,9,10,11,12] The suggested relation of K and digitalis was demonstrated during dialysis of uremic patients kept on maintenance dose of digitalis. As potassium is extracted symptoms and electrocardiographic changes suggestive of digitalis intoxication became evident and these could be reversed by administration of K salts.[13, 14]

In clinical practice the problem of K balance is further complicated by the use of acidifying agents, anoxia, carbonic anhydrase inhibitors, mercurial diuretics, sodium and potassium removing resins and anoxia. The occurrence of the signs and symptoms of digitalis intoxication following marked mercurial diuresis has been at one time attribtued to mobilization of digitalis from the edema fluid, but more recent work has shown that digitalis intoxication occurs after diuresis during which significant amounts of potassium are lost. Appearance of symptoms and signs of digitalis intoxication has been reported following the use of hydrocortisone.[14, 15]

Lown and Levine[14] recommend the use of potassium as an important measure in the treatment of digitalis intoxication. In ambulatory patients, 5.0-7.0 gm. of potassium chloride in divided doses usually suffices to control symptoms. In severe digitalis intoxication these authors administer intravenously a solution of 40.0 mEq potassium chloride in 500 cc. of 5% glucose. At the first sign of "tenting" of T-waves the infusion is stopped. This can be repeated every hour until symptoms and signs of intoxication disappear or a total of 120 mEq are given. The same authors report 10 cases of paroxysmal auricular tachycardia due to digitalis which respond to 20-100 mEq of potassium chloride, while the same arrhythmias not associated with digitalis failed to respond to potassium. Bettenger *et al*,[16] using an intravenous infusion of potassium chloride with constant electrocardiographic control, were able to suppress arrhythmias of non-digitalized patients with the same frequency as those in digitalized patients. There was no correlation between the initial level of plasma potassium and the ease with which the arrhythmias were suppressed.

For the past 3 years we have been involved in a systematic study of the effect of potassium on cardiac arrhythmias associated with digitalis therapy. It was assumed at first that if potassium had an effect opposite to digitalis, than in patients with atrial fibrillation with ectopic ventricular beats and slow ventricular rates due to digitalis, this cation should abolish the ectopic beats and at the same time speed the ventricular rate. The latter would be a manifestation of digitalis and potassium antagonism at the level of the A-V node with increased A-V conduction and resultant speeding of ventricular rate. Surprisingly, the results failed to bear out this assumption. Ventricular ectopic rhythm in each case disappeared but with parallel depression of A-V conduction. The latter was manifested by complete A-V dissociation and appearance of independent idioventricular rhythms, indicating that the effect of K was one of non-specific depression of both the ectopic focus and conduction tissue myocardium rather than any specific digitalis and K antagonism. Futhermore, the depression of ventricular ectopic beats was surprisingly shortlived and in all of our cases reap-

peared promptly when the infusion was stopped. The presence or absence of ventricular premature contractions, depression of A-V nodal conduction and the rate of discharge of A-V nodal pacemaker could often be controlled by merely speeding or slowing the rate of infusion of potassium.[17] Figure 1 is representative of the changes observed during infusion at a rate of approximately 1 mEq per min. of .5 mEq per Kg of potassium phosphate as an isotonic (155 mEq of K per liter) solution in distilled water or 5% glucose to a group of 20 patients with ventricular ectopic beats accompanying digitalis therapy. The numbers in the left upper corner of the tracings indicate the time in minutes from the start of infusion. This convention is adhered to in all figures. The control strip discloses sinus rhythm with ventricular bigeminy. The latter beats result in retrograde conduction with negative P-waves clearly visible. Two reciprocal beats are also recorded in the control strip. After 1 minute of infusion at a rate of 18 cc. per minute the ventricular ectopic beats disappear (strips 3, 4) with parallel A-V dissociation and appearance of idioventricular rhythm (strip 5). Thirty seconds after the injection is stopped the ventricular ectopic beats reappear (strip 5) and 15 seconds later the sinus rhythm is reestablished (strip 6). The same sequences of events is evident at 21 minutes after the infusion was started. At the end of administration of 40 mEq of potassium phosphate the rhythm was the same as before the administration of the cation.

We were unable to find any evidence of potassium and digitalis antagonism. All of our patients had normal plasma potassium levels and there was no reason to suspect potassium depletion. It was interesting to note that the complete

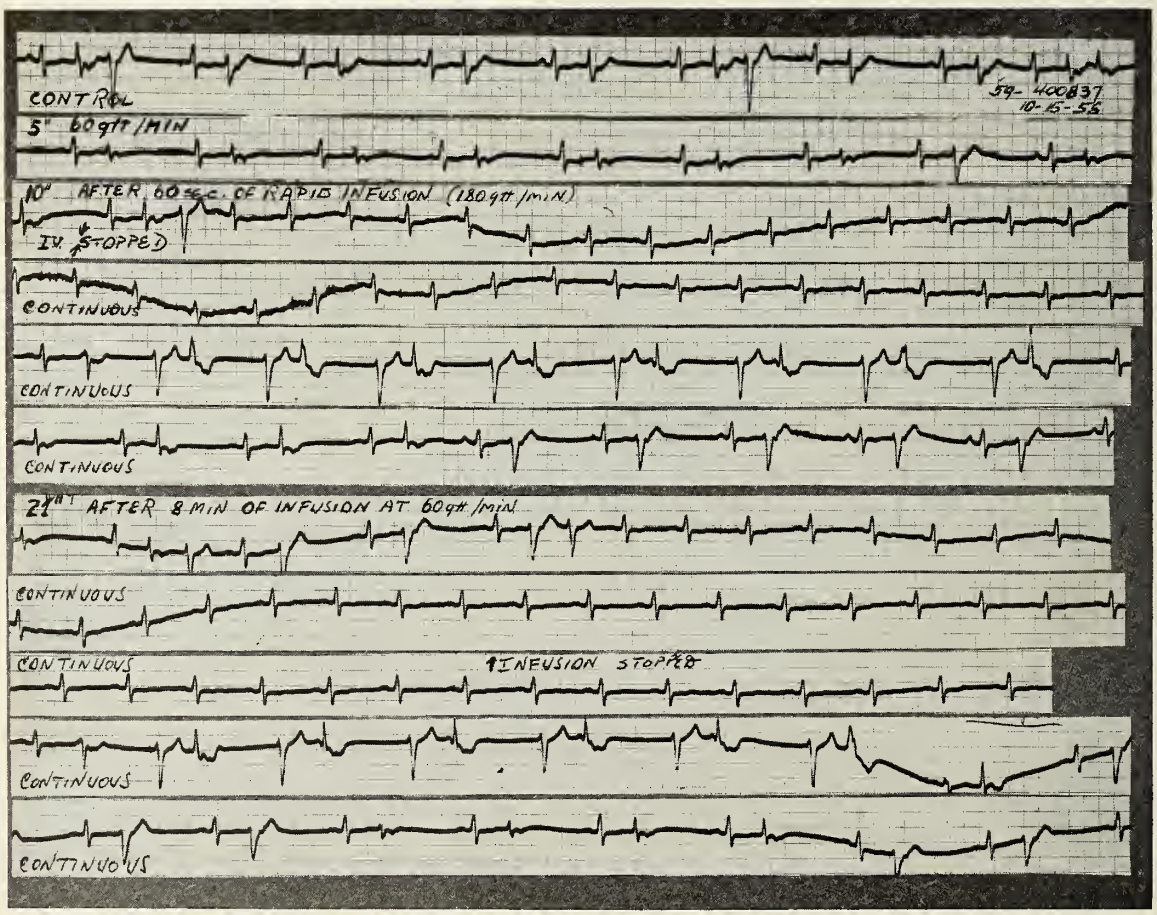


Fig. 1—The numbers in the left upper corner of the tracings indicate time in minutes from start of the infusion. This convention is adhered to in all figures. The above cardiograms show the transient effect that potassium has on ventricular ectopic beats. These ventricular premature beats disappear (strips 3, 4, 7, 8, 9) but with parallel depression of A-V conduction to the point of complete heart block (strips 5, 10). The preinfusion pattern reappeared promptly when injection of the cation was interrupted (strips 6, 11). For detailed description see text.

block so easily brought about in the digitalized individuals was not noticed in our partially digitalized individuals. Furthermore the few individuals to whom potassium was given before and after full digitalization exhibited serious signs of potassium and/or digitalis intoxication with the infusion that followed full digitalization.[18] The same phenomenon was demonstrated by us in dogs.[19] Our findings may seem contrary to present-day thinking but actually are in keeping with the known effects of digitalis on the cell. The drug in toxic doses causes egress of potassium from the cell and reduces the transfer rate of the ion in cardiac and skeletal muscle. It seems reasonable to assume, therefore, that as long as the toxic levels of digitalis block transfer of potassium into the cell the latter, if injected, will reach a high level in the extracellular compartment.

Figure 2 demonstrates the additive effect of potassium and digitalis. On March 19, 1957, prior to digitalization, the patient was given 35 mEq of potassium phosphate in form of isotonic solution in distilled water. The total time of infusion was 9 minutes. No demonstrable changes from control were observed. When next seen on April 7, 1957, the patient was fully digitalized as evidenced by slow ventricular rate varying from 40 to 44 beats per minute, appearance of runs of A-V dissociation with a R-R interval of 1.52 (first 3 R-R intervals in strip 2). During the infusion, spread of the QRS became evident within the first 5 min. Marked slowing of ventricular rate with runs of A-V dissociation with R-R interval of 2.12 sec. is evident at the end of infusion (8 min. strip). With termination of the infusion the ventricular rate became faster but runs of A-V dissociation with R-R of

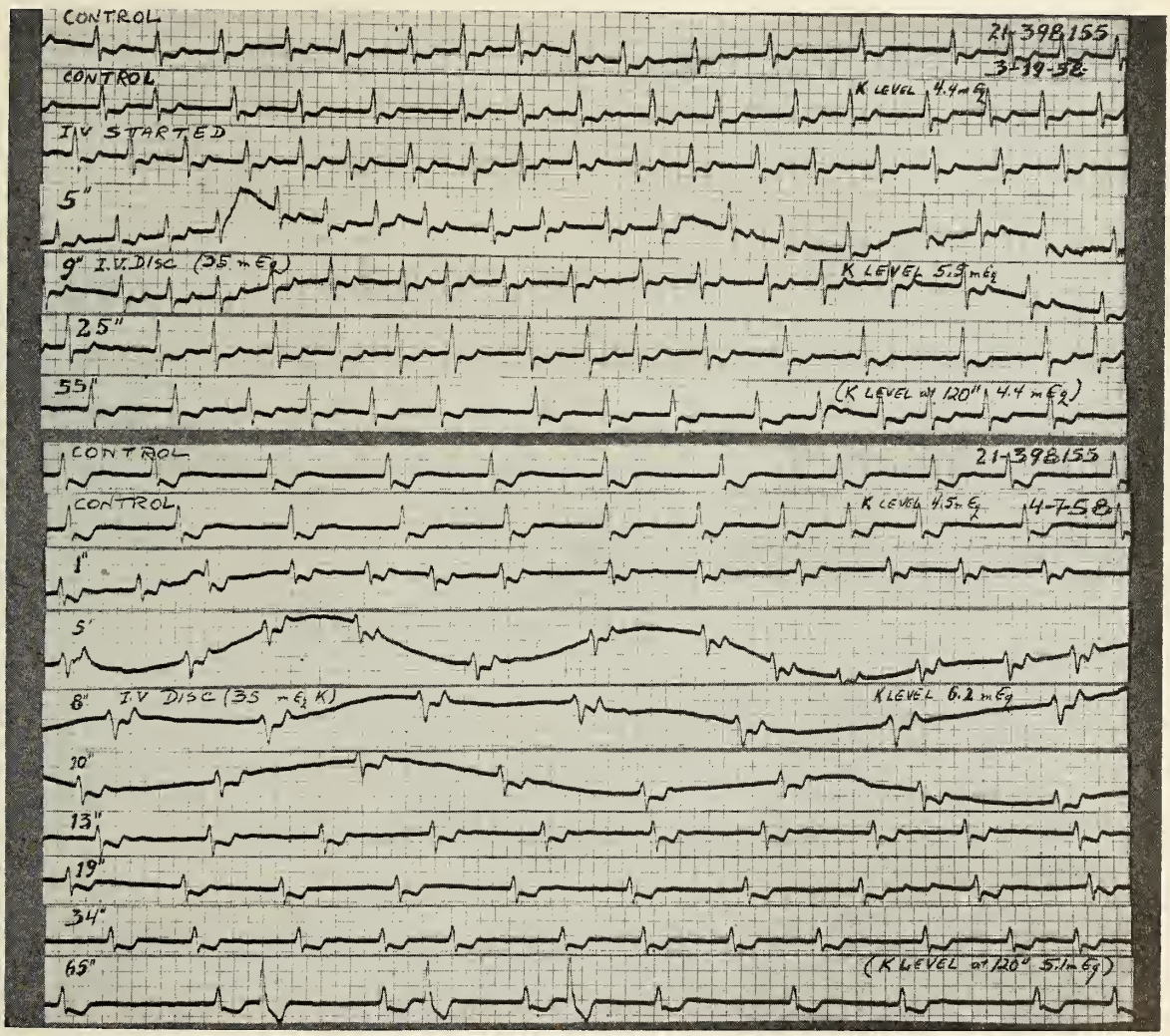


Fig. 2—This figure shows the effect of potassium on A-V and intraventricular conduction before (3-19-57) and after (4-7-57) full digitalization. For description see text.

1.92, 1.52 and 1.64 sec. are clearly visible at 10, 13 and 19 minutes from start of the experiment respectively. Supraventricular control was evident at 34 minutes and present during the 3 hours of observation that followed the infusion.

Figure 3 exemplifies the results of infusion of potassium at a rate of 4.6 cc. per min. of solution containing 155 mEq of the cation per liter to dogs. Experiments 4, 5, 6, 7 represent 4 injections of potassium in the same animal, the duration of injection being 27, 21, 49 and 37 min. respectively. Following administration of 5.0 mg. of digitoxin and with the same rate of administration of potassium the animal exhibited signs of severe intoxication at 2 minutes and was dead at 5 minutes.

Observations in animals and patients, fully digitalized or intoxicated with the drug, and who to our knowledge were not hyponatremic, failed to show digitalis and potassium "antagonism." On the contrary there is definite reason to believe that rapid intravenous administration of this drug to a patient fully digitalized or showing signs of digitalis intoxication may be dangerous.

Summary

1. The normal metabolism of potassium and the current status of the role of this cation in treatment of digitalis "intoxication" are summarized.

2. Our studies as here reported, not only (1) fail to demonstrate any lasting benefit of potassium in the treatment of ventricular ectopic rhythms accompanying digitalis therapy but also (2) suggest that potassium may actually potentiate digitalis toxicity. The observed effect of K on ectopic ventricular beats with parallel depression of A-V conduction is best explained by the known nonspecific depressing effect of K on the myocardium. It must be emphasized, however, that our results to date apply only to intravenous injection of 5 mEq per Kg at a rate of 0.5-1.0 mEq of potassium per minute to patients who have, as best as can be determined, normal total body potassium.

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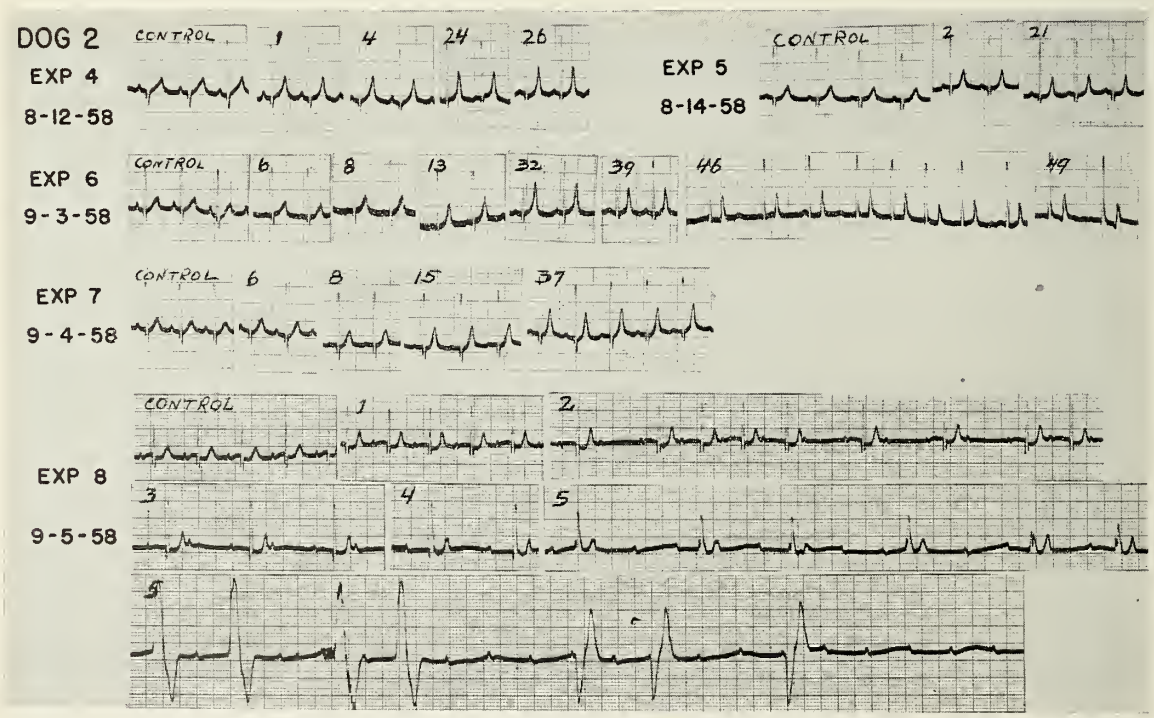


Fig. 3—The effects of uniform infusion of potassium in a dog before (exp. 4, 5, 6, 7) and after administration of toxic doses of digitalis. Note the duration of infusion before and after digitalis intoxication. For description see text.

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Medical Heart Throbs for a Valentine Cover Picture

"The heart sounds entering by way of the ear progressed downward through arm and pencil point to transpose themselves into little heart beats on the Music Staff.

"Besides the Normal Throbs, the Bouquet is composed of four heart conditions, each one stemming from its own cardiograph on the lace holder up through the staff carries the beat of each heart sound into the red heart above.

"Heart Sounds at the apex are:

1. *"Coupling"—Systolic murmur.*
2. *"Murmuring"—High pitched murmur of the dilated heart and incompetent mitral valve.*
3. *"Normal"—(booming muscular sound followed by a short, high note.)*
4. *"Galloping"—(rhythm of a horse galloping) Severe myocardial damage or heart failure.*
5. *"Rheumantic"—(rheumatic actually, spelling poetic license) Advanced rheumatic heart. Naturally the Red Rose and the mask is used for "rheumance" (romance). However, the mask with its myriad possibilities might describe advanced murmur at both valves.*



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Atypical Mitral Stenosis†

TWO CASES OF ATYPICAL MITRAL STENOSIS WITH HIGH PULMONARY ARTERY PRESSURE ARE PRESENTED. PHYSIOLOGICAL CHANGES AND CLINICAL SYMPTOMS ASSOCIATED WITH THIS VARIANT OF MITRAL STENOSIS ARE REVIEWED

WARREN E. COGGESHALL*
PASQUALE GENOVESE**
EDWARD F. STEINMETZ***

IN A MAJORITY of the cases of mitral stenosis, there is a mild to moderate increase in the pulmonary artery pressure which is in direct relationship to the pressure changes in the left atrium. It has been persistently noted that some cases of mitral stenosis develop a disproportionate elevation in the pulmonary artery pressure. According to Wood,[10] 5 to 10% of the total cases of mitral stenosis studied will have atypical symptoms associated with unusual elevation of the pulmonary artery pressure. Dexter[3] first demonstrated that this disproportionate rise in pulmonary artery pressure was due to increased resistance in the pulmonary vascular bed. This, in effect, places a second obstruction to the flow of blood located in the pulmonary vascular tree, in addition to the initial obstruction at the mitral valve. It is this secondary factor which assumes the predominate role in altering the physiology as the disease progresses, and it is the basis for the atypical symptoms. The greatly elevated pulmonary vascular resistance increases the work load of the right ventricle, and at the same time results in decreased blood flow through the capillary bed of the lungs and left heart. This is in contrast to the engorged pulmonary capillary bed so common in most cases of mitral stenosis. Cardiac output, therefore, is decreased in view of the restricted flow through the lungs. These changes remove the stress of the disease from the left atrium and place it upon the right ventricle. When this sequence of events transpires, it is accompanied by clinical manifestations which are often atypical when compared to the usual course of the patient with mitral stenosis. In the patients with mitral stenosis who have had right heart catheterization at the Robert Moore Heart Clinic, we have encountered two cases with pulmonary hypertension and atypical symptoms, which are reported below.

CASE 1 is that of a 28-year-old woman who developed rheumatic fever at the age of 7. Following this, there was an episode of polyarthritis at the age of 14, which was followed by normal activity until the age of 26. At this time the patient suffered a moderate chest contusion in an auto accident, and 2 weeks later was seen at another hospital with mild hemoptysis. It was noted upon further questioning that mild exertional dyspnea was present.

Physical examination at that time revealed the

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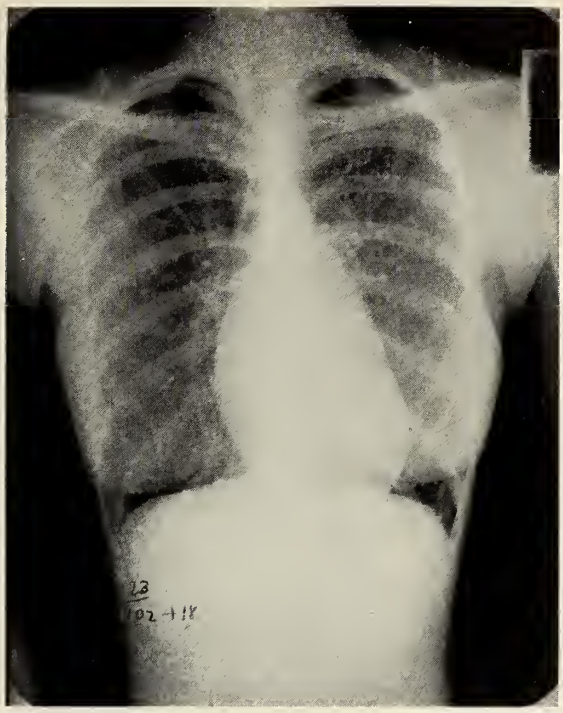


Fig. 1. The P.A. x-ray taken at the start of symptoms in case one demonstrates the minimal cardiac enlargement, prominent central pulmonary vasculature and clear peripheral lung fields suggestive of pulmonary hypertension.

heart rate to be 90 and regular. The PMI was diffuse and not well localized. The pulmonic second sound was increased and a grade 4 diastolic murmur (on the basis of 1 to 4) was noted at the cardiac apex. There was also a grade 2 systolic murmur heard at the apex. A roentgenogram of the chest revealed only minimal enlargement of the heart (Fig. 1), and on fluoroscopy the right ventricle and pulmonary artery segment were moderately enlarged. The central vasculature of the lungs was prominent but faded rapidly toward the periphery of the lung field. There was minimal enlargement of the left atrium.

The patient was digitalized, placed on a low sodium diet, and started on prophylactic penicillin, following which the symptoms cleared within a few days and the patient was able to return to normal activity. Mitral valvulotomy was not recommended at this time because of the minimal nature of the symptoms. Six months later the patient had another episode of hemoptysis and cough which cleared within 3 days. This was thought to represent an episode of pneumonia but, in retrospect, it would seem to have been a pulmonary infarction. During the next year the patient carried out normal activities and considered herself to be asymptomatic. Following this, the patient had the onset of exertional dyspnea which progressed to complete incapacity within 6 months, at which time the patient was hospitalized at the General Hospital. The exertional dyspnea and fatigue were extreme and permitted only a few steps of walking; however, nocturnal dyspnea and orthopnea were absent.

The heart rate was rapid but regular, the PMI was diffuse but thought to be within the midclavicular line, and the blood pressure was 90/75. The pulmonic second sound was loud, but the apical diastolic murmur, which was previously noted to be grade 4, was now grade 2 in intensity. The grade 2 systolic murmur at the apex was unchanged. A normal sinus rhythm and right ventricular hypertrophy were present on the electrocardiogram. There was now marked enlargement of the heart by x-ray (Fig. 2) and a very prominent ventricle and pulmonary artery segment were noted at cardiac fluoroscopy. The left atrium remained only moderately enlarged.

The patient had right heart catheterization which revealed the pulmonary artery pressure to be 85/20 mm. Hg. and the pulmonary wedge pressure to be 28 mm. Hg. During the procedure

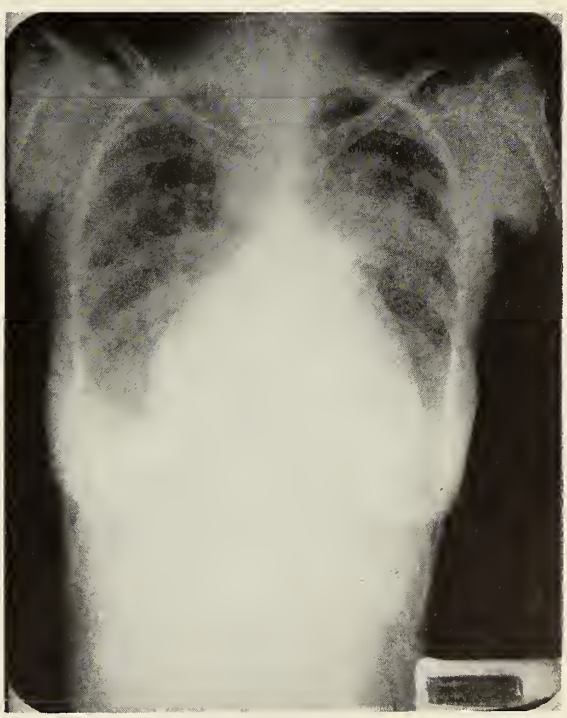


Fig. 2. This chest film taken 2 years after Fig. 1, indicates the rapidity of cardiac enlargement, which by post mortem examination was all due to dilatation of the right heart and hypertrophy of the right ventricle.

the patient sustained a chill, following which the procedure was discontinued and the patient was returned to the ward where the symptoms rapidly subsided. During the following 6 weeks that the patient was in the hospital, her clinical improvement was not marked and she sustained 3 episodes suggestive of pulmonary infarctions with compatible changes noted on x-ray. The patient was advised to have a mitral valvulotomy, but refused and requested to be discharged from the hospital. Anticoagulants were not used because of poor patient cooperation. The patient was to be followed closely in the clinic, but was indifferent to her appointments, and 3 weeks following discharge from the hospital, she was brought to the emergency room in a terminal condition with a history of recurrent episodes of chest pain and hemoptysis. At that time there was marked cardiac enlargement, a greatly enlarged liver and gross peripheral edema, associated with extreme dyspnea and cyanosis. In spite of intensive therapy, the patient expired within a few hours.

At post mortem examination the heart was only slightly enlarged by weight (400 grams). There was marked dilation of the superior vena cava, right atrium, right ventricle and pulmonary artery. The left atrium was only moderately enlarged. There was marked stenosis and calcification of the mitral valve. The left ventricle was very small but there was marked hypertrophy of the right ventricle (1 cm.). There were areas of organized thrombus on the walls of several of the larger pulmonary arteries and gross areas of pulmonary infarction were noted in the left upper lobe, right upper lobe and right lower lobe. On microscopic examination, there was marked intimal thickening of the pulmonary arterioles (Fig. 3). Multiple areas of thrombotic occlusions were seen in many of the arterioles and marked passive congestion was noted in the liver and spleen.

The second case is that of a 20-year-old woman who was seen at the General Hospital with severe exertional dyspnea which limited her activity to a few steps. The dyspnea was associated with extreme fatigue and weakness. There had been an episode of hemoptysis a few days prior to admission, but the onset of the symptoms had been 3 months previously, with rapid

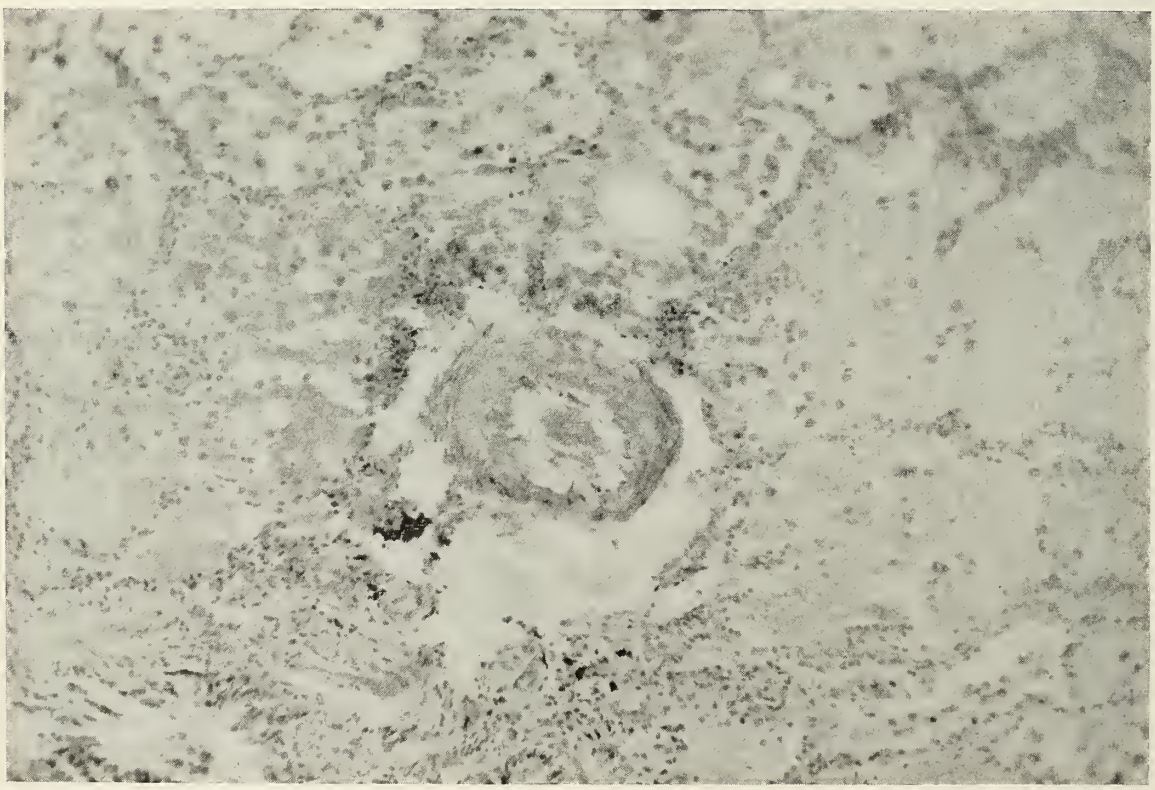


Fig. 3. The marked intimal thickening of the arteriole, noted in this photomicrograph, is representative of the changes throughout the arteriolar bed seen in case one. This represents the basic pathological changes noted in mitral stenosis with severe pulmonary hypertension.

progression to complete incapacity at the time of admission. There was no past history of rheumatic fever and the patient claimed to have been asymptomatic and carrying on normal activity before the onset of the present illness. Upon further questioning, however, it was learned that at the age of 16, when pregnant, she developed moderate exertional dyspnea and was placed on digitalis. The dyspnea had subsided following a normal delivery but the patient had continued her digitalis until a few months prior to the present episode.

On examination the heart rate was rapid and regular. The PMI was described as diffuse but within the mid-clavicular line. The pulmonic second sound was markedly accentuated and split. There was a loud diastolic murmur heard at the cardiac apex with presystolic accentuation. The mitral first sound was increased. Right ventricular enlargement was present on the EKG with regular sinus rhythm. The overall heart shadow was slightly enlarged by roentgenogram with enlargement of the right ventricle and prominence of the pulmonary outflow trace noted at cardiac fluorscopy. There was moderate left atrial enlargement and the peripheral lung fields were clear. The pulmonary wedge pressure was 35 mm. Hg., and the pulmonary artery pressure was 80/35 mm. Hg. at right heart catheterization. The patient was taken to surgery where a very tight mitral stenosis was found and opened. It was the surgeon's impression that there was no insufficiency. The post-operative course was uneventful. The patient was last seen approximately 5 months after surgery, at which time she had no limitation to normal activity. The exertional dyspnea had disappeared as well as the fatigue and weakness, and there had been no recurrent hemoptysis. The cardiac shadow and lung fields by x-ray remained unchanged as did the right ventricular hypertrophy noted on the electrocardiogram.

Discussion

It remains to be demonstrated why certain cases of mitral stenosis develop a marked increase in the pulmonary vascular resistance which is the underlying cause for the high elevation of the pulmonary artery pressure. In the two cases presented, the pulmonary artery pressure was unusually elevated (85/20 and 80/35). An exact determination of the resistance could not be obtained, since the first procedure was interrupted by a chill before all the essential determinations could be completed, and the oxygen consumption was unsatisfactory in the second case. However, the marked increase in the pulmonary artery pressure as compared with the wedge pressure (28 mm. Hg. and 35 mm. Hg.) would permit the assumption that the pulmonary vascular resistance was greatly increased.

The abnormally high pulmonary vascular resistance cannot be correlated with the severity of the mitral stenosis [1-11], nor the level of the left atrial pressure.[3] Wood had demonstrated that the increased resistance has no relationship to the duration of the disease and may appear very suddenly.[11]

More fundamentally, agreement is not complete on the nature of the changes in the pulmonary vascular bed which underlie the increase in pulmonary vascular resistance. Most investigators feel that it represents a vasoconstrictive process in the arteriolar portion of the pulmonary vascular bed. This view is supported by the ability of hexamethonium[2-8] and actylcholine,[11] which would be expected to release vasoconstriction, to lower the pulmonary vascular resistance and pulmonary artery pressure in these patients temporarily. The reversibility of the pulmonary artery pressure and pulmonary vascular resistance following mitral valvulotomy is further support for vasoconstriction.[11]

Other investigators, most recently Evans *et al*,[4] feel that organic changes in the arterioles are the predominating obstructive factors. In examining the lungs of cases of mitral stenosis who had pulmonary hypertension, they consistently noted the arterioles to be contracted and nondistensible with marked intimal thickening. They question the reversibility of the pulmonary vascular resistance following mitral valve surgery and point out that the pulmonary artery pressure reduction is only minimal to moderate in many of the reported cases.

A high incidence of pulmonary embolism has also been noted in these cases. This may be the source of additional obstruction in the pulmonary vascular bed, which if diffuse enough, would represent non-reversible changes.

The patients who have mitral stenosis associated with severe pulmonary hypertension are sometimes difficult to recognize clinically, but there are some features commonly seen in these

people which would aid in diagnosis. A rapid progression of symptomatology to incapacity is a consistent finding. This is in contradistinction to the variable prolonged course in the usual mitral stenotic patient. In both patients presented, their activity was reduced from normal to complete incapacity within 6 months in one case and 3 months in the second. Even considering the very earliest transient symptoms, this interval was 2 years in the first case and 4 years in the second case. Olesen[6] has estimated this interval (onset of symptoms to incapacity) to average 15 years in reviewing a large series of cases with mitral stenosis. Hemoptysis, a symptom in both of our cases, is common in these patients and is thought to be due to pulmonary embolism followed by pulmonary infarction.[11] This is thought to be due to peripheral phlebothrombosis which commonly occurs because of the decreased output, marked elevations of venous pressure and immobilization due to severity of the disease.[11]

The subjective symptoms are those of exertional dyspnea and fatigue due to decreased blood flow through the pulmonary capillary bed and decreased cardiac output, rather than orthopnea and noctural dyspnea usually seen in mitral stenosis where there is congestion of the pulmonary capillary bed. The lowered cardiac output is often reflected in low blood pressure and decreased mean pressure as noted in the presented cases.

The physical findings of pulmonary hypertension are usually present. The PMI is displaced towards the sternum and usually has a characteristic heave. Accentuation of the pulmonic second sound is usually present and a systolic, and even a diastolic murmur, may appear in the pulmonic area. Cases are reported where the diagnostic murmur of mitral stenosis may be absent at the apex of the heart,[5] which is apparently due to the decreased blood flow through the mitral valve. When the mitral diastolic murmur is absent, the recognition of mitral stenosis as the underlying defect becomes very difficult. In the 2 patients described, the mitral diastolic murmur was present in each although it had decreased from grade 4 to grade 2 in the first case.

Right ventricular hypertrophy is a consistent finding on the electrocardiogram. The absence of atrial fibrillation in these cases is unusual and represents a characteristic finding. This absence of atrial fibrillation is possibly related to the decreasing stress on the left atrium as the blood flow is decreased through the left heart. The heart may not show unusual enlargement on the routine chest x-ray, in that the right ventricle can undergo considerable enlargement with only minimal changes noted on the P. A. view. The lung fields are clear in the periphery although the pulmonary artery segment and central vasculature are prominent. On fluorscopy of the heart, prominence of the right ventricle is noted, but the left atrial size may be only slightly enlarged.

From the available evidence, it would seem that surgery should be performed in these cases as soon as the diagnosis is established. In this respect, cardiac catheterization often facilitates early diagnosis and demonstrates the seriousness of the situation although the clinical symptoms may not be severe early in the disease. In the progressive phase of the illness, little is gained by medical management of the symptoms. Due to the high incidence of pulmonary infarction, anticoagulants are administered by some until mitral valvulotomy can be carried out.[11] It must be remembered, however, that this group of patients has a high surgical mortality which has been as high as 33% in some series.[11] In spite of this high mortality, adequate surgical management often, but not always, gives dramatic results in contrast to progressive deterioration under the usual medical measures.

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Ventricular Arrhythmias Due to Glucose†

TWO CASES OF VENTRICULAR ECTOPIC ARRHYTHMIAS APPEARING DURING INFUSION OF GLUCOSE ARE REPORTED

FRED H. PRIEBE, M.D.*

IT HAS BEEN shown that an intravenous infusion of glucose will produce a drop in serum potassium. This is apparently due to a shift of potassium ions from extracellular fluid to intracellular fluid when glucose is assimilated by muscle cells under influence of insulin.[1] With the drop in serum potassium cardiac arrhythmias have been reported.[2] Patients who are receiving digitalis may show signs of toxicity when their serum potassium is reduced.[3] It was thought that the following two cases were worth reporting due to a paucity of authenticated examples of arrhythmias due to intravenous administration of glucose.

CASE 1—An 83-year-old man was admitted to the Indianapolis General Hospital on Aug. 5, 1957, because of a bladder neck obstruction due to a grade II transitional cell carcinoma of the urinary bladder. At the time of admission it was noted that he had atrial fibrillation which was attributed to arteriosclerotic heart disease and that he was fully digitalized. On Aug. 16, 1957, the patient was given an infusion of 5% dextrose in distilled water. The results are shown in figure 1. All numbers in the upper left represent time in minutes from the beginning of the experiment. This convention is followed in all figures. The control strips showed atrial fibrillation with prominent "U" waves and one ventricular premature systole. The 15-minute strip exhibited runs of ventricular ectopic beats (ventricular tachycardia) and these were evident for the duration of the infusion. At 25-minutes dextrose was stopped and potassium phosphate was infused at an average rate of 0.7 mEq per minute for a total of 35 mEq. With the infusion of potassium phosphate the ventricular ectopic beats disappeared (30-minute strip) and there was a definite diminution of the U wave (75-minute strip). The bigeminy noted in the 45-minute strip originated in a focus entirely different than the ectopic beats seen in control tracing as clearly manifest by a different coupling interval and contour of the premature. It has been observed in a number of our experiments that potassium, especially if administered to patients with digitalis intoxication, may precipitate ectopic ventricular beats.[4]

CASE 2—A 63-year-old woman who had been treated at the Indianapolis General Hospital since 1956 for hypertensive cardiovascular disease with a blood pressure ranging from 230-100 systolic and 140-70 diastolic. The patient was seen at the Heart Clinic on June 2, 1958, at which time her findings were compatible with digitalis intoxication and she was given potassium intravenously. Two hours after infusion of 50 mEq of potassium phosphate, 200 cc. of 10% glucose in distilled water over a period of 35 minutes was injected. The tracings taken during the infusion are shown in Figure 2. The upper three strips represent the arrhythmia at 44, 114

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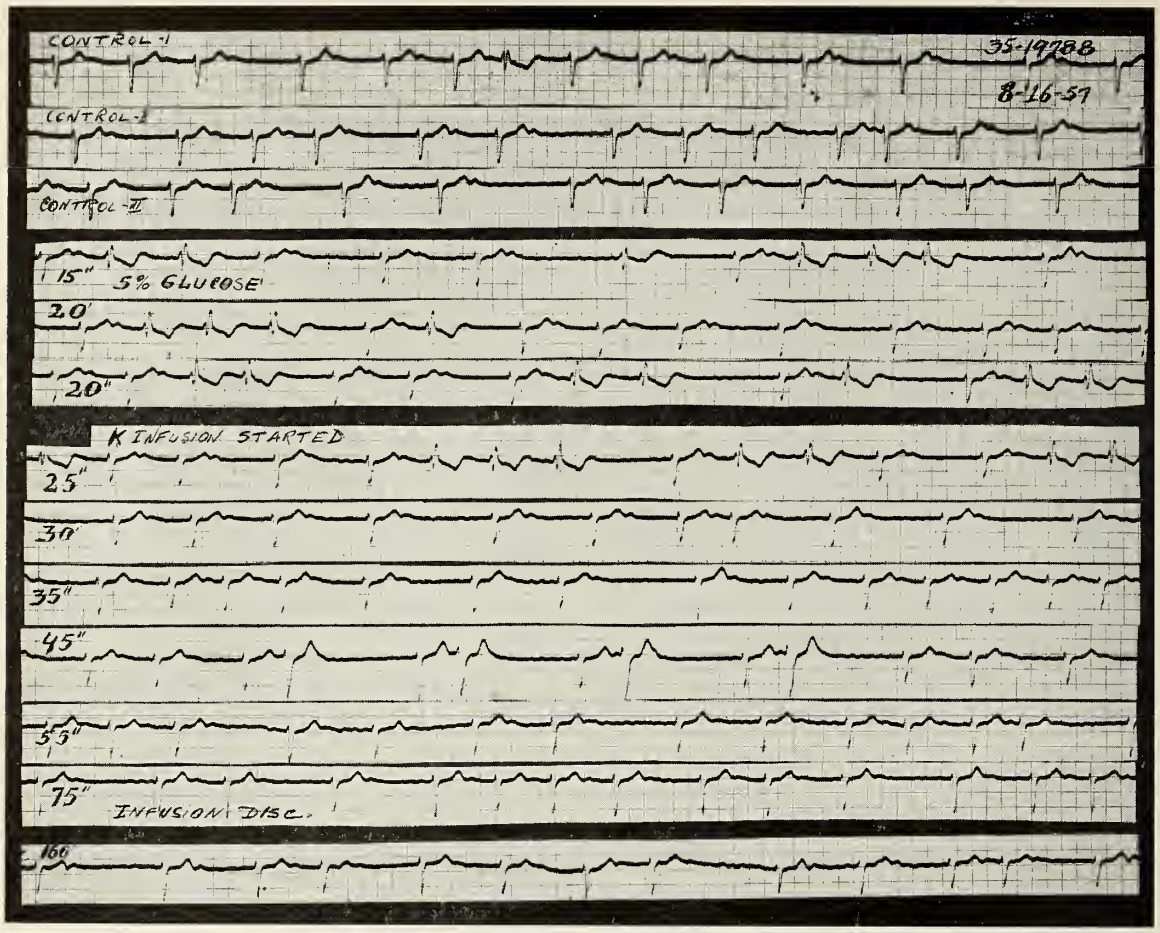


Fig. 1—Tracings obtained in Case 1 showing the appearance of ventricular ectopic beats. Note the diminution of U waves after injection of potassium.

and 135 minutes after administration of 50 mEq of potassium phosphate. Twenty minutes after starting 10% glucose (strip 5) runs of ventricular ectopic beats appeared and persisted for 50 minutes (strips 6-10).

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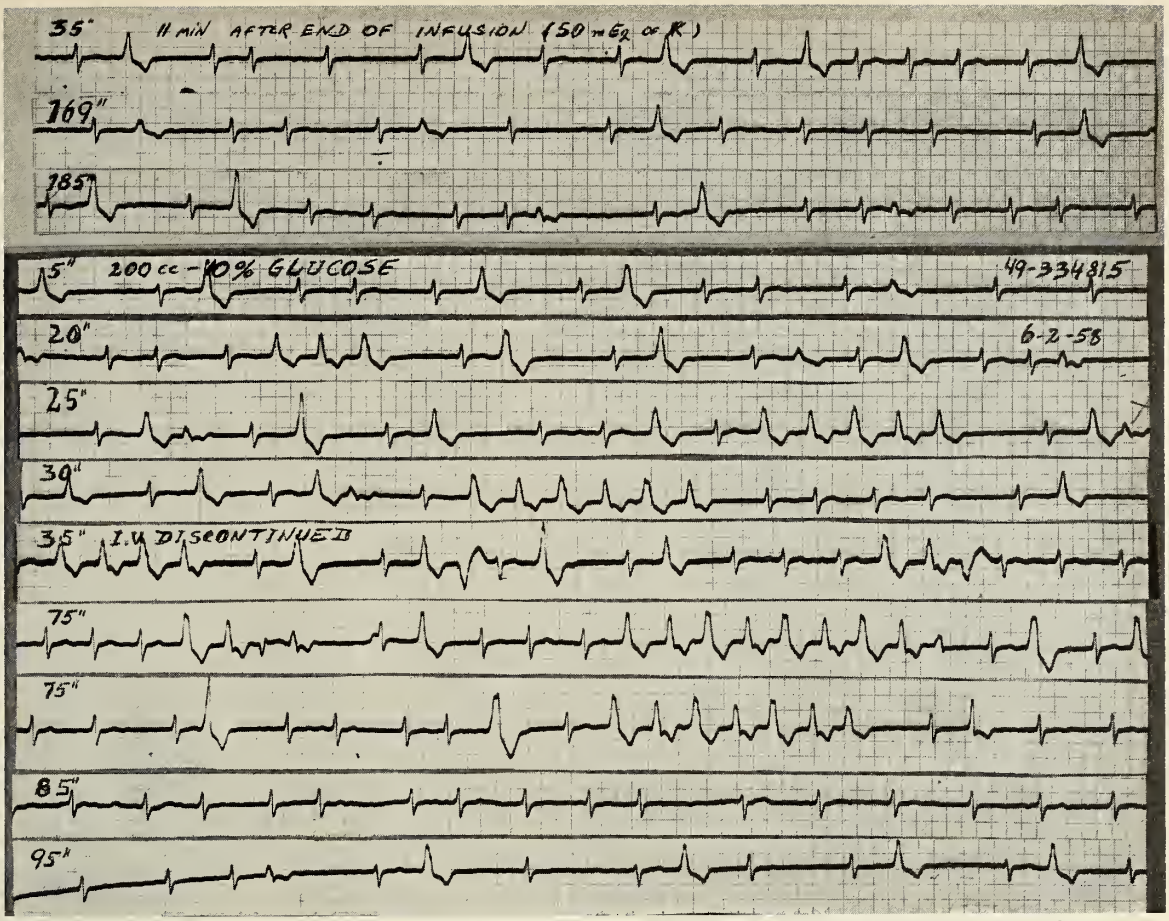


Fig. 2—Repetitive ventricular tachycardia following administration of 10% glucose intravenously.

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Case Report:

Aortitis of Unknown Etiology With Malignant Hypertension†

WARD LARAMORE, M.D.*

IN RECENT YEARS there has been an increased awareness of unusual acquired vascular abnormalities. The following case, with a review of some observations in disorders which might be allied, is submitted to further observations of these unsolved problems.

A 39-year-old truck driver was readmitted to the Veterans Hospital on March 13, 1958 complaining of severe headaches, blurred vision, urinary frequency and nocturia. He was first hospitalized at this institution from Sept. 9, 1955 to Sept. 16, 1955. Shortly before that admission he had developed a sudden right flank pain while lifting an object weighing about 30 pounds. This changed to a persistent dull pain and was followed in about 24 hours by a lower abdominal pain and a syncopal episode. He was found to have a distended abdomen with hypoactive bowel sounds; a slight narrowing of the intervertebral interspace between L 5 and S 1, a normal hemogram and urinalysis, and a blood pressure of 150/80. An appendectomy was performed and the patient was discharged shortly thereafter without any residual symptoms. The appendix showed a mild infiltrate of eosinophiles in the muscularis. The patient remained asymptomatic until December, 1955, at which time he noted the onset of progressive intermittent claudication of both lower extremities.

On readmission on April 4, 1956, the blood pressure in the arms was 118/60, a bruit was heard over the femoral arteries, the pulse was markedly diminished in the feet, urinalysis and renal function studies were normal. A lower abdominal aortic resection with insertion of a nylon graft was performed on April 28, 1956. At surgery considerable inflammatory reaction was noted around the aortic bifurcation. The gross specimen (Fig. 1) revealed a narrowed aortic lumen without any thrombus present. The microscopic study (Fig. 2) revealed intimal thickening, with a slight infiltrate of lymphocytes; marked thickening of the media and adventitia with fibrotic changes and with a marked infiltrate of lymphocytes, a few multinuclear giant cells and some granulomata. Shortly after his discharge from this hospitalization, the patient had two syncopal episodes without any demonstrable cause. Thereafter he was again asymptomatic until about three months prior to his last admission on March 13, 1958. He then noted some urinary frequency and nocturia. About 6 weeks later he developed severe throbbing headaches, blurred vision and had one syncopal episode.

The physical examination revealed a well developed male with a blood pressure of 210/120 in the upper extremities and 275/150 in the lower extremities. Funduscopic examination revealed papilledema, hemorrhage, exudates, arterio-venous nicking and arteriolar constriction.

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There was a systolic bruit over the lower abdomen. All peripheral pulses were easily palpable and equal bilaterally.

The hemogram was within normal limits. An initial urinaylsis revealed a concentration of 1.030 with 4+ albumin, 8 R.B.C., 20 W.B.C., a few hyaline casts and no sugar. The BUN was 18 mgm.%. P.S.P. excretion was 44% in 30 minutes. Urea clearances was 50% of normal. Cystoscopy revealed some constriction of the left ureteral orifice and a markedly diminished urinary flow from the left kidney. An intravenous pyelogram (Fig. 3) revealed a normal right urinary system; dye was present in the left kidney parenchyma but failed to opacify the left collecting system. Retrograde pyelography resolved duplication of the renal collecting structures without any significant abnormality. Comparison of the kidney size on a KUB x-ray in 1956 (Fig. 3) with the kidney size in 1958 revealed an increase in the size of the right kidney and a decrease in the size of the left kidney. A percutaneous aortogram on March 21, 1958 failed to visualize the renal vasculature.

At this point, it appeared that the vascular



Fig. 1—Lower abdominal aorta at bifurcation showing periaortic involvement. An extremely narrowed aortic lumen and an obliterated right iliac lumen without a thrombus present.



Fig. 2—Section through wall of aorta showing extensive inflammatory involvement of media and adventitia, granulomatous in character.

disease, which was manifested as a granulomatous aortitis in 1956, now had involved the left renal artery and produced malignant hypertension, but had not caused any other vascular obstruction. It was hoped that a localized process would be found in the left renal artery which would permit an arterial graft with preservation of the kidney. Accordingly on March 31, 1958, the patient was taken to surgery. At surgery there was found to be extensive scarring in the area of the aortic bifurcation and similar dense fibrous tissue was prominent at the level of the left renal artery. There were good pulsations throughout the abdominal aorta and the right renal artery. The left renal arterial pulsations varied from slight to absent, depending upon very slight changes in the position of the left kidney. An attempt was made to remove the dense scar tissue around the left renal artery but this could not be accomplished. An arterial graft did not appear feasible. The left kidney was removed.

Study of the left kidney revealed fetal lobulations, the cortex appeared more pale than normal, and the finer cortical details were obscured. Very little of the renal artery and vein were present on the surgical specimen; these showed no obstruction to the lumina. Microscopic examination revealed an extensive inflammatory infiltration throughout the kidney without any vascular lesions. There was extensive dense fibrosis with very little inflammatory change and with no evidence of granuloma in the small specimen of tissue taken from around the left renal artery.

Postoperatively the patient's blood pressure fell and now ranges between 150/95 and 140/85. His fundi now appear normal. He still has 2-3+ albuminuria with an occasional RBC and WBC. Except for a complaint of occasional blurring of vision the patient is now asymptomatic.

Discussion

The findings of an inflammatory lesion in and around the aorta at the time of surgery for lower aortic obstruction was totally unexpected. Perusal of medical literature has failed to clarify the disease process.

The granulomatous nature of the lesion immediately suggested tuberculosis. The entity, tuberculous aortitis, has been reviewed and case reports added on several occasions.[1-6] In all, there have been 30 case reports.[6] Twenty-nine of these were associated with aneurysmal dilatation of the affected aortic segment. Some of these

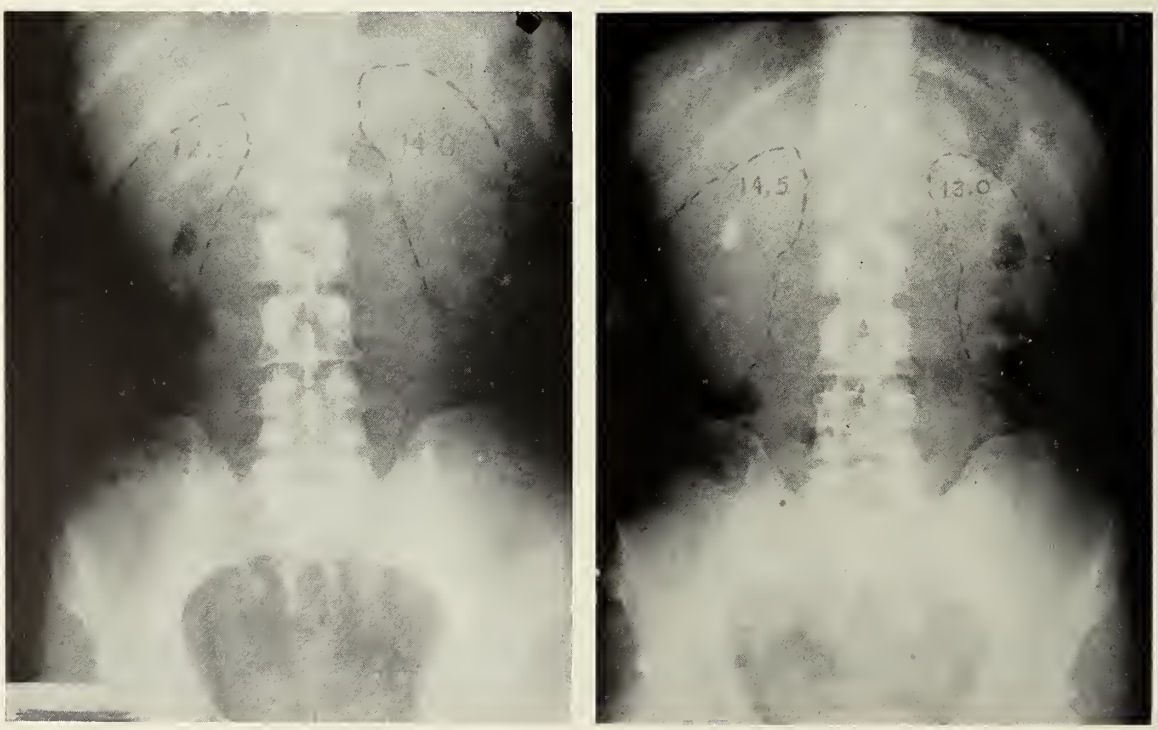


Fig. 3—Films reproduced on the left show the relative size of the two kidneys in 1956 and 1958. Please note the change in the relative size of the kidneys and the presence of a reduplication of the renal pelvis.

died of rupture of the involved area.[2, 3, 4] In one,[6] there was dissection of the aorta as well as aneurysmal dilatation. Nearly all cases had tuberculosis elsewhere in the body and tuberculosis of the periaortic lymph nodes and periaortic soft tissue was present uniformly. This case differed from these in that there was constriction of the aorta at the site of involvement, there was no tuberculosis elsewhere or in the periaortic tissues, and special stains failed to reveal any tubercle bacilli.

Non-tuberculous granulomatous aortitis is a rather uncertain entity described by several authors.[7-9] In 1941 Gilmour[7] described 4 cases of giant cell arteritis which involved the aorta. One of these died of a rupture of the involved aorta; three had involvement of temporal arteries or other arteries supplying the head. McMillan[8] described granulomatous involvement in various portions of the aorta and left iliac artery with dissection and partial rupture in a hypertensive patient who died of a stroke. Reid[9] described 4 cases of aortic dilatation due to a granulomatous inflammation; two of these were associated with temporal arteritis, one had involvement of the femoral and iliac arteries. It is a well-known fact that the entity known as temporal arteritis is granulomatous in nature and is not limited to the temporal arteries. It is intriguing to consider this disorder in this patient, but evidence of involvement of the temporal arteries and other arteries is not yet present.

The aorta also has been the site of inflammatory changes dissimilar to the above and also of unexplained etiology. Sproul and Hawthorne[10] described a chronic inflammatory change with many plasma cells diffusely spread through the media of two aortae taken from patients who died of unrelated causes. Takayasus Syndrome, or Pulseless Disease, appears to be an inflammatory disease which primarily and often solely involves the aortic arch and its branches. The pathological studies which revealed varying degrees of a chronic inflammatory reaction of the lesion of this entity precludes this diagnosis in this case. However, it should be pointed out that Pulseless Disease is of undetermined etiology, has extended to the abdominal aorta[11] and possibly could be related to inflammatory disease elsewhere in the aorta.

One other disorder must be given consideration in discussion of this case. In 1948 Ormond[14] described two cases of an inflammatory retroperitoneal process with symptoms due to bilateral ureteral obstruction. Subsequently a few additional cases of this disorder have been described.[15-17] This disease appears to originate as an inflammatory process in the region of the main vessels of the posterior abdominal wall causing a very invasive fibrosis which may surround and penetrate the ureters and compress and occlude the ureters. One case[15] had a complete obstruction of the right external iliac artery and considerable fibrosis about the bifurcation of the right common iliac artery. Giant cells were seen in the infiltrate of monocytes, lymphocytes, eosinophiles and in the fibrous tissue of another case.[16] It appears that the disorder could very easily obstruct the arterial circulation involved in this case. Furthermore, there was slight obstruction of the left ureteral orifice and there was very dense fibrous tissue around the left renal artery in this patient. However, there is insufficient evidence of this rare disorder to establish this diagnosis.

The diffuse inflammatory reaction noted throughout the left kidney cannot be explained. Renal complications of aortography are not infrequent[18] but a diffuse inflammatory infiltration has not been described. Whether either the frequent palpation of the kidney during an extended period of surgery, or the ureteral obstruction were important factors in the reaction cannot be ascertained.

Conclusion

An unusual case of granulomatous aortitis with lower aortic obstruction, later complicated by unilateral renal artery obstruction with accompanying hypertension, has been described. The cause and pathogenesis of the disorder is unknown. Some of the unresolved disorders with similar features have been discussed. This case will be followed in an attempt to further elucidate the disease process.

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Immunization Schedule Given for Adults

CHICAGO—Immunization schedules for adults were outlined in the December 27 *Journal* of the American Medical Association.

Answering a query from a Michigan physician, one of the 900 physician consultants to the *Journal* said the "optimum intervals" for adult immunization, assuming that an adequate initial immunization series has been given, are as follows:

—Smallpox. Vaccination is needed every 3 years.

—Diphtheria. Immunization is not recommended for adults except in cases where the person shows no immunity after exposure to special risks.

—Tetanus. A booster dose should be given at the time of each injury where the danger of tetanus exists, with reinjection in the absence of an injury at intervals of no longer than 5 years.

—Typhoid. Reinforcing injections are necessary every 3 years.

—Influenza. Injections should be given every year to "risk cases," such as old or chronically ill persons.

—Poliomyelitis. Not enough time has elapsed yet to learn about the duration of protection conferred by the Salk vaccine, but a fourth dose, given not earlier than one year after the third dose, could be administered to individuals exposed to special risks.

The consultant noted that these are general guiding schedules which vary according to circumstances. For instance, for persons traveling to areas where smallpox is prevalent, revaccination at intervals as short as 6 months may be desirable. The same is true for persons living in areas where typhoid is common. They should get a booster dose every year.

Post Partum Myocardosis†

THREE CASES OF CONGESTIVE HEART FAILURE OF UNKNOWN ETIOLOGY APPEARING AFTER DELIVERY ARE PRESENTED. COURSE AND FINDINGS ARE COMPATIBLE WITH WHAT LITERATURE CONSIDERS 'POST PARTUM MYOCARDOSIS'

DAVID I. MILLER, M.D.*

MYOCARDIAL degeneration associated with pregnancy and the puerperium was described in 1870 by Virchow.[1] Numerous reports have since been written about congestive heart failure in the last trimester and puerperium in patients who had no evidence of organic heart disease prior to pregnancy.

Some of the names given to this entity are as follows: toxic post partal heart disease,[3] post partal heart disease,[4, 5, 6] idiopathic-myocardial degeneration associated with pregnancy and especially the puerperium,[7] post partum heart disease,[8] post partum myocardosis,[9, 10] and idiopathic myocardial failure in the last trimester of pregnancy and the puerperium.[11]

Case Reports

CASE 1—A 35-year-old colored woman was admitted to the Indianapolis General Hospital on July 7, 1958 with the chief complaints of "swollen legs," one month's duration, and "blood-tinged sputum," two weeks duration.

In April, 1956, the patient delivered her fifth full-term baby, all pregnancies having been uneventful. Approximately one month later, May, 1956, the patient developed shortness of breath, leg and ankle edema. She was treated by her family doctor with bed rest, low salt diet, diuretics and digitalis and became asymptomatic and remained so until October, 1957. At that time, she was readmitted to another hospital for treatment of congestive heart failure. She again responded to treatment and remained active until the admission to Indianapolis General Hospital.

In 1950, the patient was seen at Indianapolis General Hospital with the chief complaint of epigastric discomfort. At that time her blood pressure was 120/80. Chest and heart were negative except for premature ventricular contractions. Both parents died of "heart disease." The patient has four siblings, living and well.

At the time of the most recent admission, July 7, 1958, the patient weighed 141 lbs., the blood pressure was 160/120 and pulse of 108 beats per minute. Respiratory rate and temperature were normal. The heart was enlarged. A right and left ventricular heave and a pulmonic shock were palpable. No thrills were present. Premature ventricular contractions with runs of trigeminy, an accentuated second pulmonic sound and a soft grade II systolic murmur at the pulmonic area were heard. The chest was clear and the liver edge was palpable three centimeters below the right costal margin. There was two plus pitting edema to the knees.

Routine hemogram, urinalysis, L-E test, catacholamines, blood urea nitrogen, PSP, serum electrolytes, serology for syphilis, cholesterol,

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prothrombin time, sedimentation rate, C-reactive proteins, basal metabolism studies, skin test for acid fast bacillus and histoplasmosis, muscle biopsy and serum electrophoretic examinations were all normal. Total proteins were 7.9 grams %. Albumin was 4.05 grams % and globulins 3.85 grams %. Anti-streptolysin titers were 833 Todd units. A chest roentgen on July 7, 1958, revealed a transcardiac diameter of 15.5 centimeters to a transthoracic diameter of 26 centimeters, and on August 11, 1958, the transcardiac diameter was 13.0 centimeters to a transthoracic diameter of 26. Intravenous pyelograms were normal. Serial electrocardiograms showed premature ventricular contractions, intermittent trigeminy, non-specific ST-T changes and left ventricular hypertrophy.

The patient responded well to routine treatment of congestive failure with a loss of 19 lbs. The blood pressure was 124/84. Cardiac catheterization before discharge revealed normal right ventricular pulmonary artery and wedge pressures.

CASE 2—A 29-year-old colored woman was admitted to the Indianapolis General Hospital on June 19, 1958, with the chief complaints of "misery in the chest," "blood streaked" sputum on two occasions and "shortness of breath."

On March 30, 1958, the patient delivered her fifth full-term baby, all prior pregnancies having been uneventful. Six weeks after delivery, the patient coughed up blood and developed pain in the left chest. This pain left after 4 days, but the patient continued to have "misery" in her chest with paroxysmal nocturnal dyspnea and shortness of breath with exertion. These symptoms became worse and forced her to come to the hospital. Past history was non-contributory, all prior physicals and one done 3 days after the last pregnancy being normal.

At the time of admission on June 19, 1958, the patient weighed 147 pounds, blood pressure was 140/108 and the pulse rate was 108. Respiration rate and temperature were normal. The heart was enlarged. The second pulmonic sound was accentuated. There was a grade I systolic murmur and a diastolic gallop at the apex. The chest was clear and the abdomen normal. There was a trace of pretibial edema.

Hemogram, urinalysis, L-E tests, sedimentation rate, basal metabolism studies, blood urea nitrogen, serum proteins and albumin-globulin ratio, serology for syphilis, protein bound iodine, blood cultures and acid fast bacillus cultures and smears were all normal. During the eighth month of pregnancy, the transcardiac diameter was 14.5 centimeters with a transthoracic diameter of 26.5 centimeters. On June 19, 1958, two and a half months after delivery, the transcardiac diameter increased to 16.0 centimeters. EKG at the time of admission showed non-specific ST-T changes and left ventricular hypertrophy.

The patient responded well to routine treatment of congestive heart failure with a loss of 12 pounds. The blood pressure was 110/80. She was discharged on June 30, 1958, and digitoxin was stopped on Oct. 4, 1958. On Dec. 2, 1958, the patient was seen in the heart clinic at which time she was asymptomatic. The physical examination and the roentgenogram of the chest were normal. The EKG revealed high voltage of QRS complexes. The waves were upright.

CASE 3—A 32-year-old white woman was admitted to the Indianapolis General Hospital on Jan. 8, 1956, with the chief complaints of "swollen left arm" of 3 days duration and "loose stools" of 2 days duration.

In September, 1952, the patient delivered a six and a half month fetus with two previous pregnancies being uneventful. Shortly thereafter, the patient had a "mild kidney infection" and was treated by her family doctor. Two and a half months after delivery, she developed congestive heart failure with hemoptysis and was hospitalized at Camp Atterbury. In June, 1953, the patient was admitted to the Indiana University Medical Center with congestive heart failure and was discharged with a diagnosis of "non-specific mild myocarditis." The patient was seen again at the University cardiac clinic on Oct. 27, 1954, at which time she was asymptomatic with a blood pressure of 120/80. Feb. 2, 1955, she delivered a five and a half pound baby after an uneventful pregnancy. Seven weeks later she was admitted to the Indianapolis General Hospital for the treatment of severe heart failure and was discharged 3 months later with the diagnosis of heart failure of unknown etiology complicated by pulmonary infarction. The patient had a bout of thrombophlebitis of the left leg in September, 1955 and was treated at the Indianapolis General Hospital.

At the time of the patient's last admission, Jan. 8, 1956, the blood pressure was 160/90 and the

pulse 144 beats per minute. Respirations were 36 and body temperature was 106 degrees. The patient was critically ill, toxic and had generalized edema. Her heart was enlarged and the precordium active. The second aortic sound was equal to the second pulmonic sound. The chest was clear and the liver was palpable four centimeters below the right costal margin. The left arm was swollen and tense. Her forearm and arm had a purplish hue. The left radial pulse was weaker than the right. Physical examinations on previous admissions revealed normal blood pressures, generalized cardiac enlargement, diastolic gallop, an accentuated second pulmonic sound and a grade I systolic murmur at the apex.

Hemogram disclosed a white blood count of 26,000 and blood cultures grew beta-hemolytic streptococcus. Spinal fluid, urinalysis, prothrombin, bleeding and coagulation times were normal. Numerous laboratory studies were performed during the various hospital admisisons and were all normal. These included skin and muscle biopsies, blood morphology, sedimentation rates, liver profile, serum proteins, electrolytes, blood urea nitrogen, L-E tests, urea clearance studies, routine agglutinins, serum calcium and phosphorus. Only the urinalysis showed an occasional 2 plus albumin. Roentgenograms of the skull, gall bladder and I.V.P. have all been normal. Cardiac fluoroscopy and films of the chest on repeated occasions since 1953 have always disclosed generalized cardiac enlargement. EKG's taken during the same period showed non-specific ST-T changes.

In spite of treatment with antibiotics, cortisone, vaso-pressors, heparin and digitoxin, the patient died 3 days after admission.

AUTOPSY—Post mortem studies were done by the chief pathologist, Dr. Paul Evans. The heart weighed 470 grams and all valves were normal. No congenital abnormalities were noted. The myocardium was moderately flabby. The left subclavian vein contained a clot which was thought to be ante mortem. The liver, spleen, lungs and kidneys were congested. Microscopic study of the heart and kidneys disclosed the following: "The cardiac muscle fibers show hypertrophy. Their nuclei are usually enlarged, frequently having squared ends and are frequently hyperchromatic. Areas of interstitial fibrosis,

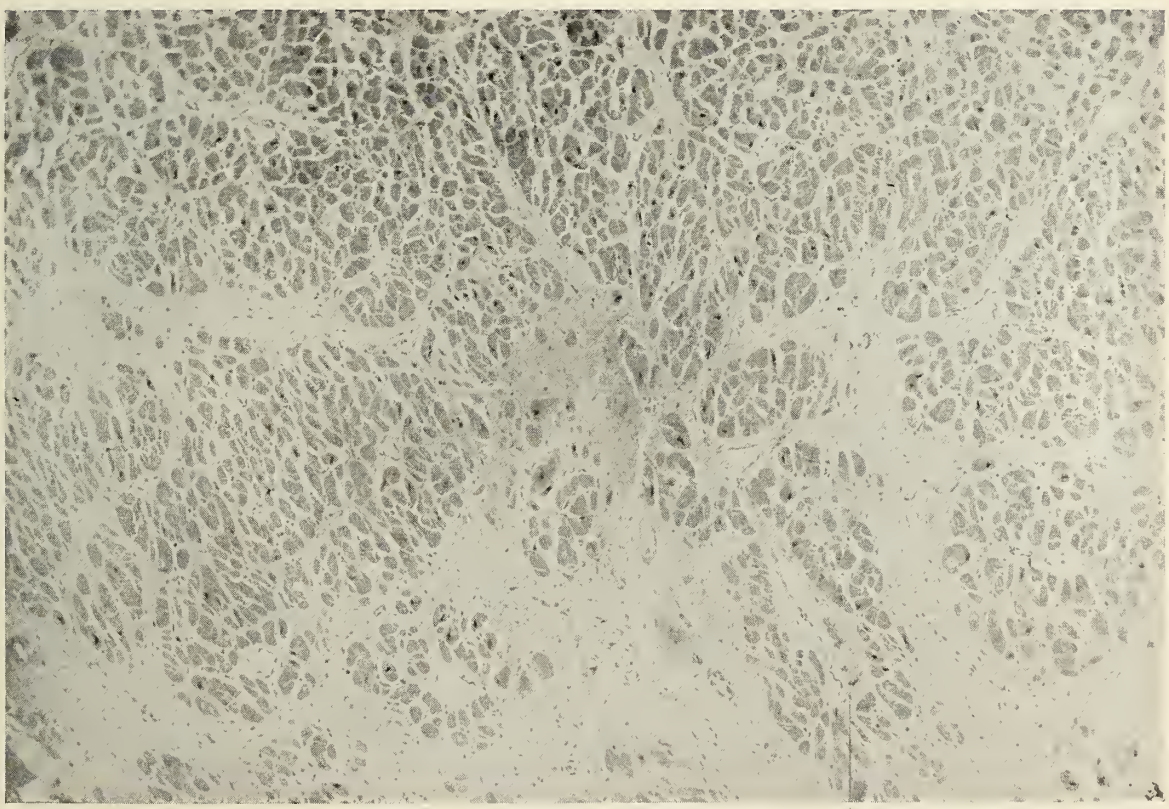


Fig. 1—Section of myocardium from case III showing atrophy of myocardium with fibrous replacement. For detailed description see test.

both large and small, are seen throughout the myocardium. In many instances, there are relatively acellular areas of dense collagen representing old scar while other areas show active connective formation with frequent macrophages having hemosiderin pigment in their cytoplasm. Atrophy of cardiac muscle fibers is evident in surrounding areas. Leukocytic infiltrate is slight but where present it shows mainly lymphocytes and mononuclear cells with rare polymorphs. Degenerative changes in the muscle fibers are seen in areas close to the most recent, active areas of scar formation. The kidneys show changes of slight chronic pyelonephritis."

Both gross and microscopic studies failed to reveal any evidence of pulmonary infarction.

Discussion

The patients observed by us were in good health until they presented themselves with congestive heart failure of unknown etiology. In each instance the symptoms appeared approximately 7 weeks after delivery. The third case experienced failure after each of the last two pregnancies and failed to recover. The outstanding findings in our patients were increased blood pressure, tachycardia, cardiac enlargement, systolic murmers, diastolic gallop, hemoptysis and peripheral edema. Electrocardiograms were abnormal with non-specific changes.

In case 2 pulmonary embolization as a cause of the patient's illness cannot be ruled out with any degree of certainty.

The so-called typical case of "post partum myocardosis" is a patient, about 30 years old, usually negro, with signs and symptoms of congestive heart failure. These symptoms of failure usually appear 2 to 6 weeks following partuition. Diastolic gallop, edema and small volume pulse are the outstanding findings.[3] The diastolic blood pressure is usually above 100 mm. of mercury and the systolic above 150 mm. of mercury. Tachycardia is frequent. The second pulmonic sound is often accentuated and a systolic murmur at the apex is not uncommon. Electrocardiograms are not characteristic, but they frequently show low voltage, flat or inverted T waves and other minor abnormalities. Fluoroscopic examination regularly shows a grossly enlarged heart.

The usual regimen for treating heart failure should be used even though its value has been questioned by some.[8, 10, 13] The majority of the cases recover.[4, 11]

Embolic phenomena occur in approximately 25% of the patients,[3] and is the usual cause of death in the infrequent case terminating fatally. If anti-coagulants are to be used, they should be started early.

The etiology of this disease is unknown. Some authors[7, 9, 12, 14] have suggested nephritis and, in fact, Sodeman[13] writes about nephritic and non-nephritic post partal heart disease. Nutritional deficiency, toxemia of pregnancy, viral infection, hormonal imbalance and hypertension have all been considered as contributory factors.

The etiology remains obscure and the names which connect this form of heart failure with pregnancy should best, for the time being, be considered as purely descriptive.

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Patent Ductus Arteriosus With Pulmonary Hypertension and Reversed Flow†

DISCUSSION OF SYNDROME OF PATENT DUCTUS ARTERIOSUS WITH PULMONARY HYPERTENSION AND REVERSED FLOW TOGETHER WITH PRESENTATION OF THREE PATIENTS. BRIEF REVIEW OF LITERATURE IS INCLUDED

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E. C. KHOO, M.D.**

Introduction

PATENCY of the ductus Botalli with reversal of blood flow is a relatively rare congenital defect. In the majority of instances the clinical syndrome presents itself with symptoms and signs of pulmonary hypertension. Even with cardiac catheterization and angiocardiography, the exact diagnosis may be a difficult one to resolve. In a small percentage of patients with patent ductus and veno-arterial shunt, there is a differential cyanosis between the upper and lower extremities with or without clubbing which immediately suggests the diagnosis.[1]

During the past 4 years, we have had the opportunity to study 3 patients with this peculiar distribution of cyanosis. In addition, they presented several other interesting features which will be discussed with the clinical histories.

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Case Reports

CASE 1.—A 40-year-old white male was admitted in September, 1958 complaining of shortness of breath and blueness of extremities. He had been told that he was born with a "double leakage of the heart." During his childhood he had frequent "colds" but he was able to go to school and play games such as baseball and even football without difficulty. He never recalled having to stop to catch his breath. It was not until 1957 that he had to stop work as a porter because of shortness of breath. During the ensuing year, he became more dyspneic and finally orthopneic. One week prior to admission it was noted by his physician that he had become cyanotic.

PAST HISTORY—The patient was a full-term normal delivery baby. He had an appendectomy at age 16. He was rejected for military service because of his cardiac condition.

Family history—The patient was the only offspring.

Physical Examination—Blood pressure was 102/75 (RAR) and 98/72 (LAR). Pulse was grossly irregular, 118 per minute. The patient was markedly cyanotic and in acute respiratory distress. There was clubbing of the toes of both feet and the left fingers. With the administration of oxygen, there was clearing of the cyanosis of the face and right hand, but the cyanosis

remained in the left hand and lower extremities. Neck veins were distended. Lung fields were dull to percussion with decreased fremitus on the left and there were moist rales on the right. There was a precordial bulge with a diffuse apical impulse palpable in the fifth left interspace at the anterior axillary line. A systolic thrill was palpable in the second left interspace accompanied by a loud systolic murmur in the same area. This was followed by a blowing diastolic murmur. The second sound was closely split, with accentuation of P_2. The liver was palpable 4 finger-breadths below the right costal margin and there was 4+ pitting edema of both pretibial regions.

Laboratory Studies — Hemoglobin 19.7 gm., hematocrit 64, RBC 6.9 million. Urinalysis showed 1^+ albumin. VDRL negative. Chest x-ray and cardiac fluoroscopy revealed a TCD of 22 as compared to a TTD of 27. There was evidence of right ventricular enlargement and prominent pulmonary artery. Calcification was noted in the aortic knob, left and right pulmonary arteries, and in the region of the ductus arteriosus (Fig. 1). Cardiac catheterization studies were done with the administration of 100% oxygen because of the serious condition of the patient. The pulmonary pressure was found to be equal to that of the systemic. It was the impression of the cardiac catheterization team that pulmonary hypertension with a bidirectional shunt was present. Simultaneous right brachial and left femoral artery oxygen saturation tests were not performed.

Course—After admission to the hospital, the patient's condition improved. Serial electrocardiograms revealed a conversion from atrial fibrillation to normal sinus rhythm with evidence of right ventricular hypertrophy. The patient was discharged but later had to be readmitted because of a recurrence of cyanosis, dyspnea and a pleuropericardial friction rub.

Comment—It was the opinion of the staff that the sudden change in the patient's clinical course was due to superimposed embolic or thrombotic phenomena in the lesser circulation. As a matter of fact, the physical findings during the second admission were quite consistent with a thrombo-embolic episode. This complication is quite common in patients with pulmonary hypertension.

It is quite unusual that this patient should have done as well as he did up to the age of 39. In a previous review of this subject only 5 out of 50 patients have lived to the age of 40.[2]



Fig. 1. Shows generalized cardiac enlargement with calcification in the aorta, pulmonary arteries and the ductus arteriosus.

Although anticoagulation therapy is indicated in patients with pulmonary hypertension, it was not instituted in this patient because of the unreliability of the patient.

CASE 2.—A 26-year-old white housewife presented herself with a history of dyspnea, cyanosis, palpitation on exertion. At the age of 5 she was first seen in the pediatrics clinic where it was noted that she had hypertension in both arms and absent femoral pulses. She was thought to have a coarctation of the aorta. At the age of 7 on her admission to grade school, it was noted that the patient was cyanotic. She had to curtail her activities even while in grade school because of shortness of breath. During subsequent admissions, her blood pressure readings averaged 140/110 in the right arm, 142/110 in the left arm, 144/122 in the right leg and 142/128 in the left leg.

Past History—The patient's father did not know much about her early childhood, as she was not with him until the age of 5. She had a severe bout of pneumonia in 1952 and an incomplete abortion in 1957.

Family History—There was no family history of congenital heart lesions. Two brothers and 4 sisters are living and well.

Physical examination revealed an obese, cyanotic, white female. Blood pressure 130/100 (RAS) and 140/100 (RLR). Pulse 120 and regular. Lung fields were clear. The second sound was split and P_2 was accentuated. There was a grade 2 systolic murmur at the third left intercostal space. Pulsations of the radial arteries were 4+, femoral arteries 2+, dorsalis pedis and posterior tibials 1+. There was clubbing of all toes and also of the fingers of the left hand but not of the right (Fig. 2).

Laboratory studies—Hemoglobin 25.4 gm. Hematocrit 78. EKG showed right ventricular hypertrophy with sinus tachycardia. Chest x-ray and cardiac fluoroscopy revealed prominence of pulmonary outflow tract. There was definite right ventricular enlargement.

Comment—This patient was advised to have cardiac catheterization studies but failed to return to the clinic. The question of whether there is a complicating coarctation of the aorta was not settled. The early pressures recorded are not unusual in the patient with patent ductus complicated by reversed flow. One cannot rule out other associated congenital defects without selective angiocardiographic studies and selective oxygen saturation studies in different parts of the circulation.[2]

CASE 3.—A 28-year-old white male was admitted to the hospital in November, 1954 for study. This patient could not date the onset of his symptoms but remembered being short of breath during childhood, especially while playing.



Fig. 2. Note the presence of clubbing of the toes and the fingers of the left hand.



Fig. 3. Note clubbing of the toes and thickness of both ankles as compared to the wrists.

He entered military service in November, 1952 and tried to fulfill his duties although he again noted dyspnea on exertion. While serving in Korea, he became very dyspneic after climbing hills. Upon returning to the States, he had a bout of hemoptysis after completing a 15-mile hike. He was hospitalized at that time at the Fitzsimmons Army Hospital where he was studied thoroughly. After cardiac catheterization, he was told he had a patent ductus arteriosus. Several pints of blood were removed and he was discharged from military service. Subsequently, the patient returned home and applied to this hospital for study.

Physical examination revealed a well developed plethoric young white male who did not appear acutely ill. Blood pressure was 116/80 (LAR) and 132/94 (LLR). Pulse was 84. Examination of the head was negative. There was no distention of neck veins. Chest was asymmetrical, the left chest being slightly more prominent than the right. Lung fields were clear. Cardiac examination revealed moderate pulsatile activity over the left 2nd and 3rd interspaces. On palpation a systolic shock was palpable over the same area. PMI was barely palpable in the 5th interspace 9 cm. from the midsternal line. No murmurs were heard over the base or at the apex. There was a systolic ejection click audible in the left 2nd interspace. The second sound was closely split and P_2 was markedly accentuated. The liver and spleen were palpable 2 finger breadths below the costal margins. There was cyanosis and clubbing of the toes of both feet and none of the hands. The legs appeared unusually large and there was moderate pigmentation of both legs with 1+ edema (Fig. 3).

Laboratory Studies—RBC 5.97 million, hemoglobin 15 gm., hematocrit 55. Previous RBC and hemoglobin at Fitzsimmons Army Hospital were 9 million and 28 gm. respectively and a hematocrit of 81. Chest x-ray in 1954 revealed prominent pulmonary artery and calcification in the region of the pulmonary artery and ductus arteriosus. Peripheral lung fields were relatively clear. X-ray repeated in 1958 revealed little change in cardiac size. An impingement plaque was visible in the aorta (Fig. 4). X-rays of the lower extremities revealed moderate periosteal elevation and new bone formation in the tibiae and fibulae (Fig. 4). Electrocardiogram was

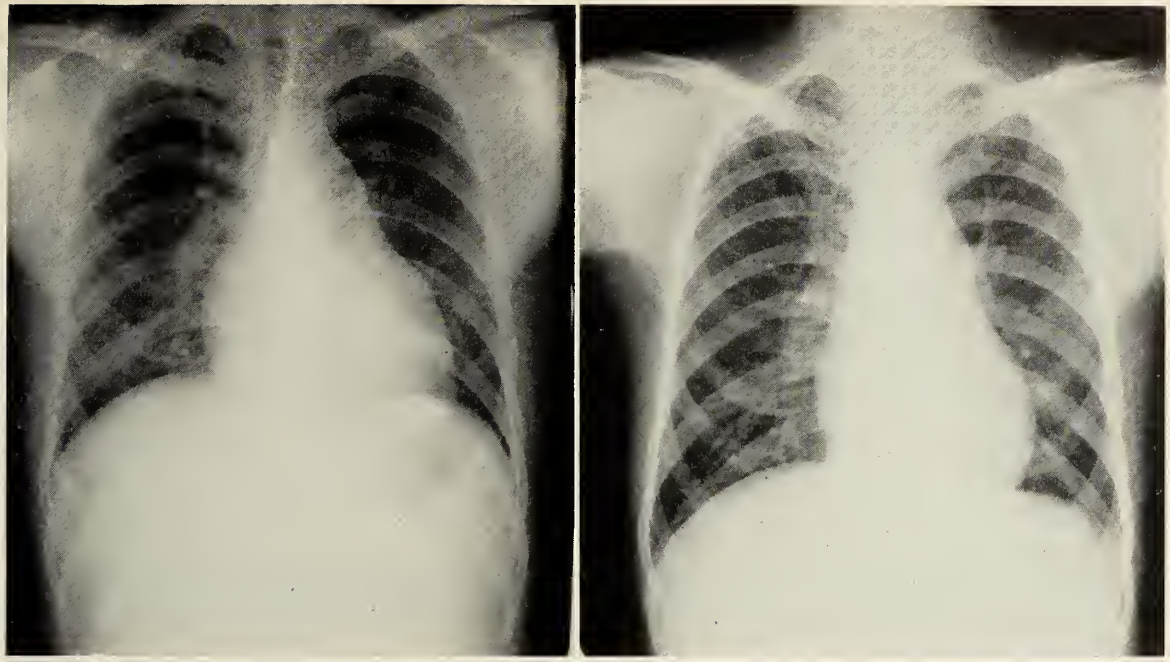


Fig. 4. Note the appearance of calcification in the region of the pulmonary artery and the ductus with an "impingement" plaque in the aorta.

compatible with right ventricular hypertrophy (Fig. 5). Cardiac catheterization studies performed at Fitzsimons on 8/11/54 yielded the following data:

Location of catheter	O_2 *saturation* (Volumes %)	*pressure*
Right atrium	16.7	
Aorta	17.5 (61.8% saturated)	112/70
Right ventricle	16.1	112/1
Pulmonary artery	16.3	112/78
Rt. brachial artery	26.0 (92% saturated)	
Capacity	28.3	

On 8/12/54 simultaneous samples of blood were obatined from the right brachial and right femoral arteries. Right brachial artery oxygen saturation was 24.8 volumes % and in the right femoral artery, it was 19.1 volumes %. During catheterization, the catheter passed directly from the right ventricle into the pulmonary artery and from there into the descending aorta via the ductus arteriosus. Angiographic studies revealed the dye to proceed from the right atrium to the right ventricle, to the pulmonary artery and from there into the aorta.

Course—Since 1954 the patient has been followed by the Medical Department. The patient has not returned to work and intermittently has complained of shortness of breath which is relieved by phlebotomy. He has been digitalized and has been on a low sodium diet. For the past year, the patient has complained of pain in both lower extremities.

Comment—This patient was seen by Dr. Paul Wood, renowned English cardiologist, in March, 1958 and he concurred with the diagnosis of

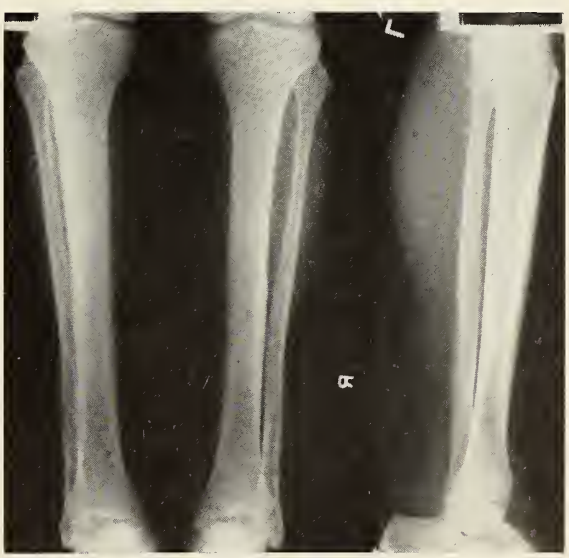


Fig. 5. Note the presence of moderate periosteal elevation and new bone formation in the tibiae and fibulae.

patent ductus with reversed flow. He strongly advised against any attempt at surgical closure of the ductus. In view of the severe pulmonary hypertension, he advised lifelong anticoagulant therapy.

Of interest in this particular case was Dr. Wood's suggestion that members of this patient's family might have a similar defect of a lesser degree. Two sisters of this patient have been examined and each has a typical form of patent ductus arteriosus.

In a recent article, Trever[3] reviewed the incidence of hypertrophic pulmonary osteoarthropathy in association with congenital cyanotic heart disease and only three instances were found. Two of these were reported in detail, and in one there was transposition of the great vessels with an interventricular septal defect. In the other, physiologic studies revealed a pulmonary stenosis, ventricular septal defect and an anomalous pulmonary vein entering the right atrium. In our patient, just described, periosteal and bony changes were confined to the lower extremities.

Discussion

As stated in the introduction, patent ductus arteriosus with pulmonary hypertension and veno-arterial shunt can be a very difficult diagnostic problem to resolve. Excellent reviews of this subject have been published.[1, 2, 4, 5]

London *et al* reviewed 47 patients with this syndrome. There were approximately twice as many females as males. The ages ranged from 4 to 53 years.[2] In Wood's series of 900 congenital heart patients, the incidence of bidirectional or reversed shunt in patent ductus arteriosus was 2%.[6]

The most common symptom in this syndrome seems to be dyspnea of an incapacitating degree and of long duration. Cyanosis at rest is relatively common but less common than in individuals with ventricular or atrial septal defect with reversed blood flow. Even on effort, one-third of those with patent ductus arteriosus remained acyanotic. However, after a hot bath, over half of Dr. Wood's patients showed differential cyanosis, the hands being pink and the toes blue. Lukas [1] found differential cyanosis between the upper and lower extremities in all 4 patients. Clubbing of the toes and not of the fingers was found in 3 of these. Clubbing, like cyansosis, is related to the distribution of the right to left shunt. Polycythemia is almost invariably present. Other symptoms that are commonly described with this syndrome include recurrent hemoptysis, anginal pain and fatigue.

The physical findings, with the exception of the differential cyanosis, are those usually found in severe pulmonary hypertension. The precordium in the left parasternal area may be prominent, and unusual pulsation may be palpable over the pulmonary artery. The typical Gibson murmur of patent ductus arteriosus is never present, and the murmurs usually described are those of pulmonary incompetency, a systolic murmur propagated through the ductus, or the systolic murmur of tricuspid incompetency. In Case 3, no murmur of any kind has ever been described. A systolic pulmonary ejection click is usually heard, and the second sound is closely split with the pulmonary component being quite accentuated.

Conventional roentgenography usually reveals the heart to be slightly or moderately enlarged. The main pulmonary artery and its branches are prominent. The peripheral vascular lung markings are light. Calcification of the pulmonary artery may be present and a comma-shaped calcification in the region of the ductus Botalli has been described. "Impingement" calcific plaques

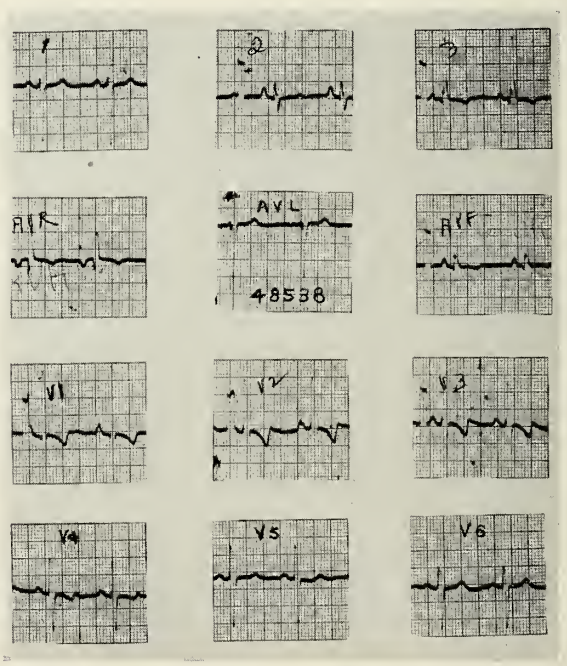


Fig. 6. Electrocardiogram compatible with right ventricular hypertrophy.

on the aortic and pulmonary sides of the ductus are not uncommon.

Electrocardiography consistently reveals the pattern of right ventricular hypertrophy.

Angiocardiography is of value if cardiac catheterization studies are inconclusive and if some additional defect such as a ventricular septal defect or coarctation of the aorta is suspected. Selective intracardiac angiocardiography and oxygen saturation studies help differentiate more complicated lesions.[2]

Cardiac catheterization studies confirm a bidirectional shunt or no shunt at all. The systolic pulmonary pressure is usually equal to that of the aorta. The ductus in this case is quite large and a catheter usually passes through the ductus into the descending aorta. The calculated pulmonary vascular resistance is always very high.

Simultaneous femoral and right brachial arterial oxygen saturation determination in patients with patent ductus and reversed flow is the most important physiologic study that can be performed since a lower femoral arterial oxygen saturation is virtually diagnostic of a "reversed ductus."

In general, after reviewing the literature, one finds that the majority of authors agree that at this time, surgical closure of the ductus in people with patent ductus with reversal of flow is contraindicated.[1, 4, 6, 7, 8]

It is true that the natural course of this disease indicates a poor prognosis. Rarely do these individuals reach the age of 40. However, London *et al,*[2] have shown in their review of the 17 patients that have been explored, only 3 survived the immediate postoperative period. One of these died shortly thereafter, one did not return for follow-up, and a third had a striking diminution in the pulmonary artery pressure. It should be emphasized that most authors agree that patent ductus arteriosus with pulmonary hypertension and an increased pulmonary blood flow should have surgery. When there is an extremely high pulmonary vascular resistance and diminished pulmonary blood flow, the results of surgery are uniformly poor. According to Wood, ligation of the ductus does not relieve the pulmonary hypertension but removes the safety valve in the pulmonary circulation. Actually, in those patients with a right to left shunt, the significant lesion is, according to Young, *et al,*[9] in the small pulmonary vessels rather than the ductus.

Attempts have been made to slowly occlude the ductus with fibrosing agents,[9] or creation of smaller shunts into the right atrium prior to attempts at closure of the ductus.[10] Data to date is insufficient to evaluate.

The medical management of these patients consists of routine cardiac regimen, phlebotomy when polycythemia becomes too severe and the use of anticoagulants.

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The Journal

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AIR POLLUTION CONTROL

THE RECENT National Conference on Air Pollution, sponsored by the Public Health Service, at the direction of Surgeon General Leroy Burney, highlighted an increasingly serious public health problem and outlined a campaign for its correction.

Research and epidemiological studies have demonstrated circumstantial evidence to link several fatal diseases with urban air pollution. Mortality rates for lung cancer among city dwellers are significantly higher than among comparable groups of rural inhabitants, smoking habits notwithstanding. Parallels are shown between air pollution and cancer of the stomach and esophagus.

The 1948 smog emergency in Donora, Pa., with a large number of respiratory deaths, and the experience of London, England, in 1952 when several thousand deaths occurred during a period of unusually heavy air pollution, are grim reminders of the acute affects.

The new Congress will be asked to extend and possibly expand the Air Pollution Control Act which is now in its fourth year. Dr. Burney pointed out that control measures are expensive, but that at the present industry is spending about 1/3 billion dollars per year for control, while the economic loss is estimated to be at least 4 billion dollars.

There are now about 250 cities in the United

States with control programs and some 10,000 cities that are in need of control. Cities like Los Angeles and the Bay area around San Francisco, with a combination of climate, topography, heavy industry and many automobiles necessary for the production and retention of harmful smogs, have been the leaders in research and in practical control measures.

Imperfect combustion of a variety of combustible materials has proven to be the main source of the irritant factors. Control of factory furnaces, limitation of fuels for home heating, supervised burning of wastes, and the control of automobile exhaust fumes by use of afterburners are among the proven methods of prevention.

More research into the extent and nature of the problem is needed. It is expected that when the automobile afterburner is developed all the automobiles in some areas will be so equipped in order to eliminate the 5% to 10% of the fuel which is exhausted in a partially burned state.

A SALUTE

THE *Rocky Mountain Medical Journal,* official journal of the state medical associations of Colorado, Montana, New Mexico, Utah and Wyoming, has announced that Nevada has been added to the quintet to form a six-state medical journal enterprise. The *Rocky Mountain Journal* has been supported and sponsored by the five states for many years. The result of the cooperation and work of the medical profession in these states has been a top-drawer journal, outstanding among the state medical journals of the United States. We salute the new member of this medical journalistic family and wish continued success for the *Rocky Mountain Medical Journal.*

ENGLISH VOLUNTARY HEALTH INSURANCE UP

ENGLAND, with its compulsory tax paid system of universal medical care, would seem to be an unpromising prospect for the sale of voluntary health insurance.

However, natural expectations to the contrary, the English are now buying private medical insurance at an increasing rate, even though they are all compelled to support the government health service with payroll deductions and general taxation.

The British United Provident Association, the most prominent writer of medical coverage, has increased its contributors from 34,000 in 1949 to over 300,000 today.

Prior to the advent of the National Health Service in 1948, private insurance in Britain limited benefits to loss of income due to accidents or illness. There was little coverage available for hospital or medical costs.

Since the government medical care system was expanded to provide for everyone, private insurance policies have been offered to cover private hospital accommodations, nursing homes, surgical fees, anesthetic services, consultants, home nursing care and diagnostic services.

Four major reasons for the popularity of the voluntary programs are cited:

1. Continued increase of the cost of certain services provided under the government program. This is particularly true of dental care, drugs and optical appliances. These items are subject to an additional fee, which the English found necessary in order to increase the income and to limit usage.

2. Desire for private rooms which are not available under NHS.

3. Limited number of government hospital beds. At the end of 1956 it was estimated that 431,000 persons were on hospital waiting lists.

4. Patients' lack of freedom of choice in se-

lection of surgeons, specialists and consultants.

The voluntary health policies are tailored to provide principally for the more serious illnesses and do not cover minor ailments.

Almost all incomes in England are moderate in size. The fact that there are an increasingly large number of Englishmen who choose to pay for their medical care twice in order to provide themselves with that type of care received in non-governmental private practice is a high compliment to private practice and to voluntary medical insurance.

LASKER AWARD FOR HEART RESEARCH TO DR. IRVINE PAGE

DR. IRVINE H. PAGE, formerly director of the Lilly Clinical Research Laboratory of the Indianapolis City Hospital, has received the 1958 Albert Lasker Award for distinguished achievement in the field of cardiovascular research. In 1939 he was the co-discoverer of angiotensin, a powerful pressure-raising substance formed in the kidney. Since 1945 he has been the director of research at the Cleveland Clinic. He and his co-workers have recently synthesized angiotensin and, thereby, opened up research to find substances to combat its action. The Lasker Award was presented to Dr. Page at the Scientific Session of the American Heart Association in San Francisco in October, 1958. Congratulations are extended to Dr. Page by *The Journal* on behalf of his many friends in Indiana.

OCCUPATIONAL HAZARDS OF PHYSICIANS*

"TOO MUCH work and not enough play" is an occupational dilemma the U. S. physician should resolve if he wants to keep up his own health standards.

Evidence presented in the current issue of *Patterns of Disease* reveals that the average physician is so busy taking care of others that he doesn't have time to take care of himself.

Prepared by Parke, Davis & Company at the Science Information Bureau, 445 Park Avenue, New York 22, New York, for the medical profession, *Patterns of Disease* reports a special survey on physicians' health practices and standards. The survey, both the largest and most recent of its kind, was conducted among more than 9,000 practicing physicians under sixty-five years of age engaged in private practice in this country.

The U. S. physician undertakes a far heavier work load than the average person, *Patterns* reports. Half the physicians in this study reported a work week of fifty hours or longer—at least 20 per cent more than the accepted norm of forty hours. In fact, 13 per cent work sixty to sixty-four hours and 6 per cent eighty hours or more!

The result is he has very little leisure time. Close to 60 per cent of the physicians in the study stated they spend less than ten hours a week on recreation. Even the physician with a hobby has virtually no opportunity to pursue it. Of the 37 per cent who mentioned hobbies, for instance, half stated that they spent only four hours a week or even less on their particular hobby.

Vacations, too, tend to be inadequate. One out of 20 physicians reported they took no time off for vacations during the year, and more than one in ten took only a week or less.

Despite his crowded working schedule, the physician loses less time from work due to ill-

* From the *New York State Journal of Medicine*, Vol. 59, No. 1, Jan., 1959, pp. 45-46.

ness than the average man. Two-thirds of the doctors in the *Patterns* study reported no time lost from work last year. The remaining third reported an average time of 3.8 days lost due to illness as against 7.4 days of work-loss by the average American man.

The practice of medicine poses occupational hazards, *Patterns* reveals. Illnesses resulting directly from their practice attacked one-tenth of the physicians in the study during the past three years. Of these, three-quarters were laid low by infections and more than one-fifth developed allergic dermatitis or other forms of allergies. One in 30 with work-related illnesses was injured by over-exposure to radiation.

Does illness vary with the type of practice? Pediatricians are more prone to infectious diseases than their colleagues, according to *Patterns,* and the risk of radiation injuries is greater among radiologists than other members of the profession.

Infectious and parasitic diseases are the commonest ailments among physicians. In the *Patterns* study, they afflicted approximately 30 per cent of all physicians reporting illness during the past five years. Cardiovascular diseases were the second commonest, being reported by about 10 per cent. Accidents and injuries, gastrointestinal disease, and allergy all ranked third, each being reported by about 7 per cent.

In general, heart disease, sometimes called the doctor's disease, appears to be the leading mortality risk among U. S. physicians. Of causes of death reported among 2,700 physicians from July 1, 1957 to June 30, 1958, heart disease was the single or contributory cause of 50 per cent.

The highest death rates from coronary heart disease among physicians occur from the ages of sixty to sixty-four, according to *Patterns.* In the under forty-five age group, auto accidents ranked first as a contributory cause of death in the study, accounting for more than 40 per cent.

What's the average doctor like? From the results of its study, *Patterns* has assembled a composite "profile" of him. He is forty-four years old, 5 feet 10 inches tall and weighs 173 pounds. He works fifty-four hours a week, plays seven hours, and takes two and one-half weeks' vacation a year. His health record, at least in terms of his working schedule, is a good one. He only lost a fraction of a day from work last year, and has had one illness in the past five years.

From Minnesota Medicine:

SURVIVAL THROUGH INSIGHT

THE WORLD is a place of turmoil, of bloodshed, of naked and covert cruelty. The mass of men lead lives of quiet desperation. We have the means for happiness but most men live in misery, openly or privately. That we tremble on the brink of destroying our species with atomic power instead of using it for security and happiness, reveals in one stroke how irrational, how destructive and self-destructive our behavior is. For today the suffering with which most people live is, in overwhelming part, man made. No longer the elements, wild beasts or even infectious diseases are the great dangers. The central threat is in man himself; it is his hostility to his own kind. Probably no other species in nature is so cruel and destructive to its own members. War, crime, delinquency reveal man's destructiveness to man directly; and underlying hostility to his fellows is central in the neuroses, psychoses and psychosomatic symptoms. It is obvious in paranoia and in suicidal depressions. It is also central in human affairs, in the home and in business, professional and social life.

We see it regularly in books, plays, movies and television. People try to love each other—husband and wife, parent and child, brothers and sisters—but how often does there flow an undercurrent of hostility. And if a child grows up with hostility to members of his own family, even to his father and mother, small wonder that he becomes hostile to others and often laden with guilt—small wonder, therefore, that the crime rate, the divorce rate, the alcoholism, the cruelty, violence and war, hot and cold, go on endlessly all over the world.

This hostility of people to each other, which

keeps humanity suffering in so many ways and in constant fear of each other, is part of a primitive mechanism of adaptation—the fight or flight response to any threat, irritation or frustration. How powerfully people seek to vent hostility in myriad forms, and to escape via alcohol and drugs and mental illness, is a measure of how frustrated and anxious they are. Most people look for the sources of their anxieties and frustrations in the external world alone, in others. But however correct this is, yet there is almost invariably another source—within the person himself.

This inner source of fears and frustration, and therefore of hate and hostility, few people recognize; or they may sense its existence without being able to define it. The basic source is almost always a warping in the emotional development caused during the earliest formative years of life, the most sensitive period being from conception to age about six. "As the twig is bent, the tree is inclined." "The hand that rocks the cradle rules the world." "There are no problem children, only problem parents and environments." "Give me the child until he is six, and you may have him all the rest of his life." The overwhelming weight of clinical psychiatric experience confirms the truth of this folk wisdom and this educational principle. This conclusion is often criticized, even attacked, because of the weight of responsibility it lays upon parents. But it is the truth, and the truth alone will make us free. Only upon it can we build a better world.

At any rate, the great diversity among individual persons is predominantly a reflection of the different emotional pressures through which they have passed in early childhood. It is a result of the differences in conditioning by the training and examples and stresses to which they were subjected during their earliest years by those responsible for them and important to them emotionally. Liddell has shown how the instinctual mother-child relationship can be disrupted as between goat and kid, with devastating after-effects.[1] Each person, as a result of his early conditioning, has at the core of his personality a certain pattern of motivation, reaction and seeing life. The child he once was lives on in the adult, but little changed. If this child is a disturbed one and too greatly influences the feelings and behavior of the adult, disturbing his mature motivations, then all forms of emotional and behavior disorders ensue.

It is of the greatest importance in many ways to understand the nature of this childish core, the nature of the total personality, of emotional maturity and the course of development to it.

Such knowledge is basic to education. No education can be called liberal which teaches subjects not students, books not reality and intellects without regard to their base in the emotional life. No man is educated who does not know the nature of man.

Such knowledge is important for religious feeling. How can a person feel at one with the forces which move the universe and himself if he has no knowledge of them? Great men have divined these truths, but we ordinary people need laboriously to learn them.

Such knowledge is a sturdy staff and shield in personal living, which is a complicated and difficult task. Knowledge of self aids understanding of others—and compassion for others. Knowledge of others helps understanding of self. Both help toward mature motivations upon which alone any stable life, family, group, nation or world can be built.

Such knowledge provides the key to human behavior and thereby to the central problems of our time: social unrest, crime, cruelty, tyranny, war.

Look at the home life of any individual from birth to six years of age, and you will have the clue to later behavior. The spear creates the shield, the cannon—armour, gun powder—atomic bombs, missiles—antimissiles. We move to greater danger, greater destruction. We raise orbiting satellites; we raise good mature corn and hogs, but we do almost nothing to raise good mature human beings. The pine tree grows straight if it is not warped early. So do children. But we are a world of bent trees—because children are unwanted, neglected, victims of disrupted marriages (one in three), or over-protected, dominated, and otherwise traumatized by the emotional disorders or only the well-meaning misguidedness of those who rear them.

If throughout the schools and the churches and other agencies and mass media, parents and children both learn the bases of human nature in general, and something of themselves in particular, they will be helped in handling their own

lives and in helping others; their capacity for love, brotherhood and cooperation will increase at the expense of hostility; and a step will be taken toward a better world if not toward survival itself. However much we need armanents for the present, in the long run our only security must rest upon the strength of mature adults. In making better satellites for the present, let us not be deflected from the only ultimate need and solution—better people—which means an increased percentage of mature people, which means people of goodwill.

What makes Lincolns and Jeffersons or Bluebeards and Billy the Kids, is now known, and much of it can be taught. Such courses have been tried successfully in many places throughout the country at all age levels, from the Bullis plan in grade schools, through Elizabeth Force's course in high school[2] and at college level at Swarthmore and other colleges.[3] Making better people and better lives for individuals is a colossal task, but not impossible. The formula for atomic power is $e=mc^2$. The formula for proper mature people, i.e., people of inner strength and goodwill (for only the strong can be gentle) is proper rearing from birth to six years of age. It can be done. The knowledge is available. The great need now is education at all levels.

LEON J. SAUL, M.D.

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Guest Editorial:

THE PERILS OF EMPLOYMENT

PERHAPS the gravest present social dilemma in the United States is of our own making. We are confronted with the question of what to do with a population which has added about 20 years to its average life span in half a century, largely through the advances in medical knowledge.

Disability and death are now, to a major degree, the results of disease states predominantly related to aging—chiefly cardiovascular and neoplastic—and whose etiologies remain obscure; obscure at least to scientists, but not apparently to legislators, juries and compensation boards. In certain states, for example, the lawmakers have decreed that if firemen and policemen (and as many others as can influence legislation) develop heart disease or hypertension, it is to be presumed that their occupations were wholly responsible and that they, therefore, shall receive special pension privileges.

Similarly, the laws relating to industrial accidents and workmen's compensation have been subtly modified by legal interpretation to a point where they supply a form of disability insurance and death benefit.

These laws were originally worthily inspired in the attempt to recompense an employee actually injured by something peculiar to his work. They have been altered by several maneuvers. One was the removal of the principle of contributory negligence, so that no matter how unheeding, or willful, the worker, his injury is compensable. On the other hand, it need not be proved that the employer was negligent before he is judged liable, and no overt accident or injury appears to be necessary.

Then came the decision that disease was an "injury" under the law. This was reasonable in relation to silicosis, industrial poisoning and similar obvious results of specific industrial hazards. When, however, diseases such as coronary artery atheroma and hypertension were admitted to the tent, the original purpose of the law became seriously perverted. Especially incongruous is the conclusion by lay administrators and legal pundits that certain occupations are to be categor-

ized as emotionally stressful and therefore dangerous. This point of view is vigorously espoused by some legislators relative to their own occupations and the danger to their health in their selfless devotion to their constituents.

One other baneful distortion of fact is in the interpretation of the legally useful word "aggravation." If it can be shown to the satisfaction of the controlling authority that a man's work brought him to a disabled condition or to death "sooner than otherwise would have occurred," then his occupation is to be held totally culpable even though two thirds of his 24-hour existence is spent away from his job. Ford and Hellerstein[1] have recently quoted the work of Garry *et al,* who found that *during their 8 non-working hours* clerks and coal miners expended more energy than the *average man at work* in Cleveland in industries typical of one-third of the working force of that city. What is particularly pernicious about the unsupported conclusions regarding the malign effects of work are decisions that the ordinary work to which a man is accustomed and which he has performed for years, is to be adjudged the influence that disabled him when chronic degenerative disease finally overtakes him.

In 1957 the Moreland Commission[2] in New York directed its attention to the cardiac problem and sent questionnaires to 700 internists in the United States, of whom 381 were certified in the cardiovascular subspecialty. Three hundred and ninety-eight physicians replied and 93.9% of them concluded that "work does not produce heart disease."

A hypothetical case was described in the questionnaire—a man who had worked for 20 years, since the age of 25, at moderately heavy work and at the end of this time, while on the job, without any unusual exertion or strain, suffered a coronary occlusion. In assessing the cause of the occlusion, 88.6% of the physicians felt that there was no relationship to the man's occupation at the time of the attack; only 7.1% thought there was a relationship.

It is clear that in spite of a more than a 12.1 vote by competent medical authority against the culpability of ordinary work in aggravating coronary disease, the courts and compensation boards persist in resolving these cases for the defendant. It is a rich field for certain lawyers and doctors and, of course, this use of the medical profession is pleasing to segments of organized labor whose avowed intent is to have industry absorb all the costs of employee disability, no matter what its origin. Essentially, then, medical testimony is disregarded in many industrial cases except as a minority of physicians can be induced to testify that, no matter how improbable a casual relationship may be, if it can be conceived as "possible," it is acceptable.

In New Zealand (a highly socialized country), on the other hand, the original rule is adhered to, namely that a definite and unusual strain must be proved in cardiac cases before the employment is to be blamed for the precipitation of a "heart attack."

The medical profession in the United States should take a long look at its social responsibilities and help a situation which is becoming scientifically intolerable. The employment of not only the cardiac, with good work tolerance, is becoming increasingly difficult, but also that of all older workers, even those above the age of 45. Employers naturally have to avoid mounting insurance costs and higher employee disability risks, even if such risks are imposed quite arbitrarily.

More research in the field is needed and the American Heart Association with the support of the National Heart Institute of the United States Public Health Service is engaged in an investigation of the medico-legal aspects of industrial compensation in heart cases. If the etiologic role of emotional stress in coronary disease is accepted on the basis of our present evidence, there will be no occupation which will be exempt from fancied dangers. Even now *lack of stress* at work appears inimical, for compensation is reported to have been awarded an employee who dislocated his jaw yawning while at work.

It may be that the disregard of competent medical evidence, unless for the plaintiff, has removed the whole area of workman's compensation from the medical field into a new framework of social mores. However, it seems wise for us, as physicians, not to foster the idea that the cardiac and the older worker are, by definition, forever unemployable merely on the assumption that work accelerates all chronic disease. The newer concepts of the protective value of an active life are far more encouraging than the accent on disability and law suits.

Howard B. Sprague, M.D.

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1. Ford, A. B., and Hellerstein, H. K.: Work and Heart Disease. I. A Physiologic Study in the Factory. *Circulation,* Vol. XVIII, p. 823, 1958.
2. Costs, Operations, and Procedures under The Workmen's Compensation Law of the State of New York. Moreland Report. January 28, 1957, p. 104 Appendix A—The Cardiac Problem.

Notice

MEMBERS

Notice

The 1959 Yearbook with Roster will be issued in May instead of July.

The May issue is made up in April. To be included in the membership roster, members' dues must be in the state office before that time.

Get Your Dues in Early!

President's Page

This is the time of the year to start talking to your patients about getting polio immunization injections for protection beginning this summer and fall. Last year the majority of polio victims were under 5 years of age. In 1958 there were about 40% more paralytic cases in about the same number of infected persons. It is indeed tragic that hundreds of children and young adults will spend the rest of their lives in wheel chairs or using crutches because someone failed to see that they had been vaccinated. It is important that each physician must assume responsibility for making sure that all members of families he has for patients are fully vaccinated. We must never let up on promoting immunizations of all types.

We have for years advocated that immunizations should be done in the early months of life and not delayed until school age. The place for giving the inoculations at the early age is in the doctor's office during the time when the doctor is checking the early development of the child. It is probably true that, following their births, a number of infants do not have medical guidance between the period after leaving the hospital until entering school. We must develop a better liaison between the doctor who delivers a baby and the doctor that cares for the infant (who may or may not be the same physician) to promote immunization of the young child. A greater effort should be made to see that every infant or young child visits a doctor for all types of immunizations.

The state medical association and all county societies should work out a program of having the doctor's office become immunization centers. Mass public inoculation centers are usually set up for older children and adults who should have had their inoculations at about 6 months of age. If done at the proper time, this would prevent unnecessatry disease, paralysis and deaths during the early years of life. If we are able to increase the inoculation rate of our patients the mass public inoculation centers will not be demanded by the public. Our Indiana State Medical Association Commission on Public Health has been assigned the project of promoting immunizations. Doctors and families should keep accurate health and inoculation records which may prevent unnecessary deaths because of inaccurate memories.

A child in Indiana this past year died of tetanus because of a misunderstanding and poor memory as to whether or not the child had been immunized against tetanus. We should encourage families and individuals to have readily available health records. Let us doctors promote the idea of having the doctor's office become the immunization center for patients.

Kenneth L. Olson M.D.

The Woman's Auxiliary

REPORTS TO I.S.M.A.

Dear Doctor:

First of all the State Auxiliary American Medical Education Foundation committee wishes you a very happy and prosperous New Year and reports to you their plans and aims for the year.

Again the American Medical Education Foundation has been made a priority project in the total auxiliary program. The theme this year is "A Goal for Every Auxiliary." To help implement this theme each auxiliary has been asked to decide on a goal for their own auxiliary. The state committee has asked them to give at least five dollars per capita, and again we are striving for a state goal of ten thousand dollars. Perhaps you would be interested to know that since its inception in 1951, the American Medical Education Foundation has contributed about one million dollars annually to the medical schools.

The state American Medical Education Foundation committee consists of eight auxiliary members, including the state chairman and a treasurer. We are proud of the fact that money is rolling in from all over the state from the use of memorial and appreciation cards. The use of these cards is an excellent way to honor a friend, and at the same time contribute to the American Medical Education Foundation and the medical school of your choice. These contributions also apply to the auxiliary's goal.

What is the auxiliary's role in the American Medical Education Foundation? Each year the Woman's Auxiliary increases its interest in this project through its various activities—benefits, memorials, articles made for sale and direct gifts—the auxiliary works diligently raising money for the nation's medical schools. For the past two years Indiana was third in the nation, contributing over nine thousand dollars to the Foundation.

We hope that next spring will find us with the victory of a check for more than ten thousand dollars as the Indiana Auxiliary's contribution to the medical schools of our country.

This is our aim and our report to you, doctor.

Sincerely,

Mrs. Wendell C. Stover
A.M.E.F. State Chairman

Medical Panorama—

A. W. Cavins, M. D.

Terre Haute

FROM THE DEEP SOUTH

The "President's Page" has become a popular feature in more and more state medical journals. Indiana has had one for a long time. Here is a sample from Mississippi, and it shows keen insight into the purpose and accomplishments of organized medicine. The second paragraph in the following excerpt from the October, 1958, *The Mississippi Doctor* is the key to the need for doctors to *be* organized:

THE AMERICAN SYSTEM of medical care is truly unique in quality and availability. Of no less importance than scientific advancement are the strides made in achieving the present effective distribution of quality care. Throughout the entire nation, about 98% of all Americans are but minutes away from a doctor and a hospital. There is no basis in fact for anyone's saying that medical care is economically unavailable and especially is this true in Mississippi. For most Americans extensive care is economically convenient because of voluntary health insurance, better incomes, and a growing awareness of the value of preventive medicine.

DOCTORS AS individuals could not possibly have brought this economic miracle to pass but doctors as participants in medical organization did achieve this. The county medical society, the state medical association, and the AMA provide the only possible climate for this unified progress, doing things for physicians which they cannot do for themselves alone. And therein lies proof that medicine's detractors deal in half-truths. The best example of this is found in the 102 years of MSMA's proud history.

OUR ASSOCIATION, voluntarily supported by the dues of ethical, dedicated physicians, sponsored laws creating the State Board of Health before the nineteenth century reached the three-quarter mark. For 60 years, MSMA has protected the people from the danger of licensed cultism and health quackery. The nation's most stringent anti-abortion law was put on Mississippi's statute books single-handedly by our state medical association.

WHO ASSUMED leadership in the hospital construction program and led the way to finance and build the new four-year medical school? Who has sought sound medical legislation, never once asking special favor or professional advantage? Who has built the most powerful force for service and good among Mississippi's voluntary organizations? Four words give the answer in each case: Mississippi State Medical Association.

PHYSICIANS AS individuals are responsive to duties of citizenship and community service obligation. That isn't to say that the M.D. degree simultaneously confers mortal sainthood, and nobody, least of all physicians themselves, claims perfection for the medical profession. Taken as a group, doctors measure up in service and civic responsibility.

THE PAST IS today's inspiration to meet the challenging problems in science, socioeconomics, and our individual practices which are before us. We must never expect to rest on laurels because service and achievement are merely the prices we must pay for the privileges of professional skill and public confidence. A noble profession, unified through a dedicated organization, will be better equipped to increase its service capacity and meet new challenges. MSMA will stand uppermost in discharging these responsibilities only as we doctors give it the strength and support it must have.

Guy T. Vise, M.D., *President*

A review of achievement is often the bracer needed to boost the will to future accomplishment. We thank Dr. Vise for reminding us of our own stature.



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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

The Heart Problem in Workmen's Compensation Is Settled— Until the Next One

BEN F. SMALL*

"The mere showing that he was performing his usual routine everyday task when he suffered a heart attack does not establish a right to workmen's compensation because there was no event or happening beyond the mere employment itself."

SO ENDS, for the time being at least, the Dykes case, *United States Steel Corporation v. Bessie Dykes,*[1] Cause Number 29733 in the Supreme Court of Indiana, decided Nov. 20, 1958. The Supreme Court has spoken on the subject of preexisting disease aggravated by the usual and the unusual stresses of employment.

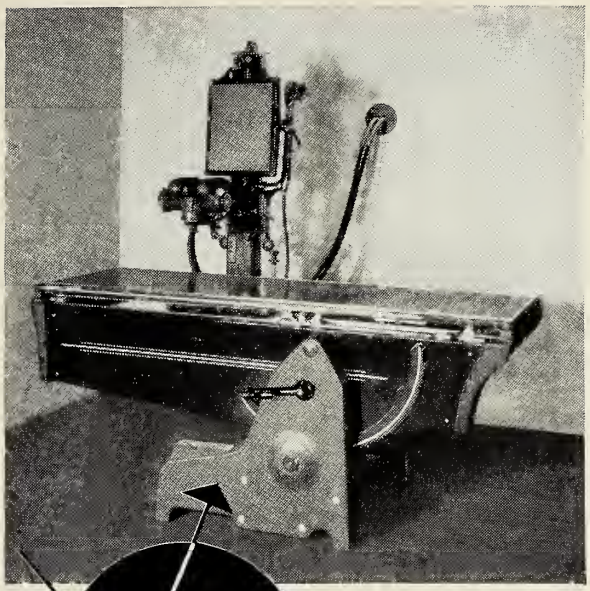
John Dykes, a 55-year-old grinder in U. S. Steel's Gary Mills, was doing his customary work on the morning of Sept. 7, 1954, operating his grinding machine weighing between 12 and 35 pounds, until about 10:45, when he seemed to run down physically. Shortly thereafter, he clapped his hands to his chest, staggered a few steps and fell to the floor; it was a fatal coronary occlusion. Claim for death benefits was filed with the Industrial Board of Indiana, charged with administration of the Indiana Workmen's Compensation Act, which provides certain limited statutory benefits—a maximum of $15,000—for "personal injury or death by accident arising out of and in the course of the employment."

The Industrial Board, after a single member hearing, followed by a review by the full 5-man Board, found the death compensable under the above formula and awarded compensation. Appeal was taken to the Appellate Court of Indiana, which, generally speaking, writes the last word in Workmen's Compensation cases. Its function as a reviewing body is to examine the record of proceedings in the Industrial Board to determine if the Board's award is supported by some competent evidence. The Court's function is not to weigh the preponderances of all the conflicting evidence, but simply to see if the primary determination is supported in the record by some competent evidence. The Appellate Court found this to be the case and affirmed the award of compensation. It was at this stage that our highest Court, the Supreme Court of Indiana, granted a petition to transfer the case, thus removing it from the Appellate Court's jurisdiction, and reversed, saying "the only conclusion which reasonable men could reach . . . is that the decedent was afflicted with a diseased heart and coronary system, which had deteriorated to the point where it could no longer stand the load imposed upon it by his regular and usual work, and that his death resulted solely from coronary arteriosclerosis progressing gradually to the point where it caused his death."

The point would be an easy one if, to make out a case for coverage the claimant had to show that the employment was the sole moving cause of the accident. But the language is "personal injury or death by accident arising out of and in the course of the employment." Under this language it has long been held that a preexisting infirmity, no matter how advanced, can be compensably ac-

Continued

* Professor of Law, Indiana University School of Law, Indianapolis Division, and author of the book, *Workmen's Compensation Law of Indiana* (Bobbs-Merrill, 1950).

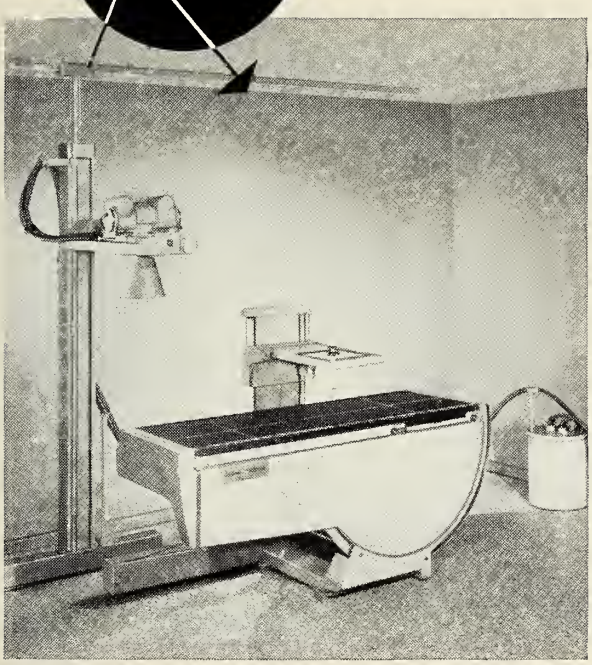


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The Heart Problem

Continued

celerated or aggravated by employment stresses. There has never been much doubt that structural breakdown is a personal injury (or death) by accident. That point was established by the British House of Lords in 1903 in the case of *Fenton v. Thorley & Co.*,[2] where the Court construed the statutory formula for injury to include "any unexpected personal injury resulting to the workman in the course of his employment from any unlooked for mishap or occurrence." All that remains then, is to determine whether such a mishap arises out of the employment, or whether it arises out of something else.

In most cases it arises out of a combination of several causal factors. Yet the courts have pretty consistently held that where some employment stress constitutes the exciting or precipitating factor, where it triggers off the breakdown, the ultimate harm results out of that employment stress. Thus, in Indiana such occurrences as heat prostration, whether from natural[3] or artificial heat,[4] typhoid fever,[5] tuberculosis,[6] Dupoytren's contracture,[7] bursitis,[8] and many other kinds of somewhat self-propelled maladies have been held to arise out of some employment circumstance.

The cases of cardiovascular breakdown pose no different problem from the others, just more difficult. Two cases of ruptured aneurism, one in 1917 and one in 1918, set a certain pattern in Indiana, and to the extent that they were among the first to be tried, they tended to set a pattern for the nation. In the first case, *Haskell & Barker Car Co. v. Brown,*[9] the deceased experienced his accident shortly after trying to pry two sheets of steel apart with a heavy crowbar. In the second, *Indian Creek Coal & Mining Co. v. Calvert,*[10] the deceased, a middle-aged coal miner, had been loading coal cars and pushing them around in a tunnel of the mine. The Industrial Board had awarded compensation in both cases and the Appellate Court, in affirming, noted the undisputed evidence of preexisting degenerative changes, even admitting in the Calvert case that the deceased might have suffered the same fate while sitting still, or while coughing or laughing. At the same time, while recognizing that "the malady was an active and potent agency in causing his death," it affirmed the Board's award of compensation because it believed there was a sufficiency of evidence to establish the employment stresses as the exciting factor which hastened the inevitable end.

From that point on, the heart and circulatory accidents were treated in about the same manner, at least down to 1953. Occasionally compensation was denied where the causal circumstances in the employment were felt to be too remote,[11] but generally speaking, wherever they seemed significantly climactic, the resultant harm was found to arise out of the employment. These included cases of trauma to various parts of the body,[12] falls,[13] electric shock,[14] excitement[15] and overexertion.[16]

Not until 1953 did much attention begin to focus on whether the employment stresses, whatever they might be, had to be out of the ordinary and unusual. The issue was pinpointed in that year in the case of *Slaughbaugh v Vore*,[17] where the Appellate Court said specifically that the Industrial Board's finding of extreme exertion and unusual circumstances in support of its compensation award was surplusage, it being "sufficient under the circumstances of this case that injury occurred unintentionally as a result of exertion or strain occasioned in the course of the employ-

Continued



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References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. *257*:278 (Aug.) 1957.

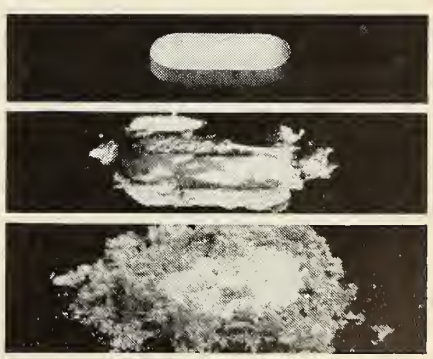
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The Heart Problem

Continued

ment." It was this line of reasoning, repeated in at least 3 other cases since 1953,[18] that generated so much interest in the Dykes case and caused the Supreme Court to transfer it for reversal. It is curious that if it did not have Supreme Court approval, it should have survived as long as it did, since a similar petition to transfer was filed in the Slaughbaugh case in 1953, and was denied by the high Court. Be that as it may, the Supreme Court has now entered the arena of the heart litigation and has remodelled the causal approach formerly used by the Appellate Court to require some showing of unusual or extreme exposure to the risk.

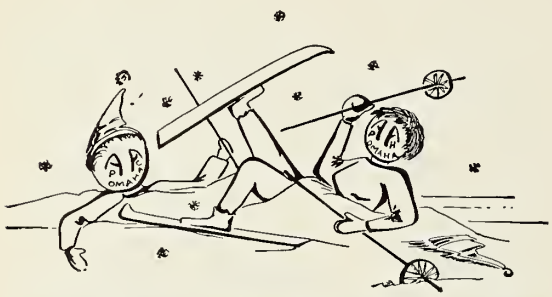
This is not, however, the end of the line for the heart cases, if other precedents have any parallel. Perhaps the best example lies in the lightning cases which only a few years earlier went through the same metamorphosis in Appellate Court—Supreme Court reviews. Succumbing to lightning or other Acts of God, as such natural phenomena are spoken of in the cases, is not necessarily an employment risk. Anyone who happens to be outside during an electrical disturbance is fair game whether on the job or not. Yet, if one is hit while doing something his employment requires him to do, at a place where his employment requires him to be, does the injury or death arise out of the employment? It is clearly in the course of employment, but what about out of? In 1947, the Appellate Court overruled an earlier case[19] which had required a showing of increased risk in lightning cases and held simply that the victim would not have been at the spot where he was hit except for the duties of his employment which placed him there, on a loading platform which became the target for a bolt of lightning.[20] Here too, the Supreme Court exercised the right, which it seldom does, to grant transfer. Instead of reversing, as in the heart cases, it affirmed the Industrial Board's award of compensation, but restated the reasons therefore, restated them in terms which require for a lightning death an unusual exposure of the employment, which it then proceeded to find in testimonial evidence that the area in which the deceased was struck was somewhat more susceptible to lightning than other areas might be.[21]

Thus chastened, the Appellate Court in the next lightning case,[22] two years later, corrected its causal approach by saying "the Supreme Court opinion uses language which compels us to regard the increased risk doctrine as the law of Indiana." Then, having to find increased risk to support the compensation award, it found it in the fact that the deceased workman had gone inside a shelter house to escape the very elements that found him there. It might seem that a man inside a shelter might be in a position of decreased, rather than increased lightning peril, but instead, increased risk was found in such circumstances as damp clothing and the proximity of electrical wiring and outlet sockets.

If we were to crystal gaze, could we not envisage the same increased peril in future heart cases where the Appellate Court, adhering strictly to the Supreme Court's new test for compensable exertion, might find it in a man's lifting and operating a 12 to 35 pound electric grinder, the very thing which the hapless John Dykes was doing at the time of his death?

In the good old days of the Common Law these problems didn't exist. A century ago laissez-faire traditions let any man do pretty

Continued on page 242



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1. Editorial: New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med. & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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Lederle

The Heart Problem

Continued from page 240

much as he pleased, and if he wanted to die on the job, that was his affair. Employers had no responsibility in such matters except possibly to get the body out of the way before it became too much of an eyesore. There were instances, of course, where money could be recovered for really reprehensible conduct on somebody's part, but that was a recovery of money for liability based upon a wrongdoer's culpable misconduct. That sort of recovery still exists, but not within the workmen's compensation system, except where the injury is attributable to someone outside the employer-employee relationship. Workmen's compensation legislation is not based on anyone's fault or misconduct and the employer and his insurance carrier who may be held responsible for an injury or death are not really liable in the old sense at all; they are not made to respond in damages for a wrong done to an employee. It is the job that is assessed with responsibility. True, the money comes out of management's pocket, but it is not a dollar-for-dollar formula of liability equal to the harm suffered. The formula is one of limited economic assistance to an injured worker and his dependents that is automatically due whenever the harm arises out of and in the course of the employment. It constitutes a part of the operating overhead expense of running the enterprise in which the injury occurred. It is quite a substantial item to be sure, but in the long run it is still cheaper than if the employer should be compelled to shoulder the full money load of Common Law liability. In view of the limited nature than, of the compensation remedy courts often tend to shade borderline cases into the coverage of the act, so while the claim of Bessie Dykes may now be dead, what of the future claims of similar nature? Lifting a drill, pushing a wheelbarrow, pulling a cart, followed by cardiovascular failure can arise out of the employment even under the Supreme Court's formula if they were unusual acts. Just how unusual do they have to be? We can only wait and see; there will be more Dykes cases.

FOOTNOTES

1. — Ind. —, 154 N.E.2d 111 (1958), superseding 148 N.E.2d 844 (1958).

Continued

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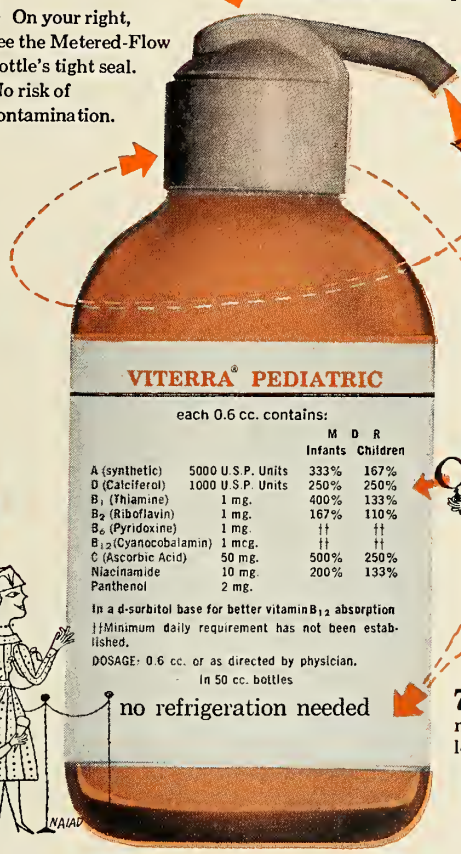


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The Heart Problem

Continued

2. A.C. 443 (1903) (hernia suffered while turning a heavy press wheel).

3. Townsend & Freeman Co. v. Taggart, 81 Ind. App. 610, 144 N.E. 556 (1924).

4. Fox v. Banet, 111 Ind. App. 460, 40 N.E.2d 356, (1942).

5. State Highway Comm. v. Smith, 93 Ind. App. 83, 175 N.E. 146 (1931).

6. Republic Iron & Steel Co. v. Markiowicz, 75 Ind. App. 57, 129 N.E. 710 (1921).

7. American Maize Products Co. v. Nichiporchik, 108 Ind. App. 502, 29 N.E.2d 801 (1940).

8. Standard Cabinet Co. v. Landgrave, 76 Ind. App. 593, 132 N.E. 661 (1921).

9. 67 Ind. App. 178, 117 N.E. 555 (1917).

10. 68 Ind. App. 474, 119 N.E. 519 (1918).

11. See Bierck v. Spiegel Furniture Co., 99 Ind. App. 340, 192 N.E. 726 (1934); Schmid v. Indiana Travelers Accident Assn., 42 Ind. App. 483, 85 N.E. 1032 (1908).

12. Mansfield Eng. Co. v. Winkle, 77 Ind. App. 237, 133 N.E. 390 (1921); Bucyrus Co. v. Townsend, 65 Ind. App. 687, 117 N.E. 656 (1917).

13. Owens v. McWilliams, 85 Ind. App. 92, 152 N.E. 841 (1926).

14. Carnegie-Illinois Steel Corp. v. Flack, 116 Ind. App. 427, 16 N.E.2d 167 (1945); Town of Newburgh v. Jones, 115 Ind. App. 320, 58 N.E.2d 938 (1945).

15. Owens v. McWilliams, supra, note 13.

16. Haskell & Barker Car Co. v. Brown; Indian Creek Coal & Mining Co. v. Calvert, supra, notes 9 and 10.

17. 123 Ind. App. 497, 110 N.E.2d 299 (1953).

18. Sollitt Constr. Co. v. Walker, — Ind. App. —, 135 N.E.2d 623 (1956); E. Raugh & Sons Fertilizer Co. v. Adkins, 126 Ind. App. 251, 129 N.E.2d 358 (1955); United States Steel Corp. v. Douglas, 125 Ind. App. 212, 123 N.E.2d 899 (1955).

19. Deckard v. Trustees of Indiana University, 92 Ind. App. 192, 172 N.E. 547 (1930).

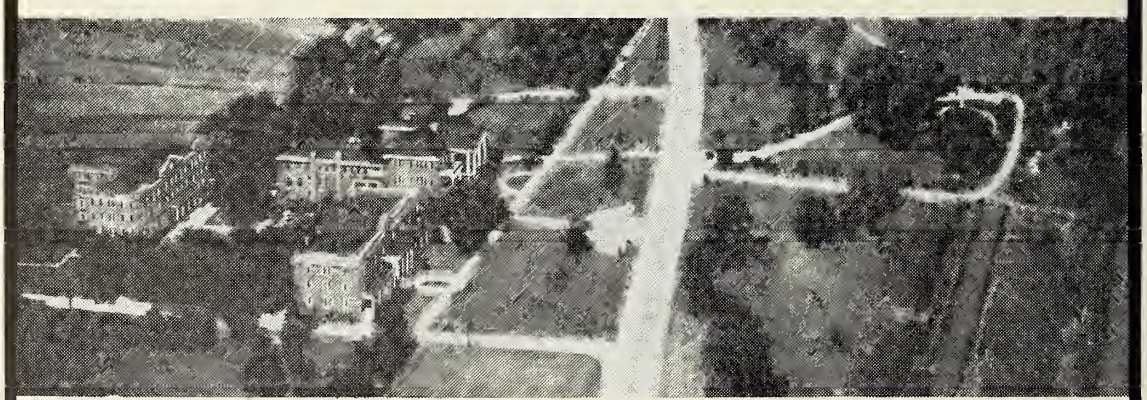
20. E. I. DuPont de Nemours Co. v. Lilly, 75 N.E. 2d 796 (1947).

21. E. I. DuPont de Nemours Co. v. Lilly, 226 Ind. 267, 79 N.E.2d 387 (1948).

22. Citizens Independent Telephone Co. v. Davis, 121 Ind. App. 20, 94 N.E.2d 495 (1950).

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Abstracts:

SIGNS AND SYMPTOMS. By Cyril Mitchell MacBryde, A.B., M.D., F.A.C.P.

Third edition, cloth, 973 pp., illustrated. Philadelphia: J. B. Lippincott Company, 1957. Price $12.00.

As the author himself states, "this book approaches diagnosis as the physician must when studying patients. In each chapter a major sign or symptom is analyzed, and the processes causing it are clarified by considering whatever influences are important in anatomy, pathology, physiology, chemistry and psychology."

In such a way it approaches the study of signs and symptoms along two important thoroughfares for diagnosis: application of morbid anatomy and pathologic physiology, and clinical interpretation and correlation. This fact alone makes the book quite invaluable, especially so because the anatomic and physiologic basis of signs and symptoms are presented in orderly fashion, making understanding of such phenomena very easy for the reader.

This book includes 191 figures, 6 plates and 50 tables, being divided into 34 chapters, each followed by a fine reference list of bibliography. Some of these chapters, not included in previous editions, make this an outstanding text in its field: Growth and Sex Development, Generalized Vasospasm and Hypertension, Lymphadenopathy and Disorders of the Lymphatic System.

Very helpful information is also available in excellent chapters on pain, palpitation and tachycardia, cough, anorexia, nausea and vomiting, fever, fainting, dehydration, and itching, which are just a few of the subjects so well presented in this book.

A general index and an itemized index are included, permitting easy location of subjects.

All of this, added to the clear, didactic style in which the text is written, makes it eminently readable and strongly recommended, not only for the medical student but for the general practitioner and the specialist as well.

Lall G. Montgomery
Pathologist
Ball Memorial Hospital

VACCINIA OF THE LIP

Kibrick, Sidney, Kunz, Lawrence J.: New Eng. J. of Med., Vol. 258:421-424, 1958.

The authors report two instances of vaccinia of the lip in each of which the diagnosis was confirmed by the isolation of vaccinia virus from the lesion. Case 1 had been having recurrent herpes simplex of the lips, because of which she had been vaccinated with smallpox virus 10 days and 3 days before developing a pustular lesion on the lip which later crusted. Case 2, a child, had developed an

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ulcerating lesion in the corner of the mouth following what had been considered to be a cold sore. The patient had not been vaccinated but a sister had been several weeks previously. It was assumed in this second case that there had been spread from the vaccinated sister. The authors discuss at some length the significance of the development of a vaccinial lesion in a previous herpes simplex lesion and question the rational for use of smallpox vaccination in the prophylaxis of recurrent herpes simplex. Emphasis is also placed on the potential danger of vaccinating any patient with widespread skin lesions, particularly of an eczematous type. Finally, they stress the fact that not only is the smallpox vaccine itself an infectious agent but so is the vaccinial lesion and the detached crusts from the site of vaccination.

Stephen L. Johnson, M.D., Evansville.

AIR EMBOLISM

Schmidt, Paul J., Kevy, Sherwin V.: New Eng. J. of Med., Vol. 258, 424-426, 1958.

Two instances of air embolism, one with severe symptoms, affecting blood donors inspired this report. In each instance the blood was being taken by gravity rather than by use of a vacuum bottle. In each instance the air vent needle in the bottle had been ineffective so that the blood entering the bottle had compressed the air above it. Failure to clamp the blood delivery tube before removing the pressure in the tourniquet on the arm resulted in the delivery of variable amounts of air into the venous circulation. In the second instance the patient became cyanotic and pulseless until turned on his left side. In an experimental set-up the authors established that it would be possible to force as much as 100 cc. of air back into the donor within a 3-second period. The 2 points brought out in the article are: first, the potential danger inherent in the gravity system of collection with the indication for clamping the blood delivery tube before releasing the tourniquet; and second, the use of the maneuver of turning the patient onto his left side should massive air embolism occur.

Stephen L. Johnson, M.D., Evansville.

BOOK REVIEW

Emergency War Surgery: U. S. Armed Forces Issue of NATO Handbook—United States Government Printing Office. For sale by the Superintendent of Documents, Washington 25, D.C.—Price $2.25.

This manual is the United States revision of the NATO Handbook and will be used by all the Armed Forces. It is well organized and carefully written and covers the entire field of traumatic surgery. Its 409 pages contain many useful tables, 18 illustrations, a useful table of contents and a complete index.

In addition to practical discussions of treatment at the several military echelons, there is an ample and edu-

Continued on page 250

LETTERS
TO THE MEDICAL DIRECTOR

Dear Doctor:

Rauvera* was used on five patients with essensential hypertension varying from moderate to severe. The highest blood pressure was 220/130 and the lowest 180/105.

All patients have shown a consistent response to the drug and the continuation therapy has effected a good control so far . . . approximately two to three months. In four patients systolic blood pressure was reduced from 20 to 50 mm. Hg and the diastolic from 10 to 15 mm. One patient, who had a pressure of 220/130 has had a phenomenal response, and I brought the systolic down to 165 and the diastolic to 95.

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Dear Doctor:

Rauvera has produced satisfactory reductions of blood pressure in every hypertensive case in which I have used it.

M. D., Colorado

Dear Doctor:

Rauvera tabs are my choice for hypertension over 170 . . . they give me the best results.

M. D., Texas

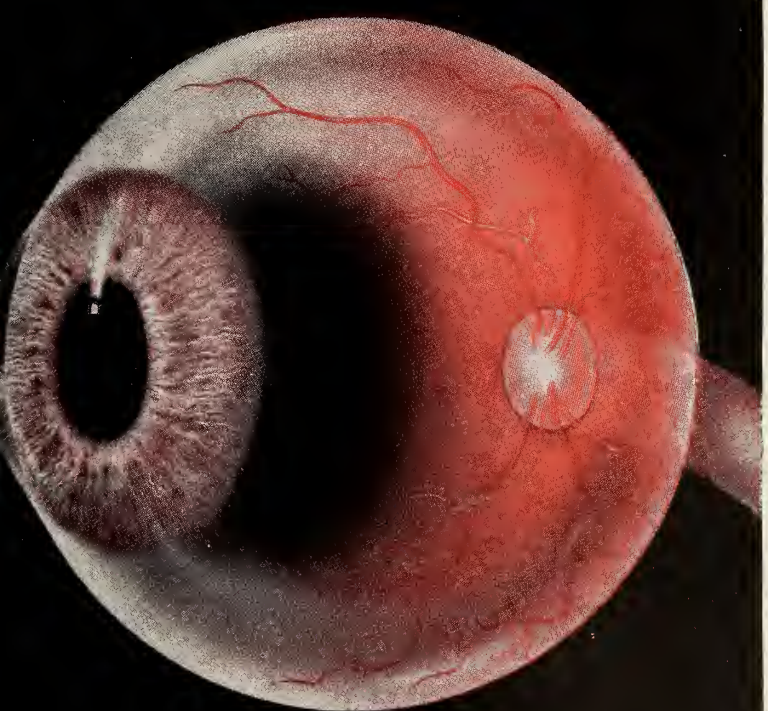
Comment: *It is interesting to note that no adverse side effects were reported in connection with Rauvera's effective antihypertensive action.*

*Rauvera contains 1 mg. alseroxylon (purified Rauwolfia serpentina alkaloid), 3 mg. alkavervir (Veratrum viride fraction) in each scored tablet.

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"It appears that there is now available in chlorothiazide a drug which is a specific antagonist to the abnormal sodium metabolism seen in the vast majority of hypertensive patients. The use of this agent [DIURIL] may stand the test of time as the most vital and specific weapon in the treatment of a relatively non-specific disease in which the only specific abnormality known is one of sodium metabolism. . .. Chlorothiazide now appears to be the drug of choice when initiating therapy in the average hypertensive patient."

Reinhardt, D. J.:
Delaware State Med. J. **30**:1, January 1958.

RESULTS

"We have presented a group of 48 patients previously treated with a variety of antihypertensive agents." "Upon the addition of chlorothiazide to their regimens, there was realized an additional blood pressure lowering effect of 23 mm. systolic and 11 mm. diastolic."

Bunn, W. H., Jr.:
Ohio State Med. J. **54**:1168, September 1958.

MINIMAL SIDE EFFECTS

"There is an extremely wide range between therapeutic and toxic dosage, and no significant side effects and no sensitivity to the drug as yet have been observed."
". . . it seems desirable to add potassium chloride 4 Gm. per day . . . in cases of hypertension. . . ."

Herrmann, G. R., Hejtmancik, M. R., Graham, R. N. and Marburger, R. C.:
Texas State J. Med. **54**:639, September 1958.

dosage: one 250 mg. tablet DIURIL b.i.d. to one 500 mg. tablet DIURIL t.i.d.

supplied: 250 mg. and 500 mg. scored tablets DIURIL (Chlorothiazide) bottles of 100 and 1000.

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Book Review

Continued

cational presentation of the physiological and pathological considerations of each type of injury.

The book is surprisingly compact, having been designed for carrying in a uniform pocket.

It is admirably suited as a textbook for traumatic surgery and, in fact, it has been adopted by several medical schools for this purpose.

It should be a valuable addition to the equipment of every hospital emergency room and all industrial first-aid rooms. It will be an excellent text for medical civil defense.

The manual has achieved a significant advance in military surgery in eliminating the use of the word "triage" and substituting therefor a much better understood word "sorting." Sorting of casualties, in order to render care first to those who need it the most, is discussed for each of the major classifications of severe injury.

The book is outstanding in its coverage of shock.

An Indianapolis doctor, Franklin B. Peck, was elected second vice-president of the American Diabetes Association at the association's 18th annual meeting in San Francisco. Dr. Peck is associate professor of medicine at I. U. Medical School and an Eli Lilly & Co. physician.



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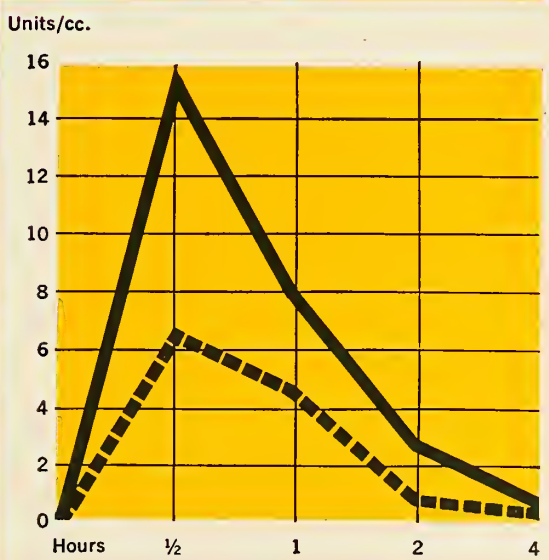
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Doses of 400,000 units were administered before mealtime to 40 subjects involved in this study.

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NEWS NOTES—from State and Nation

Economics Professor to Direct A.M.A. Bureau

CHICAGO—Dr. F. J. L. Blasingame, executive president of the American Medical Association, announced recently the appointment of Arthur Kemp, professor of economics, Claremont Men's College and Claremont Graduate School, Claremont, Calif., as director of the AMA Bureau of Medical Economic Research.

He took over his new duties, January 2, succeeding Frank G. Dickinson, Ph.D., Evanston, Ill., who is retiring after serving in the AMA position since 1946.

Receiving his Ph.D. degree from New York University in 1949, Dr. Kemp has taught economics for nearly 18 years. He taught at New York University from 1946 to 1953, and at Claremont from 1953 to date.

Since 1943, Dr. Kemp has assisted former president Herbert Hoover in the preparation of books, articles, statements and addresses. Between 1946-54, he assisted Mr. Hoover in writing and preparing for publication eight books and more than 85 articles, addresses and reports to Congress and to the President.

Dr. Kemp, who was born in Buffalo, N. Y. on Jan. 29, 1916, is affiliated with seven economic or related associations.

Occupational Health Congress Planned

New York's Waldorf Astoria Hotel will be site of the 13th International Congress on Occupational Health July 25-29, 1960. The scientific program committee invites submission of papers for presentation at the Congress.

The program will be devoted to discussion of the following aspects of occupational health: administrative practices, medical practices, surgical practices, education and training, social and legal aspects, environmental hygiene, influence of environmental factors in health, work physiology and psychology, specific industries and general.

Those desiring to present papers must submit abstracts before Jan. 1, 1960 to Dr. Irving R. Tabershaw, chairman, Scientific Program Committee, International Congress on Occupational Health, 375 Park Avenue, New York City.

Ob-Gyn Therapy Course Planned at I.U. Center

A post-graduate course, Obstetric and Gynecologic Therapy, will be presented March 4-5 at I. U. Medical Center, Student Union Building, 1100 W. Michigan, Indianapolis. The course will give 12 A.A.G.P. credit hours.

Guest lecturer will be Edwin B. Astwood, M.D., Ph.D., professor of medicine, Tufts Medical School, Boston, and Squibb Centennial Lecture at Indiana University. His lecture will be on "Infertility—Current Diagnostic and Therapeutic Procedures."

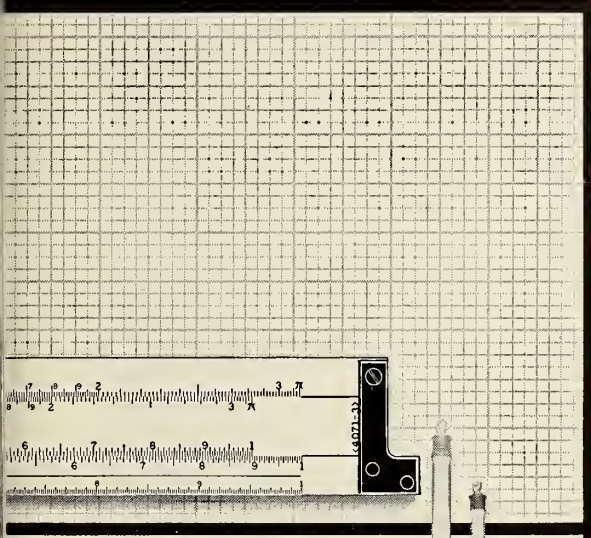
Wednesday's subjects will include "Current Trends in Obstetric Analgesia and Anesthesia" by Drs. Virgil K. Stoelting and Sprague H. Gardiner; "Hypotensive Drugs in Pregnancy Toxemias" by Dr. Walter E. Judson; "Effectiveness of Poliomyelitis Vaccine in Obstetrics" by Dr. Franklin B. Peck, Jr.; and "Uterine Activity in Labor: Current Studies" by Dr. Charles A. Hunter.

On March 5 the program will consist of "Clinical Management of Prolonged Labor" by Dr. Carl P. Huber; "Anemias of Pregnancy" by Dr. Hunter; "Brief Reports of Current Research Psychosomatic Studies in Obstetrics," Dr. Gardiner; "Subacute Bacterial Endocarditis," Dr. John Lein; "Fetal Mortality in Breech Delivery" by Dr. Joseph Thomson; "Vaginal Metabolism" by Dr. Hunter.

"Physiologic Trophoblastic Cell Metastasis," Dr. Gardiner; "False Positive Frog Tests for Pregnancy," Dr. James Brillhart; "Catacholamines in Amniotic Fluid," Dr. Richard W. Stander; "Anoxia and Placental Changes," Dr. John R. Melin; "'Nosocomial' Infections," Dr. Huber; "Local Perfusion Technics in Gynecologic Cancer," Dr. Thompson; "Postmenopausal Uterine Bleeding—Diagnosis and Treatment," Dr. Stander; and "Recent Studies of Ovarian Histology," James A. Green, Ph.D.

Dr. Astwood's lecture will be given at 1:30 p.m., March 5. Following him will be a panel on "Office Gynecologic Therapy."

Continued on page 258

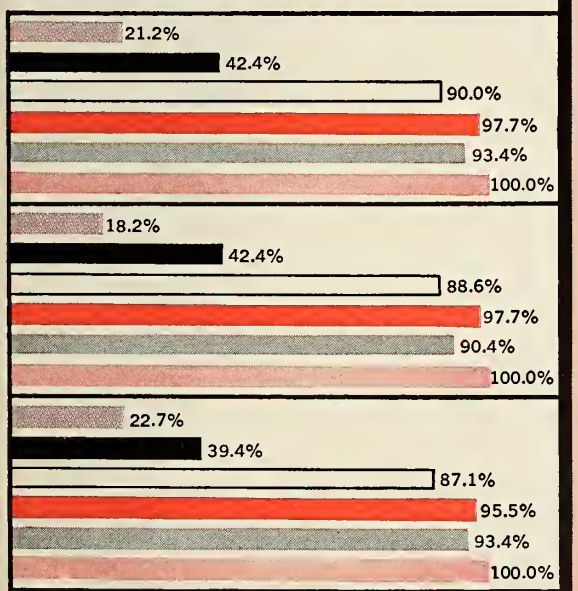


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Antibiotic A 2-10 units
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Rapidly absorbed—stable in gastric acid,[7] TAO needs no retarding protective coating

Low in toxicity—freedom from side effects in 96% of patients treated; cessation of therapy is rarely required

Highly palatable—"practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. **For adults,** the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. **For children** 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

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References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Oiansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, inc., 1958, p. 679. 6. Isenberg, H., and Kareiitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

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Supplied: When reconstituted, 100 mg. per cc. Special calibrated droppers—5 drops (approx. 25 mg.) and 10 drops (approx. 50 mg.). 10 cc. bottle.

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To eradicate pain and physical discomfort in respiratory disorders.

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TAOMID* (TAO with triple sulfas)

For dual control of Gram-positive and Gram-negative infections.

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News Notes

Continued from page 254

Emergency Medical Packet Designed for Mass Casualties

U. S. Army Medical Service recently demonstrated an emergency medical packet for use in a mass casualty situation.

Mass casualty situations occur whenever the number of persons injured is out of proportion to the medical resources available. The problems of mass casualty care are thus not confined to nuclear warfare, but can result from fires, floods, hurricanes and other civil disasters.

The new medical packet—called Phase I Emergency Medical Treatment Unit—is designed to meet conditions immediately following a military disaster. It has been assumed that during this period no direct professional medical help may be expected, and casualties will either treat themselves or be cared for by other non-medical personnel. Containing 23 items, the emergency packet will provide medical material for treatment of approximately 100 casualties for about 72 hours.

This packet is, however, designed for much more than first aid. The items included have been carefully selected.

Packaged as one unit, the emergency care packet has 9 component cartons: 2 master packs containing Dextran and miscellaneous items, 1 fracture pack, 2 burn packs, and 4 wound packs. The packages contain 23 items and sufficient medical material to provide care for 100 casualties for 72 hours.

In developing the packet a number of guidelines were followed to assure that the container would be light and inexpensive; easily distinguished from all other material either by use of color or symbol; of weight and bulk to permit handling and transport by individuals; and that the single load could be sealed in such a way as to give visible evidence of inadvertent or malicious opening.

Markings on the outer container include the assembly stock number, nomenclature, weight and cube, the level of packing, month and year assembled, caution information and control serial number.

I.U. Center Plans Cancer Program

Indiana University Medical Center will present the 12th Annual Symposium on Malignancy March 31 and April 1 at the old medical school auditorium on West Michigan in Indianapolis.

"Neoplasms of the Salivary Glands," will be presented by Dr. James H. Maxwell of Ann Arbor Tuesday evening, March 31, with discussion by Dr. Mark Whealock, Chicago.

Wednesday program will include "Cancer of the Pharynx and Hypopharynx," by Dr. John J. Conley of New York with discussion by Dr. Frans Buschke of San Francisco and Dr. Whealock. This will be followed by "Cancer of the Nose, Para-nasal Sinuses and Naso-pharynx," presented by Dr. Whealock, Dr. Harold Tabb of New Orleans and Dr. Buschke.

During the afternoon session, three more papers will be presented.

Hoosier Doctor's Wife to Speak

Indiana's Mrs. Kenneth Schneider of Nashville has been asked to participate in the 14th National Conference on Rural Health by F. S. Crockett, M.D., chairman of the Council on Rural Health.

Theme of the conference, to be held March 5-7 at Wichita, will be "Horizons in Rural Health." Mrs. Schneider will give a 15-minute presentation on "some of the things that go to make up the daily chores of a physician's wife."

"Some of us are very much aware of the important part doctors' wives play," Dr. Crockett wrote Mrs. Schneider, "but we would like more of this information disseminated in order that the general public may understand some of the problems from the distaff side." The talk will be followed by a discussion period.

Dr. Dickinson Retires From AMA

Dr. Frank G. Dickinson, Ph.D., has retired as director of AMA's bureau of economic research, it has been announced by AMA, the retirement effective January 1.

He is now available for consultations in economics and plans to carry on a program of research under sponsorship of a foundation from his home in Evanston, Ill.

Dr. Dickinson joined the AMA staff in 1946 after teaching economics at the University of Illinois for 25 years.

Continued



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Rautensin provides a smooth, gradual and sustained reduction of blood pressure without sudden rebounds or abrupt declines.[1] Rautensin's tranquilizing properties calm the tense and anxious hypertensive without impairing alertness, without producing excessive lethargy or drowsiness.

The risk of Rauwolfia-induced depression is markedly reduced since the alseroxylon fraction alone is used.[2] Even on long-term administration side actions "...are either completely absent or so mild as to be inconsequential."[3]

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Each tablet contains 2 mg. of the purified alseroxylon complex of Rauwolfia serpentina

1. Wright, W. T., Jr.; Pokorny, C., and Foster, T. L.: Kansas M. Soc. *57*:410, 1956. 2. Gilchrist, A. R.: Brit. M. J. *2*:1011 (Nov. 3), 1956. 3. Terman, L. A.: Illinois M. J. *3*:67, 1957.

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News Notes

Continued

Ob-Gyn Boards in May

Next scheduled examinations (Part II), oral and clinical for all American Board of Obstetrics and Gynecology candidates will be conducted at the Edgewater Beach Hotel, Chicago, by the entire Board May 8-19, 1959. Formal notice of exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part I Examinations will be notified of their eligibility for the Part II Examinations as soon as possible.

Deadline date for receipt of new and reopened applications for the 1960 examinations is August the first, 1959. Candidates are urged to submit their applications as soon as possible before that time. Write to Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

More Grants for Indiana

Seven new projects were approved in December for Hill-Burton grants in Indiana. These include Clay County Hospital, Brazil (69 additional beds); Bartholomew County, Columbus (two grants) (18 beds); Huntington County, Huntington (59 beds); Witham Memorial, Lebanon; St. Joseph Hospital, Logansport (80 beds), and Wabash County at Wabash (69 beds).

A total of 47 Hill-Burton projects have been completed in Indiana to the tune of $45,366,264 (with $16,476,330 of that in federal contributions), supplying 2,266 extra beds.

Nuclear Medicine Society Meets

The Southwestern Society of Nuclear Medicine will hold its fourth annual meeting at the Roosevelt Hotel in New Orleans March 14-15, 1959. Members of the ISMA are invited to attend. Program details may be obtained by addressing Samuel B. Nadler, M.D., 1520 Louisiana Ave., New Orleans, 15, Louisiana.

Flying Medics Meet

The 30th Annual Meeting of the Aero Medical Association will be held April 27-29 at the Statler Hotel, Los Angeles. Charles I. Barron, M.D., of Lockheed Aircraft Corporation, is general chairman.

PHS Exams Announced

Competitive examinations for appointment to the Commissioned Corps of the United States Public Health Service will be held throughout the nation in April. Examinations will cover six professional health, medical and scientific categories.

Regular Corps examinations for physicians, dentists, sanitary engineers, clinical psychologists and biochemists will be held April 21-24. Applications for these examinations must be filed with the Surgeon General no later than March 6.

Application forms and further information may be obtained by writing to the Surgeon General, U. S. Public Health Service (P), Washington 25, D. C.

Examinations are customarily held at the Public Health Service installation nearest the applicant's home, school or place of business. Time and place of the examinations will be announced to all applicants in advance.

Chicago Medics Plan Clinic Conference

"Keeping up" with current medical developments is one of the most pressing problems of the practicing physician. Medical meetings are one of the main sources of new information. The Annual Clinical Conference of the Chicago Medical Society will be held at the Palmer House, March 2-5, 1959.

A faculty of outstanding speakers will present 33 half-hour lectures on subjects of interest to the general practitioner and the specialist. Panels on timely topics, a clinical-pathologic conference and medical color telecasts will be presented. Teaching demonstration and instructional courses will be presented to small groups to encourage a close relation between instructor and physician. Scientific and technical exhibits have been carefully selected.

Instruction courses will be an innovation of the Conference. The four courses cover "Problems in Surgery" to be held from 9 to 10 a.m. each day; "Problems in Medicine" which will be held daily from 11 to 12 o'clock noon; "Problems in Obstetrics and Gynecology" to be held daily between 1:30 and 2:30 p.m.; and "Problems in Allergy" which will be held between 4 and 5 p.m. daily. Instruction courses will be limited to 20 physicians per class and registration must be made in advance. Fee for each course is $5.00.

Continued

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Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. **166**:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

†TRADE-MARK

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News Notes

Continued

2nd Symposium on Gnotobiotic Technology: The Rearing and Use of Germfree Animals

A national symposium on the technology of germfree research will be held Wednesday and Thursday, April 8 and 9, 1959, at Lobund Institute, University of Notre Dame. Though germfree research began more than a half century ago, it has not progressed beyond the experimental work conducted by a handful of researchers. Needed is widespread dissemination of information about the design, construction and maintenance of germfree equipment as well as more knowledge of workable technics for rearing animals in a germfree environment. These are the aims of the forthcoming symposium. Papers at the April, 1959 symposium will be presented on microbiological control procedures, methods of diet sterilization, and technics of rearing animals in a germfree environment. Ample time will be allowed for roundtable discussion. Further information is available from Philip C. Trexler, Lobund Institute, University of Notre Dame, South Bend, Indiana.

Dr. Robert J. Scott, director of professional services at the Veterans Administration Hospital at Richmond, Va., has been appointed manager of the VA hospital in Fort Wayne, Ind.

Dr. Scott will succeed Dr. Michael H. Travers, who was recently appointed director of domiciliary homes for VA in Washington, D. C.

Dr. Linus J. Minick of Churubusco and Dr. James Roth, Wolf Lake, have been named members of the medical advisory board to the newly formed Fort Wayne chapter of the National Cystic Fibrosis Research Foundation.

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by corki

I get on a Soapbox! Perhaps this is the wrong medium for expressing this particular thought; yet, couldn't it be that the luxury loving softness of modern Americans would come under the heading of preventive medicine as well as a national catastrophe?

After viewing an hour-long TV program titled, "The Face of Red China," one couldn't help but again review and compare the "American way" with the rugged life now being lived by millions and millions of our political enemies and wonder if that old American ability to come through in a tight spot (or war) will actually work again.

In the face of what happened in Korea, and the constant civilian interference with attempts by military organizations in giving rugged basic training to new troops (that would make fighting *men* from *boys*) to actually engage an enemy who has made a lifetime project of being ruggedly fit, one must wonder what will happen when and if the big boom comes!

Do we rely too much on mechanical ingenuity and not enough on physical fitness? Do we rely too much on our "way of life" in "protecting" our youth from struggle and assuming responsibility and learning to stand on their own feet? Do we rely too much on acquiring physical luxuries and not enough on acquiring physical stamina along with that emotional stability which became such a controversy following the Korean Conflict?

In fact, to my way of thinking, it seems the findings of the many experts who studied reactions of our troops in Korean (Red Chinese) POW camps boils down to a *lack of emotional stability* or faith or self confidence or whatever name you care to give it, and to too much physical softness. An article appearing in our January *Journal,* "Let's Keep it Simple," by Lt. Col. Samuel McClatchie, M.D., brings out the fact that "native" labor must always be used by our Army because Americans don't have the stamina and strength of the local inhabitants of countries in which we have fought—such as in Korea.

If this condition is ever to be counteracted, many must join in the fight; but what more pertinent group than physicians who have their fingertips (and minds) on the pulse of American health?

Just a thought to mull over in your "leisure" moments.

This is not to say I am against our way of life in the least—I'm 100% for it!—but it is to say that perhaps we DO give too much thought to luxury (drive 2 blocks to the corner grocery instead of walking) and not enough to body building.

Any comment, doctor?

(Incidentally, if you get the chance to see "The Face of Red China"—and I do hope it is rerun—don't miss it. The tremendous effort Red China is now conducting is, I feel, more frightening than the efforts of Russia . . .

Continued on page 266



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. . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function.

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Ascorbic acid	20 mg.

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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

Subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

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Continued from page 263

and Red China is going all out to engender hate for the Americans.)

Whose face is red? This seems to be my month for seriousness, but serious I must be on this question of highway fatalities.

You may know, and if not, I'm tellin' you, that I've spent 8 years away from Indiana, most of those years being spent driving western highways, five of them specifically on California by-ways.

Now, admittedly, the accident toll is high in California, but I personally think a good percent of that is due to traveling bumper-to-bumper at high speeds, which often winds up in what Californians call "bumper tag." In those accidents, sometimes involving as many as 30 or more cars, the injury and death toll still would be kept way down by use of seat belts. (That, in case you didn't recognize it, is a plug for the use of seat belts!)

However, there are a few habits here that have given me, a California driver tried and true, a pretty bad time. I approached Lt. Charles W. Harbison of the Indiana State Police the other day on why didn't Indiana get a law against using parking lights as running lights like in California.

Was my face red! *Indiana does,* indeed, *have such a law!* Now, whether it is lack of publicity to this effect or complete disobedience of the law by Hoosier motorists, I can't say. But all too often cars use parks, inadequate and dangerous, for driving lights!

During the severe cold spell in January when windshields were frozen over and when even the more safe drivers who tried to keep them clear were fighting a losing battle, parking lights could not be seen through the ice. Yet it seemed half the drivers were running with those little, most inadequate parking lights.

The law says if it is dark enough to use lights at all, it is too dark to drive with parks! I'll try to make up for my red face by publicizing this as much as possible.

Let's stay with this problem a bit longer, huh. Bear with me—it might save both our lives!

Next, in the discussion with the good lieutenant, I put my foot in my mouth again by remarking that I'd noticed so many people driving without paying any attention to their driving—gawking off into the yonder spaces, some talking, some making their kids sit down, etc. Won't go into the answer I got to that one, but the fact remains that this, too, is mighty dangerous driving!

Admittedly (again), there are California drivers who do the same. However, it actually isn't a question of where it is or is not done, but an important fact that driving without keeping every facility atuned to road conditions and actions of other motorists is a one-way ride! It is suicide!

Since this seems to be my gripe session, might as well get the last one out . . . that of driving TOO SLOW! So much of the safe-driving publicity seems to stress driving slow . . . but this can be as dangerous as fast driving!

Suppose speed limit is 35, traffic is running between 30 and 35, and along pops a guy going 20 (and bet he thinks he's a good driver, too!). Slow driver blocks traffic behind him, a line of cars stack up behind him, and finally someone tries to cut into the next lane to get around 20 mph and resume normal speed. Bang! He doesn't make it. But old 20 mph goes merrily

Continued

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by taking rest periods from your own responsibilities. And we at Original Contour Chair Lounge feel our product can give you the most beneficial rest possible. Original Contour Chair Lounge gives you support in all six body zones (and it is sized to fit you), lets you change elevations without changing body position, and can be obtained with entire body massage and/or thermonic heat . . .

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Continued

along, probably patting himself on the back as a good driver who doesn't cause accidents . . . when, in reality, old 20 mph caused that accident!

In the same breath I'm not—repeat, NOT—setting myself up as a good driver. I'll probably be the next person some law officer will nail! I still have California driving habits, and if I don't keep my mind real busy remembering the different laws here, it's pretty easy to revert to coast driving habits (like going through on a yellow light or turning right on a red light).

(This all reminds me of when I was an editorial editor of the Indianapolis Tech *Arsenal Cannon*. My best editorials always came to mind from some of my own infractions of the rules!)

This is just to remind my reader (me!) not to drive with parks (mine don't work anyhow), to keep every facility atuned to road and traffic, and to drive with the flow of traffic!

I beg your pardon! "Research Dog Hero of 1958" was a title formally conferred on a 3-year-old, mixed breed dog of the deep south! Honest. Was done by the National Society for Medical Research in all seriousness.

Name of Big Ben, the dog was selected for the honor because of his part in Tulane University research which, according to the news release, "has placed medical scientists on the threshold of a startling new technic for attacking brain cancer."

It was in all seriousness, but still sounds like something from Lichty.

Christmas card business bigger than we think! A couple issues back, I reported about the Vanderburgh Auxiliary asking members to donate to AMEF instead of exchanging Christmas cards. A recent News Letter from that county tells that $600 was raised by this means. Wow! Think next year I'll delete a few of my cards and put the money in a Collection for Corki!

Seriously, it was a good idea and medical education has been helped and no one hurt.

A good laugh cures many ills Dept.:

With many thousands of persons traveling by plane, it's strange that nobody has figured out how to stick a billboard on a cloud.—*Grit.*

Some are old at 20; their notions harden long before their arteries do.—E. B. White, *Science Digest.*

An optimist is someone who thinks that love is a game of chance.—Cy N Peace.

It seems a pretty young nursing student and her doctor fiancee had just broken their engagement . . . nurse was telling her girl friend about it.

"Do you mean to say," exclaimed her friend, wide-eyed, "he actually asked you to give back all his presents?"

"Not only that," sniffed the young Florence Nightingale, "he just sent me a bill for 36 visits!"—*United Mine Workers Journal.*

No bills, please, doctor! I'll quit now!



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Deaths . . .

Thomas J. Beasley, M.D.

Thomas J. Beasley, M.D., 78 and an ISMA senior member, died December 30 at his Indianapolis home.

Born in Hendricks County, Dr. Beasley practiced medicine in the Hoosier capitol 51 years. He was a staff member of Methodist and Indianapolis General Hospitals.

Dr. Beasley was a veteran of the Spanish-American War and served in a leper colony in the Philippines in his earlier days. He founded the old Rockwood Sanitorium at Danville in 1907 as one of the first exclusively tuberculosis treatment hospitals in the Midwest at that time.

A graduate of Purdue University School of Medicine in 1907, he was a member of Meridian Heights Presbyterian Church, Calvin Prather Masonic Lodge, Volunteers of America, Trudeau Society and the county, state and American medical societies.

James N. Collins, M.D.

James N. Collins, M.D., 63, staff physician at St. Vincent's and Methodist Hospitals in Indianapolis, died January 3 at Methodist Hospital.

A resident of Indianapolis since 1926, Dr. Collins was a native of Fayette, Ala. and a graduate of Emory School of Medicine, Atlanta, in 1922. He also graduated from the University of Alabama and University of Michigan School of Radiology. He received his radiology board certification in 1932.

Dr. Collins was a member of Second Presbyterian Church, Woodstock Club, Players' Club, Radiology Society of North America, American Roentgen Society, American College of Radiologists, a past secretary of the Indiana Roentgen Society, and member of the county, state and American medical societies.

Charles D. Linton, M.D.

Charles D. Linton, M.D., 54, of Walkerton, died December 30 at his office where he had gone during the night, supposedly to get medication in that he had not been feeling well.

A native of Medarryville, he graduated from Indiana University School of Medicine, 1929, and interned at St. Elizabeth Hospital, Lafayette. He also attended Hines Hospital, Illinois,

Continued

Indiana State Board of Health

DIVISION OF COMMUNICABLE DISEASE CONTROL

A. L. MARSHALL, JR., M.D., *Director*

MONTHLY REPORT - DECEMBER 1958

Disease	Dec. 1958	Nov. 1958	Oct. 1958	Dec. 1957	Dec. 1956
Animal Bites	227	326	784	76	177
Chickenpox	606	360	104	308	701
Conjunctivitis	61	40	41	26	17
Diphtheria	0	1	4	2	0
Dysentery, Unspecified	29	11	14	5	7
Impetigo	77	61	175	29	36
Infectious Hepatitis	56	11	17	15	41
Infectious Mononucleosis	12	7	19	1	3
Influenza	616	706	753	1024	179
Measles (Rubeola-Rubella)	456	270	171	188	105
Meningitis, Meningococcal	5	0	4	7	4
Meningitis, other	10	13	15	10	16
Mumps	127	147	87	218	245
Pertussis	61	91	147	30	32
Pneumonia	163	148	138	112	119
Poliomyelitis	8	22	39	9	11
Streptococcal Infections	292	232	372	217	262
Tinea Capitis	21	72	67	17	19
Vincent's Infection	4	3	7	2	4

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Deaths

Continued

in 1953 for additional training in anesthesia, which was his specialty.

He was a Delta Chi and Phi Beta Phi; member of Walkerton Lodge No. 619, F.&A.M., Scottish Rite body in South Bend and Indianapolis Shrine, the local, state and American Medical associations and the Walkerton Methodist Church.

Earl H. Mitchell, M.D.

Earl H. Mitchell, M.D., 69, died December 20 at Methodist Hospital, Indianapolis.

Dr. Mitchell was born at Dover Hill, Ind. He graduated from the University of Louisville Medical School, 1921, and interned at Louisville General Hospital. The following year he began medical practice in Maxwell, Ind.

A staff member of Methodist, Community and Indianapolis General Hospitals, Dr. Mitchell had served as a medical examiner on the old Indianapolis Board of Health for about 12 years. Besides belonging to the local, state and American medical societies, he was a member of the Kentucky State Medical Association, the American Academy of Medicine, Michigan Street Methodist Church, Order of the Eastern Star, Scottish Rite, both of Indianapolis, the Moores Hill Masonic Lodge and the Corinthian Chapter.

Abraham M. Owen, M.D.

Abraham M. Owen, M.D., 58, a Bloomington physician for 26 years, died January 12 at his home.

Dr. Owen and his wife, Dr. Margaret Owen, had practiced medicine together since they graduated from I.U. School of Medicine in 1940.

During W.W. II he was a captain in the Army Medical Corps, serving in the South Pacific Theater.

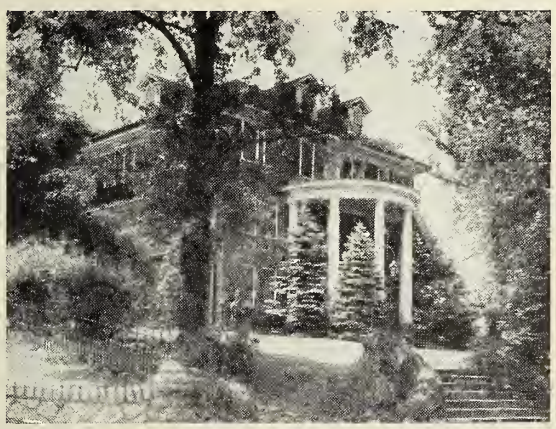
He was a member of the local, state and American medical societies, American Legion, Phi Chi and Delta Tau Delta. At the time of his death he was medical director of Monroe County Civil Defense.

Russell J. Rossow, M.D.

Russell J. Rossow, M.D., 56, Evansville surgeon, died January 10 shortly after reaching Vanderbilt University Hospital.

A native of Wisconsin, he graduated from the University of Wisconsin, then attended Wash-

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R. Charman Carroll, M.D.
Medical Director

Robert L. Craig, M.D.
Associate Medical Director

John D. Patton, M.D.
Clinical Director

Deaths

Continued

ington University School of Medicine to receive his M.D. in 1939. He interned at St. Louis County Hospital. He also served with the University of Illinois Health Service.

He was on the staffs of Welborn Baptist, Protestant Deaconess and St. Mary's Hospital in Evansville, and Methodist Hospital, Henderson, Ky.

Dr. Rossow took his surgical residency at Welborn Baptist Hospital, Evansville, from 1942 to 1947.

He was a member of the Vanderburgh County Medical Society, ISMA, and AMA.

Lester A. Smith, M.D.

Lester A. Smith, M.D., 68, Indianapolis physician and radiologist, died December 15 at his home.

A Portis, Kans. native, Dr. Smith was a graduate of the Medical College of Chicago, 1916, and interned at Washington Soul and Cook County Hospitals, Chicago. He took his residency in radiology at Cook County Hospital immediately thereafter.

During W.W. I he served as a first lieutenant in the Army Medical Corps and was a consultant in roentgenology for the 11th Congressional District Draft Board during W.W. II.

Dr. Smith was a member of First Presbyterian Church, Roentgen Ray Society, Radiology Society of North America, Marion County Medical Society and ISMA, and was a Fellow of the American College of Radiology.

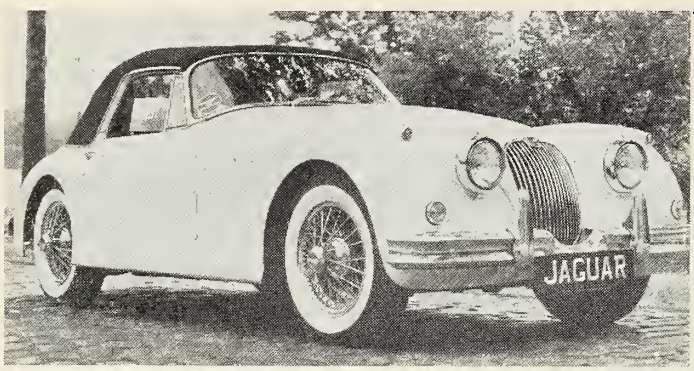
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County Societies and District Reports

Boone

Sixteen members of the Boone County Medical Society gathered at Witham Hospital, Lebanon for their January 6 meeting.

Next meeting was scheduled for February 3.

Fayette-Franklin

The Upjohn Grand Rounds film on Diabetes was shown at the January 13 meeting of the Fayette-Franklin County Medical Society meeting. There were 15 members present to view this showing. Meeting was held at the Connersville Country Club.

February 10 was the date chosen for their next meeting.

Floyd

Ray Bryant, M.D., was the speaker for the January 9 meeting of the Floyd County Medical Society. Dr. Bryant's topic was "Home Treatment of Tuberculosis." Twenty-one were present at the meeting which was held at the New Albany Country Club.

Special action was taken to discontinue their emergency roster due to small number of members cooperating; however, the exchange will be continued to locate physician of patients' choice. All members were asked to keep exchange informed of their where-abouts.

Next meeting will be February 13, same place.

Fountain-Warren

"Principles of Splinting" was the title of the film shown at the January 8 meeting of the Fountain-Warren County Medical Society. Eleven members viewed this film.

Date set for the next meeting was February 5 at the Attica Hotel.

Howard

Local talent presented papers "Cancer of Breast" at the January 6 meeting of the Howard County Medical Society, with 36 members in attendance.

February's meeting will be held Tuesday the 3rd.

Continued



Safe Driving Habits:

Set your speed according to Road Conditions

County and District

Continued

Jay

Mr. L. Converse, Blue Cross-Blue Shield representative, spoke on recent advances in health insurance before 12 members of the Jay County Medical Society, held December 3 at the Portland Country Club.

Next meeting was set for January 7.

Marshall

Marshall County Medical Society met December 3 for the purpose of electing new officers. Officers elected were: James F. Rimel, M.D., president; Ernest B. Norris, M.D., vice-president and James O. Coursey, M.D., secretary-treasurer.

Orange

Spring Mill Hotel was the meeting place for the Orange County Medical Society, January 6. Business conducted at this meeting included the appointment of special committees.

Six members attended this meeting.

Next meeting will be February 3.

Perry

December 2 meeting of the Perry County Medical Society was held at the County Nursing Center. Seven members viewed the movie "Highlights of AMA Convention."

Outline of the program for the year was the special business for the January 6 meeting.

February 3 was the date chosen for next meeting.

Pulaski

Winamac was the meeting place for the November 24 Pulaski County Medical Society Meeting. Seven members attended this meeting.

Next meeting will be January 1.

Putnam

Robert Webster, M.D., 5th District Councilor, presented a paper entitled "State Level Problems." Fifteen members of the Putnam County Medical Society were present at the DePauw Union Building on January 9.

February meeting will be on the 13th, same place.

Randolph

January 12 a meeting of the Randolph County Medical Society was held at the Ratcliffe House in Farmland.

R. L. Converse, Blue Cross-Blue Shield representative, was present along with 14 members of the society. Mr. Converse spoke on Blue Shield.

Rush

A luncheon meeting, December 19, was held by Rush County Medical Society at Rush Memorial Hospital. A film "Skin Grafting" was viewed by 14 members of the society.

New officers were elected as follows: Davis Ellis, M.D., president; Marvin Norris, M.D., vice-president; Charles Sheets, M.D., secretary-treasurer.

January 8 the society held a dinner meeting.

Starke

Home Hotel at Knox was the meeting place January 13 for 7 members of Starke County Medical Society.

Wayne-Union

Arthur Evan, M.D., professor of Urology at University of Cincinnati, was the speaker at the January 13 meeting of the Wayne-Union County Medical Society.

Forty-four members heard Dr. Evan's speech, "Renal Aortography."

Next meeting will be February 10 at the Reid Memorial Hospital.

Whitley

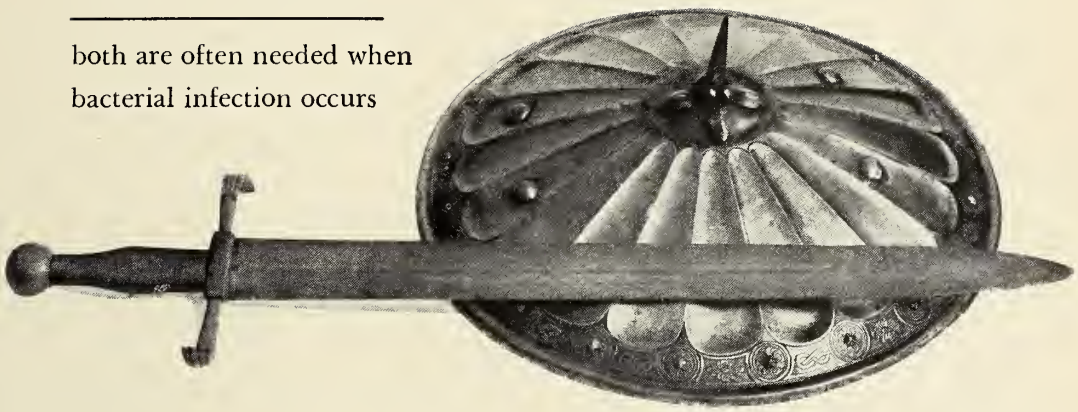
Warren Niccum, M.D., presented Kodachromes and lectures on "Diagnostic Facies", "Dermatoses of Newborn" and "Unusual Skin Lesions," at the January 13 meeting of Whitley County Medical Society. Sixteen members were present.

February 10 was the date set for next meeting.

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Association Reports

Executive Committee

December 10, 1958

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Kenneth L. Olson, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D., and O. W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of The *Journal;* Robert Hollowell, attorney, and James A. Waggener, executive secretary.

Guests: Harry Pandolfo, M.D., and P. T. Lamey, M.D.

Membership Report

Number of members Dec. 10, 1958 4,184*
Number of members Dec. 10, 1957 4,140
Gain over last year 44
Number of members Dec. 31, 1957 4,149

*Includes 68 in military service (gratis)
167—$10 members (residents and interns)
393—senior members
52—members, dues remitted by Council
1—honorary member

Number who have paid AMA dues:
November, 1958 4,038**
November, 1957 3,971
Gain 67

** Includes 660 exempt members (gratis)—394 prior to 1/1/58; 266 so far this year.

Headquarters Office

The secretary reported on the accounting situation, and the fact that Miss Kruge was still in the hospital, and on motion of Drs. Olson and Owsley, the secretary was instructed to employ temporary help to get the accounting in order.

On motion of Drs. Olson and Owsley, the management consultant firms are to be asked to appear before the Executive Committee at the January meeting.

The secretary reported on the replacement of the typewriter being used by Miss Kribs and the necessity of another typewriter for use by Miss Chapple, and purchase of this was approved on motion of Drs. Olson and Owsley.

Annual Session, October, 1959

The secretary informed the committee that there had been some statements made by some members indicating that they feel that the annual conventions in Indianapolis should be held in the Indiana Theater building rather than the Murat Temple. Information regarding rental costs and available space in the Indiana Theater building was presented to the committee. On motion of Drs. Covalt and Olson, the committee voted to hold the 1959 convention at the Murat Temple.

The secretary was instructed to conduct the survey of the membership on suggestions for the 1959 convention, as authorized by the Council, through the News Flash.

Medicare

The secretary read a letter from the Office for Dependents' Medical Care, in which it was proposed that renewal of the Medicare contract be made through the mails rather than having a delegation travel to Washington for this purpose.

Organization Matters

The chairman raised the question concerning Blue Shield Board representative, and it was suggested that Dr. Owsley report the policy actions of Blue Shield to the Executive Committee and the Council.

The secretary reported on the actions of the House of Delegates of the American Medical Association at its recent meeting in Minneapolis. The result was to order from the American Medical Association a digest of actions of the A.M.A. House of Delegates.

The report of the Maternal Mortality Study Committee was presented and the question raised as to method of distribution of this report to the profession. Upon motion of Drs. Olson and Sicks this question and information is to be referred to the Council.

Letter from the Indiana Association of Medical Assistants was read in which permission to make a change in the association's bylaws was requested. This was approved on motion of Drs. Olson and Covalt.

The suggested program for the 1959 meeting of the Indiana State Association of Medical Assistants was discussed, and the Executive Committee authorized the secretary to inform the organization that they give support to the University program in this field as one of their projects.

Letter from L. G. Seebach, M.D., medical officer of U. S. Naval Ammunition Depot at Crane, Ind., was read, in which Dr. Seebach requested use of the tape loan library of the Association without the payment of the deposit, pointing out that there were no funds available to handle this on the basis established by the Commission on Medical Education and Licensure. Permission to obtain tapes without deposit was approved on motion of Drs. Owsley and Olson.

Legislative Matters

Legislative matters at national and local levels were discussed by Dr. Wood, chairman of the Commission on Legislation.

New Business

The secretary informed the committee of the desire of the Woman's Auxiliary to meet with the Executive Committee for their annual meeting. The secretary was instructed to invite the Auxiliary officers in for dinner at the January meeting of the committee.

Dr. P. T. Lamey, secretary of the State Board of Medical Registration and Examination, reported on legislative matters in which the Medical Board is interested, namely, the regulation on temporary

permits, and asked the Association to support a bill requiring citizenship as a basis for licensure of doctors of medicine in Indiana.

Dr. Harry Pandolfo, chairman of the Commission on Public Information, asked the committee for its approval and support of a proposed course at Indiana University Extension Center in Indianapolis, designed for medical assistants, and requested $500.00 for publicizing and promotion of this course. Upon motion of Drs. Covalt and Mericle the committee approved the idea of the Extension Center offering this course but recommended that the publicizing and promotion be done through the News Flash of the Association.

Dr. Wood discussed plans for the two-year medical school on the Bloomington campus of Indiana University, but no action was taken.

Dr. Olson read a letter from the Hospital Advisory Council which deals with the administration of the Hill-Burton program in Indiana, the letter requesting the appointment of three representatives from the Association to this Council. On motion of Drs. Mericle and Covalt the present members are to be renominated for another term. Present members are Drs. Kenneth L. Olson, David L. Adler and James W. Crain.

The Journal

The advertisement of the Farm Home Insurance Company was submitted for approval or disapproval of the committee. On motion of Drs. Covalt and Olson the advertising was approved for publication in The *Journal*.

The secretary read proposals for an increase in the cost of printing of The *Journal*, pointing out that there were two basic proposals: (1) a flat 8 per cent increase, and (2) an increase based on a per page rate. Upon motion of Drs. Mericle and Covalt the secretary was instructed to make the best deal possible.

Medical Defense

The Bylaw change concerning the handling of medical defense was called to the attention of the committee, and in the future the correspondence is to be between the physician and the Association in the employment of counsel in medical defense cases.

Future Meetings

Meeting of the state chairmen of the American Medical Education Foundation in Chicago, January 24 and 25, 1959, was called to the attention of the committee. No action was taken.

January 9 and 10, 1959—Cancer meeting, Minneapolis. Expenses of a representative of the Association will be paid by the Indiana Cancer Society. The secretary was instructed to ask the chairman or some member of the Commission on Voluntary Health Agencies to attend this meeting.

February 19 and 20, 1959—Cancer Control Meeting, Chicago. A letter from the Public Health Service concerning this meeting, in which the Public Health Service would pay the expenses of a representative from the Association, was reviewed. The secretary was instructed to ask the chairman of the Commission on Voluntary Health Agencies or one of the members of the commission to represent the Association at this meeting.

December 16, 1958—Nurses meeting. A member of the Commission on Legislation was to be asked to represent the Association at this meeting, and Dr. Earl Mericle accepted.

There being no further business the committee adjourned, to meet again at 4:00 p.m. on Saturday, January 17, 1959.

SPONTIN IN SERIOUS

A Special Report from Abbott
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on a Year's Clinical Experience
with SPONTIN®
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In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

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STAPHYLOCOCCAL INFECTIONS

Excerpts from Reports Read at the Antibiotics Symposium

Spontin In Treating Severe Respiratory Infections —"In 13 of 20 patients the results were excellent, with clinical response being evident within one to four days after institution of therapy. In three additional patients, there was some degree of improvement in pneumonic processes superimposed on tuberculosis in two cases and on pulmonary neoplasm in one. In all other cases, serious antecedent pathology undoubtedly influenced the negative or equivocal response to ristocetin therapy.[6]"

Spontin In Treating Staphylococcal Infections—After successfully treating 28 patients, the authors wrote, "Ristocetin or Spontin has proved to be bactericidal and bacteriostatic, particularly for the *Staphylococcus aureus,* which is often resistant to many other antibiotics.[5]"

Spontin In Treating Seven Difficult Cases — "Ristocetin has produced excellent results in eradicating, mitigating or preventing infection in seven selected difficult cases. Six of the seven cases involved *Staphylococcus aureus* which did not respond to chemotherapy with other antibiotics.[7]"

Spontin Blood Levels In Children — "Ristocetin was administered as a single intravenous injection of 12.5 milligrams per kilogram. This resulted in serum levels ranging from 1.3 to 10.6 mcg. after two hours with a gradual fall to a level of 0.7 mcg. per cubic centimeter or less after 12 hours.[8]"

Spontin In Treating Staphylococcal Pneumonia —"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults — "Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.
2. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
3. Romansky, M. J., and Holmes, R., Successful Short-Term Therapy of Enterococcal and Staphylococcal Endocarditis with Ristocetin—Seven Patients. Preliminary Report, Antibiotics Annual, 1957-58, p. 187.
4. J. A. M. A., 167:1584, July 26, 1958.
5. Bush, L. F., et al., The Use of Ristocetin (Spontin) in Staphylococcal Infections, In Press, Antibiotics Annual, 1958-59.
6. Billow, F. J., et al., Clinical Observations on Ristocetin—A Preliminary Report on its Efficacy and Toxicity in 20 Unselected Severe Respiratory Infections, In Press, Antibiotics Annual, 1958-59.
7. Miller, J. M., et al., Ristocetin in the Treatment of Seven Selected Difficult Cases, In Press, Antibiotics Annual, 1958-59.
8. Asay, L. D., et al., Ristocetin Serum Levels in Children, In Press, Antibiotics Annual, 1958-59.
9. Schumacher, L. R., et al., Experiences with Ristocetin in Staphylococcal Pneumonia: Observations in 23 Cases, In Press, Antibiotics Annual, 1958-59.
10. Terry, R. B., Ristocetin in Children and Adults, In Press, Antibiotics Annual, 1958-59.

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1	William B. Challman, Mt. Vernon	Oct. 1959
2	J. H. Crowder, Sullivan	Oct. 1960
3	John M. Paris, New Albany	Oct. 1959
4	Joseph E. Dudding, Hope	Oct. 1959
5	Robert K. Webster, Brazil	Oct. 1960
6	Harry P. Ross, Richmond	Oct. 1961
7	Ralph V. Everly, Indianapolis	Oct. 1959
8	Guy Owsley, (Chairman), Hartford City	Oct. 1960
9	K. O. Neumann, Lafayette	Oct. 1961
10	J. P. Vye, Gary	Oct. 1959
11	Max R. Adams, Flora	Oct. 1960
12	Maurice E. Glock, Fort Wayne	Oct. 1961
13	G. O. Larson, LaPorte	Oct. 1959

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Terms expire December 31, 1959:

Delegates	Alternates
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Wendell C. Stover, M.D., Boonville	John M. Paris, M.D., New Albany

Terms expire December 31, 1960:

Delegates	Alternates
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E. S. Jones, M.D. Hammond	Robert M. Brown, M.D. Marion
Francis L. Land, M.D. Fort Wayne	George W. Willison, M.D. Evansville

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1959-60 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	W. Lawrence Daves, Evansville	J. D. McDonald, 517 Sycamore, Evansville	April 30, 1959
2.	Fred M. Dukes, M.D., Dugger	J. S. Brown, M.D., Carlisle	May 7, 1959
3.	Robert LaFollette, M.D., New Albany	Daniel H. Cannon, M.D., New Albany	New Albany, May 6, 1959
4.	Robert O. Zink, M.D., Madison	Frank W. Hare, M.D., Madison	Madison, May 20, 1959
5.	James Richart, M.D., Terre Haute	Roy Pearce, M.D., Terre Haute	Terre Haute, May 20, 1959
6.	Frank Lewis, M.D., Liberty	John H. Smith, M.D., Greenfield	New Castle, May 7, 1959
7.	Leon Gray, M.D., Martinsville	Herbert L. Egbert, M.D.	Indianapolis, April 28, 1959
8.	Forrest Keeling, Portland	Ara Badders, Portland	Portland, June 3, 1959
9.	S. E. McClure, M.D., Monon	David C. Beck, M.D., Monticello	Monticello, May 21, 1959
10.	Ralph T. Hartsough, M.D., Remington	Kenneth Ockerman, M.D., Rensselaer	Whiting, May 13, 1959
11.	Eugene Cook, M.D., North Manchester	C. L. Wise, M.D., Delphi	Logansport, May 20, 1959
12.	F. B. Kantzer, M.D., Garrett	Max M. Gitlin, M.D., Bluffton	Fort Wayne, May 20, 1959
13.	R. L. Bender, M.D., Elkhart	James M. Wilson, M.D., South Bend	South Bend, Nov. 18, 1959

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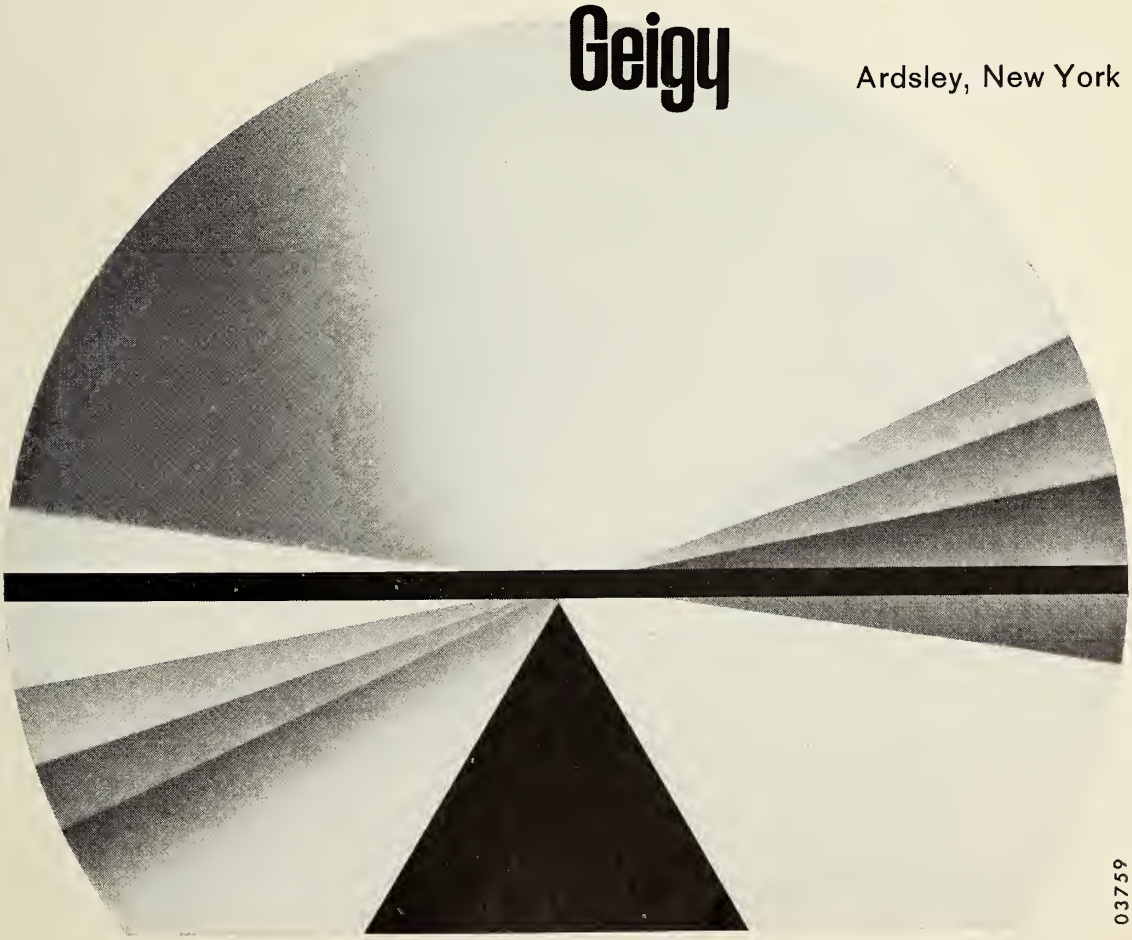
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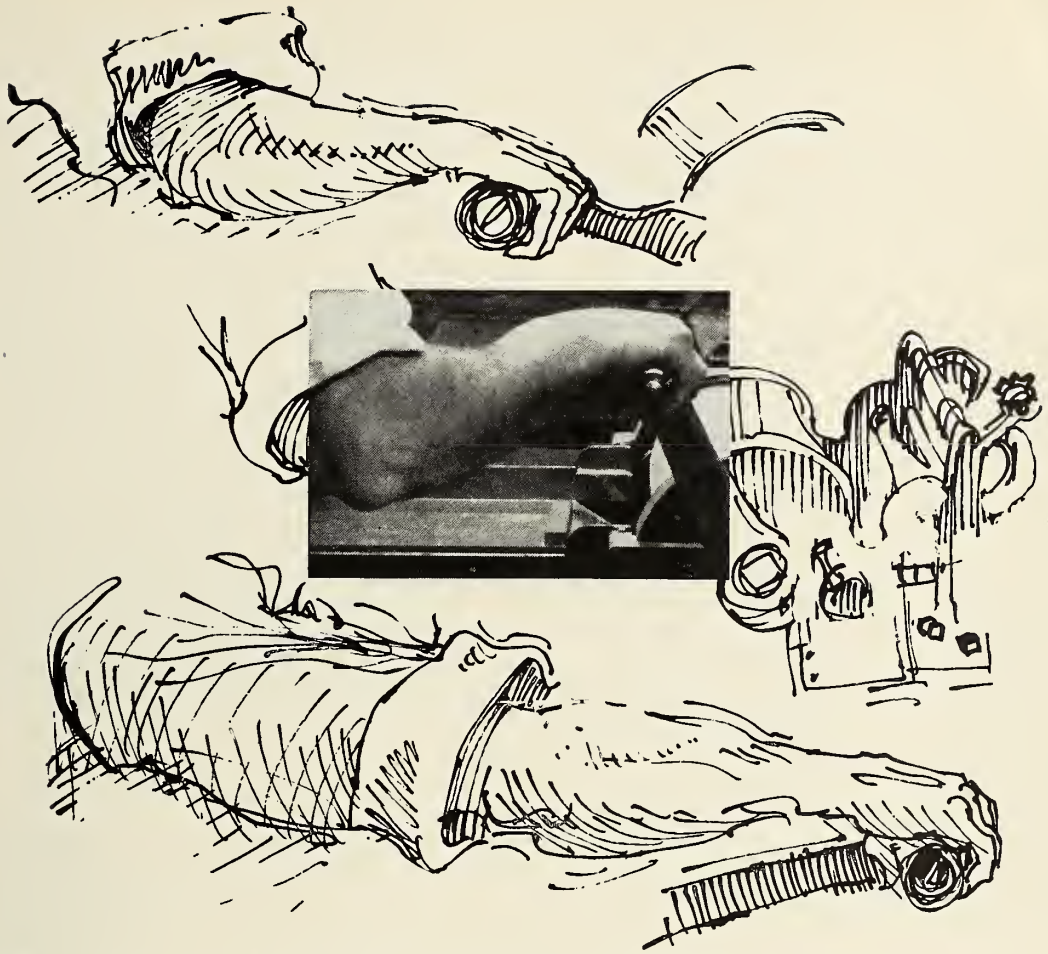
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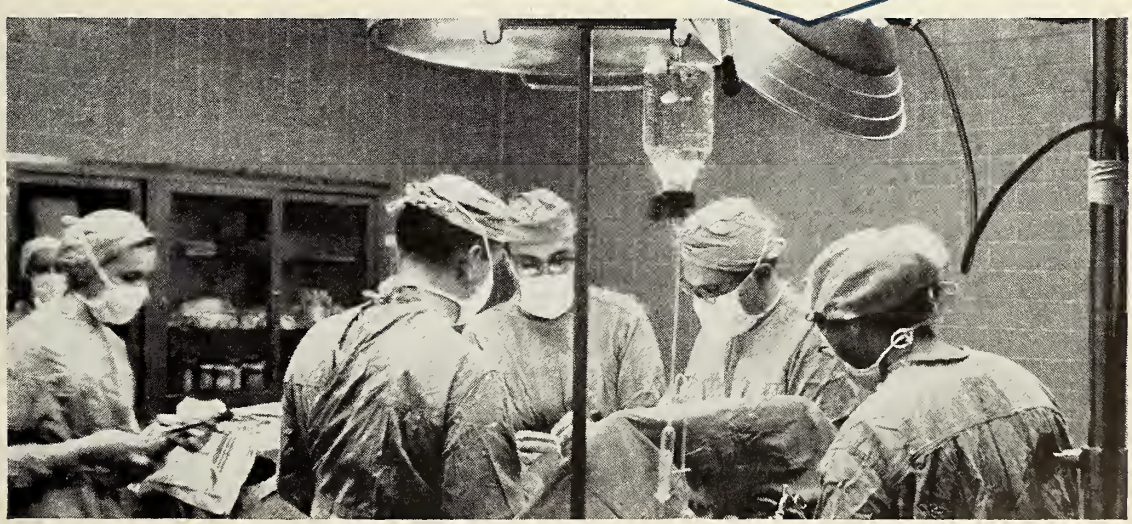
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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month preceding month of issue.

THE MONTH IN WASHINGTON

Washington, D.C. — Contrary to the usual procedure in a first session, the 86th Congress this year already is getting on with its work, particularly in health fields. In past Congresses, not much is accomplished the first session, with most bills held over to the second, which always is an election year.

The session was only weeks old when action was under way. Here are some of the developments, portending enactment before adjournment of a number of bills:

1. After hearings, a subcommittee of the Senate Banking and Currency Committee reported favorably on a housing bill that contained provision for mortgage guarantees for proprietary nursing homes. Subsequently, the measure was passed by the Senate.

At this writing the House is at work on another housing bill that also contains the nursing home loan section. With House passage assumed, the question is whether the bill (containing more money than the White House wants spent) will be vetoed, and if vetoed, whether it can be enacted anyway by two-thirds majorities in both houses.

2. Without bothering with hearings, the House Ways and Means Committee overwhelmingly approved the Keogh bill to encourage retirement plans for the self-employment. It acted in line with the committee's established procedure to quickly reapprove bills that passed the House the previous Congress, but not the Senate. The Keogh bill is identical with a measure that easily cleared the House last session but lost out in the Senate.

3. Driven forward by Chairman Carl Vinson of the House Armed Services Committee, legislation to extend the regular and doctor drafts 4 years rolled through the House. However, indications were the Senate would take its time and give careful consideration to the need for a 4-year extension.

4. The Senate Labor and Welfare Committee, under the leadership of Chairman Lister Hill (D., Ala.), demonstrated its interest in legislation for the aged. Senator Hill named a subcommittee to make a full year's study of problms of the aged, taking in housing, employment and recreation, as well as medical aspects.

Chairman of this subcommittee is Senator Pat McNamara, Detroit Democrat. Other Democrats are Senators John Kennedy of Massachusetts, Joseph Clark of Pennsylvania and Jennings Randolph of West Virginia. Republicans are Senators Everett Dirksen of Illinois and Barry Goldwater of Arizona.

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Deprol is unlike central nervous stimulants

► does not cause insomnia

► produces no amphetamine-like jitteriness

► does not depress appetite

► has no depression-producing aftereffects

► can be used freely in hypertension and in unstable personalities

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. **166**:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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5. At the same time, 3 members of the standing health subcommittee of the Hill Committee, Senators Jacob K. Javits of New York, Clifford B. Case of New Jersey and John Sherman Cooper, all Republicans, asked Congress to authorize a 2-year study of the health problems of the entire population. If approved by Congress, the investigation would look into the quality and quantity of health services, problems of extending health insurance, special problems of the aged and minority groups, and the distribution of health services.

NOTES:

Fifty-four Senators are supporting legislation that would project the U.S. farther into the international medical picture. It would set up an Institute of International Medical Research as part of NIH, establish an advisory council, and authorize spending of $50 million a year for research, part of it to go to foreigners in the form of grants.

Medicare has not been able to keep within the $72 million "ceiling" recommended by Congress for the present year. Through the Navy it is asking $6 million more. In addition, Army and Air Force will shift funds to meet the bill, estimated at $93.6 million. The budget asks $89 million for next year, in expectation that restrictions begun in October will bring a saving of between $4 million and $5 million.

Medicine has won an argument within the new Federal Aviation Agency. As a consequence, FAA's civil air surgeon will assist the administrator in setting standards for fitness, direct physical examination and inspection programs, advise on research needs, and evaluate all of FAA's medical personnel plans.

The President's health budget, now under scrutiny in Congress, is expected to be substantially increased. As an example of the White House efforts for economy, Mr. Eisenhower recommended $101.2 million for Hill-Burton hospital construction grants, in contrast to $186.2 million HB has for the current fiscal year.

Through the Civil Service Commission, the Federal government is attempting to recruit physicians for service in this country and abroad. Salary ranges from $7,510 to $12,770.

The Administration is pressing Congress to pass legislation giving the U.S. power to regulate coaltar and other colors in foods, drugs and cosmetics. One objective is to require that manufacturers demonstrate that the colors are harmless before the products can be put on the market.

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The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Malpractice Suits Put Doctors on Spot

By Ed Klingler
Press Associate Editor

It would be considered utterly ridiculous if clients sued their lawyers because they lost a case.

Yet something very comparable is happening with the increasing number of so-called "malpractice suits" patients file against their physicians.

A half dozen such suits have been filed in Vanderburg County courts within the last two years. All over the country there's an increasing number of malpractice accusations which seek sums up to $200,000.

Roughly, the charges in malpractice suits fall into one of these classifications:

1. Lack of skill.
2. Lack of attention.
3. Doing the wrong thing.

Any of these might be true, as it might in the case of an attorney, a dentist, the mechanic who works on your car, or the service man who doctors your refrigerator.

In any case, however, the net effect of such a suit is the same: The expectation of a guaranteed result.

Obviously, no physician could guarantee the outcome of his treatment of an illness.

Physicians carry insurance, at a very high premium, as a protection against suits. But that's monetary protection only.

Professionally, nothing is quite so embarrassing to a physician as a malpractice suit, because it casts the shadow of doubt on his integrity.

When a physician finds himself defendant in a malpractice suit, his first impulse is anger, and the second is to settle it.

The impulse to settle out of court is prompted mainly by two considerations. The first is prolonging the embarrassment by standing trial in which the issue is the doctor's professional ability. The second is the fact that doctors are notoriously busy people, with the health of their patients at stake, and and they can't spare the time.

If insurance companies that protect physicians had their way, almost every case would be fought to a standstill in court. When they go to court, the physician usually wins. But because so many physicians balk, and so many out-of-court compromises are reached, the malpractice insurance rate has gone steadily upward.

Is all this any concern of yours?

It certainly is, and if it's proof you want, ask your own family physician.

He will likely tell you that to an increasing degree he is altering his procedures—not necessarily for the benefit of the patients, but to build his defenses against a future suit. For to the physician, every case he handles represents the possibility of a damage suit by the patient.

These procedural changes can cost you money.

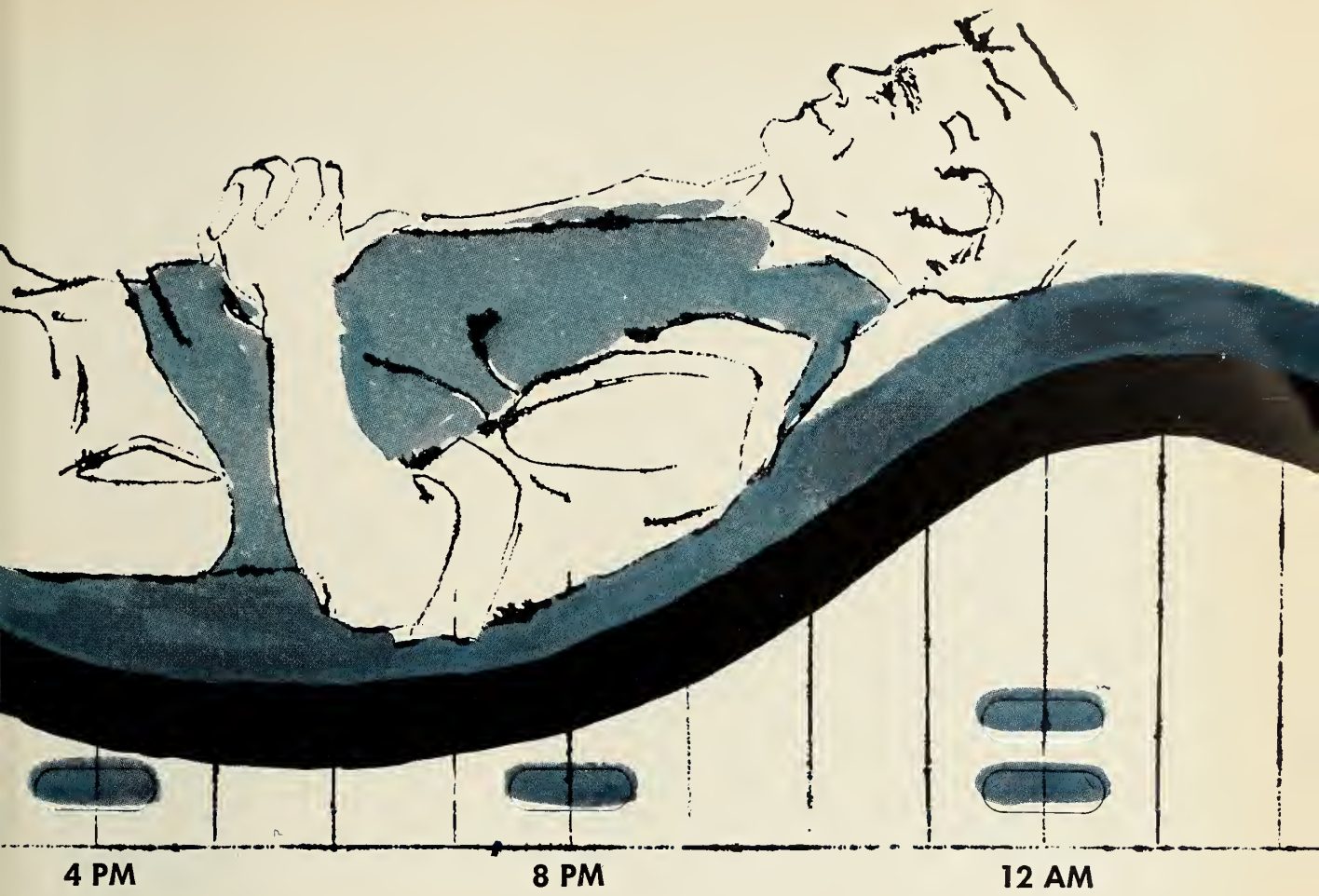
The doctor is more prone to invite in other doctors to consult on a case, even when he's reasonably sure of his diagnosis; he's more apt to send you off to the hospital for skilled attention, rather than home treatment; he may keep the patient in the hospital longer; he's more likely to prescribe an expensive miracle drug, rather than something just as effective.

You pay for all this, and if you carry health insurance, it's reflected in the insurance rate.

The human body is not a perfect machine, and keeping it in running order is not an exact science. For the physician, every case poses a new problem for his solution. His oath requires him to make every effort for the benefit of the patient.

But in view of the rash of suits, he must keep himself in the position of being able to prove it.

Continued on 310



Phenaphen and Phenaphen with Codeine provide
a wide range of analgesia, plus complete dosage flexibility,
to match varying pain requirements.

Yours to prescribe:

The **right** dose of the **right** potency at the **right** time.

Phenaphen

Basic non-narcotic formula

For mild to moderate pain

Each capsule contains:

Phenacetin (3 gr.) 194.0 mg.
Acetylsalicylic acid (2½ gr.).....162.0 mg.
Phenobarbital (¼ gr.) 16.2 mg.
Hyoscyamine sulfate.....0.031 mg.

Phenaphen No. 2

Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

For moderate to severe pain

Phenaphen No. 3

Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

For severe or stubborn pain

Phenaphen No. 4

Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

For stubborn or intense pain—to obviate or postpone use of morphine or addicting synthetic narcotics

DOSAGE: One or two capsules as required.

Fourth Estate

Continued from 306

Otherwise, he's a sitting duck for those who came in pain, and survived to complain—in court.

—*The Evansville Press*
November 29, 1958

Howard County—Testing Ground

Twice in recent years Howard County, Indiana, has had national recognition by being selected as a testing ground for important experiments.

One of these was in 1954 when our county was one of eight counties chosen for testing areas for the new Salk vaccine which has since proved such a Godsend in checking poliomyelitis. The vaccine was given to second grade pupils, with approximately 18,000 youngsters in the eight-county area receiving it. The counties were chosen on the basis of incidence of polio among children of the lower grades in recent years. As everyone knows, the experiment was a success.

The second instance in which this county has been picked for a significant experiment, and one of which we can be proud, took place six months ago and is continuing. This was the selection of the county by the University of Chicago for a test of its theory that clergymen can be an important link in the fight to save thousands of persons from mental illness.

The university devised a pilot study and called it "Project Kokomo." Last summer it invited clergymen from Howard County to come to its campus for a week-long workshop during which mental illness was discussed. The university gave these ministers the benefit of findings and opinions of its experts who have become world famous in the study of mental illness.

It then asked them to apply some of the workshop recommendations in their own ministry here in Howard County and to return to the campus in six months for a comparison of notes and further discussion.

The clergymen have just had their second week of meetings at the University of Chicago, and the university considers the project so successful that instead of terminating it now, it is continuing it.

The idea is that ministers can be of inestimable help in detecting cases in which men and women are on the verge of mental breakdown, and can help to ward off these illnesses. Through this help the pastors of churches can play a role, with psychiatrists, doctors and others in holding down the number of mental cases.

If Project Kokomo is proving as much of a success as the university believes, Howard County again will have served as a testing ground for an attainment which will benefit an untold number of human beings. We take much pride in having furnished that testing ground.

—*Kokomo Tribune*
January 20, 1959

The Welfare State Is "Legal" Thievery

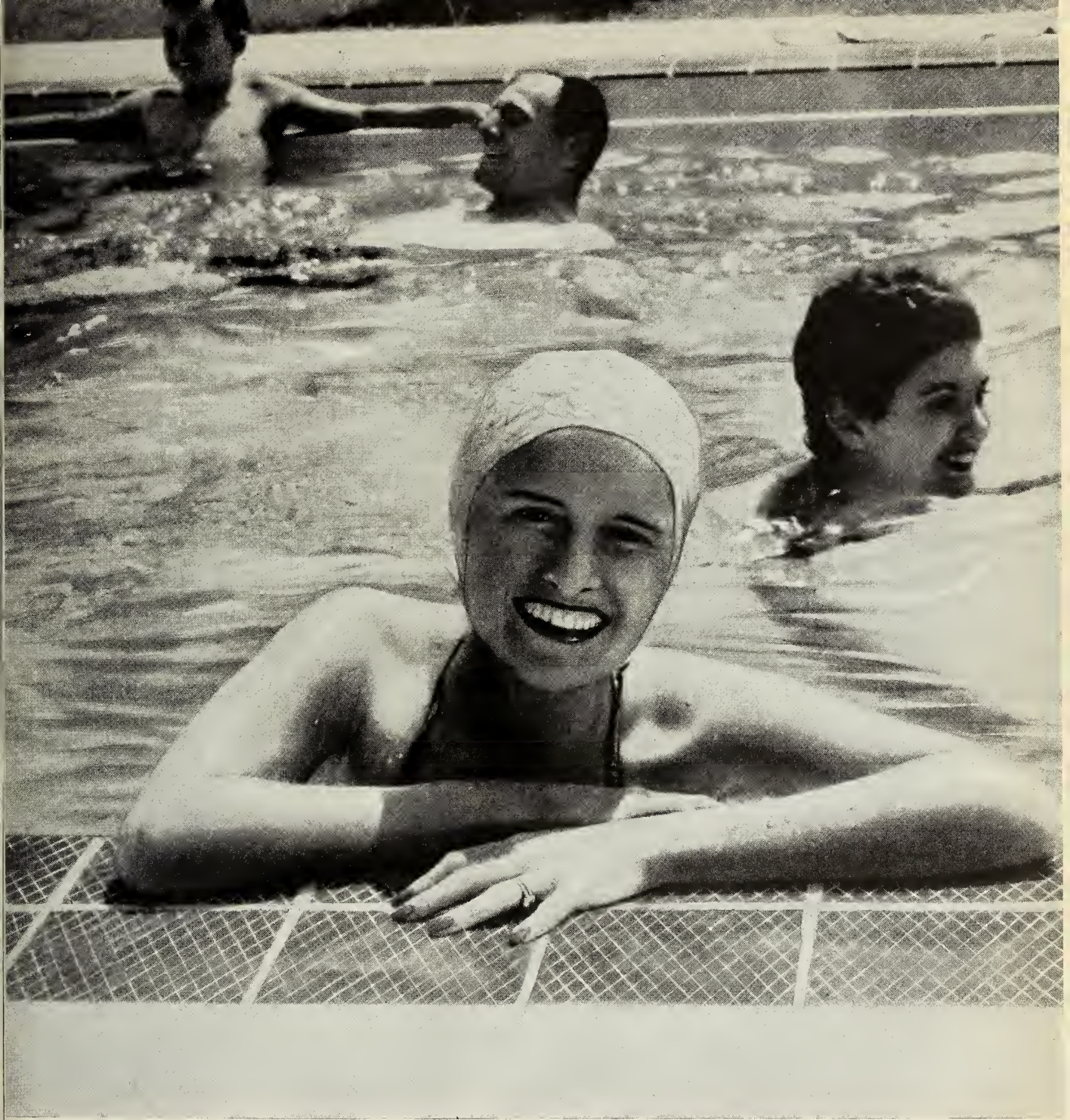
By Howard E. Kershner, L.H.D.

One of the most common but, at the same time, one of the worst of all sins is committed when man's ego asserts itself to gain its own end at the expense of one's fellows. That is what Paul was talking about when he said, "For the love of money is the root of all evil." I Timothy 6:10.

The ramifications of the welfare state sum up the efforts of the people to enjoy more than they produce by taking something from the production of others.

Pressure groups obtain wage increases by the coercive power they are able to exercise. Monopolists who take unfair advantages are using coercive power to gain their ends. Rent control is a means of seizing the property of landlords for the benefit of tenants. Featherbedding is a very important and widely-practiced method of taking the property of others without giving an adequate return. Tariffs and subsidies fall into the same classification. Paying farmers more than the market price for what they produce is seizing some of the property of consumers for the benefit of the farmers. Paying a recipient of social security more than the sum collected on his behalf plus interest is seizing some of the wealth of others for his benefit. TVA, rural electrification, loans at below the market interest rates, subsidies for housing development and, in fact,

Continued



Of course, women like "Premarin"®

THERAPY for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

The patient isn't alone in her devotion to this natural estrogen. Doctors, husbands, and family all like what it does for the patient, the wife, and the homemaker.

When, because of the menopause, the psyche needs nursing—"Premarin" nurses. When hot flushes need suppressing, "Premarin" suppresses. In short, when you want to treat the whole menopause, (and how else is it to be treated?), let your choice be "Premarin," a complete natural estrogen complex.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

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5854

Continued

all forms of socialistic action by government are at base seizing some of the property of others and distributing it to the individuals and groups favored by government usually where it will influence the most votes.

Welfare statism, socialism, government intervention, government-managed economy, fascism, communism and all the rest are the result of man's ego expressing its defiance of God and His laws, in a selfish effort to seize the wealth of one another.

—*Indianapolis Star*
January 25, 1959

No Traffic Triumph

When the highway fatality total for a long holiday weekend falls somewhat short of the National Safety Council's prediction, that fact is treated in some quarters almost as if it were a triumph of safe driving.

But a four-day holiday span in which 594 Americans lose their lives on the streets and highways hardly suggests that congratulations are in order.

What does it matter that 620 deaths were forecast? The thing that counts is that 594 individuals who were alive before 6 p.m. Dec. 24, looking forward to a happy holiday season, were dead four days later.

This is a colossal price to pay for the privilege of moving about in our own vehicles, at times and places of our own choosing.

The horrible part of it is that it is so largely a predictable price. The only thing we don't know in advance is who the ones are who will pay it.

—*Kokomo Tribune*
January 9, 1959

"Only Rich Can Get Sick"

By Dick West

A disturbed lady writes in about doctors and hospitals:

"The medical profession is bringing socialized medicine upon itself. Only rich people can afford to be ill now.

"Doctors won't treat you at home. In a hospital they spend your money freely for nurses, unnecessary medicine, laboratory tests. I went on a medical binge—and at the conclusion my 'specialist' could find nothing wrong, and referred me to Dr. Blank."

The lady is partly correct. It does cost more to get sick. Thirty years ago doctors and hospitals were cheaper. Doctors came to the home willingly and dispensed a kindly understanding.

They also dispensed rock and rye, sassafras tea, aspirin and calomel. Average life span was about 50.

Today life expectancy has been increased to 68. Of course doctors come higher, as do hospital rooms. An automobile that cost $1,000 in 1938 now costs $3,500.

In the last 20 years doctors' fees have gone up 84 per cent. But haircuts have gone up 205 per cent, movie admissions 120 per cent, baby shoes 171.

A plumber's wife had an emergency appendectomy and was rushed to the hospital. Her total medical bill came to $148. The plumber figured that the hospital would have paid more than $148 for three sets of plumbers

Continued on 316

"I WEAR A HANGER LEG..."



. . . yet ride a bike and ice skate, and have learned to roller skate, skip, and walk down the steps foot-over-foot."

Marion Phillips, school girl, began wearing a Hanger Hip Control Leg at the age of 10. The correct fit and dependable performance of her Hanger Leg have enabled Marian to take part in the normal activities of a teen-age girl. Her amazing rehabilitation is not unusual, others have been equally successful, and most Hanger wearers are able to return to a normal active life.

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A workhorse "mycin" for common infections



respiratory infections

prompt, high blood levels

consistently reliable and reproducible blood levels

minimal adverse reactions

With well-tolerated CYCLAMYCIN, you will find it possible to control many common infections rapidly and to do so with remarkable freedom from untoward reactions. CYCLAMYCIN is indicated in numerous bacterial invasions of the respiratory system—lobar pneumonia, bronchopneumonia, tracheitis, bronchitis, and other acute infections. It has been proved effective against a wide range of organisms, such as pneumococci, H. influenzae, streptococci, and many strains of staphylococci, including some resistant to other "mycins." Supplied as Capsules, 125 and 250 mg., vials of 36; Oral Suspension, 125 mg. per 5-cc. teaspoonful, bottles of 2 fl. oz.

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Philadelphia 1, Pa.

Fourth Estate

Continued from 312

on 8-hour schedules with the overtime figured on a 24-hour basis.

Biggest factor in the 20-year rise in hospital costs is labor. At most modern hospitals 2.2 workers are required for each patient. Latest figures show the average cost per patient per day in a hospital is $28.81. Of that, $22 is for hospital personnel.

Big reason people get mad over sick bills is that sickness comes unexpectedly and they are not ready to pay for it. They budget for food and rent. They save for a down payment on a car. They won't budget for illness. Is that any reason to socialize medicine any more than to socialize the automobile or baby shoe industries?

—Dallas Texas Morning News
October 7, 1958
Reprint by Assoc. of Surgeons, Chicago

Fourth Salk Dose Has "Marked Effect"

Ann Arbor, Mich.—A fourth dose of Salk vaccine has proved effective in persons with little or no detectable antibody for types I and III poliovirus, Dr. Jonas E. Salk, University of Pittsburgh School of Medicine, told a polio vaccine symposium conducted here by the University of Michigan School of Public Health.

One group of 462 individuals, chosen because of their antibody deficiencies, were given a fourth does of vaccine prepared in Dr. Salk's laboratory. The additional dose "had a marked effect and in the majority of instances raised antibody concentrations to levels that have been described for the effect induced by a third dose when prior inoculations have been with vaccines of good potency," he said.

"It is clear," Dr. Salk said, "that widespread application of a fourth dose could be expected, in a great many instances, to compensate . . . for the deficiencies in the effects induced by three doses of vaccine that may have been of less than optimal potency."

Dr. Salk also reported on the persistence of protective antibodies in those experimentally vaccinated almost five years ago. He said antibody levels in these children have been maintained "with only a slight tendency to decline" from levels measured a year ago.

(World Wide Medical News Service)
—Scope
January 14, 1958

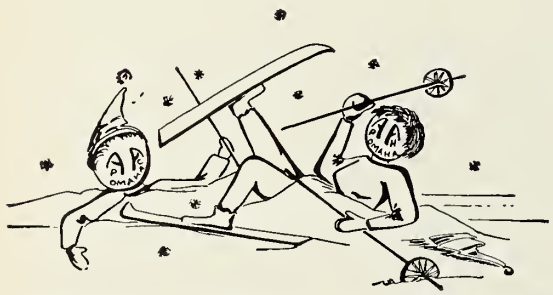
Dr. Thomas J. Beasley

If when a man reaches the end of his years he can look back swiftly to his contribution to the people around him, and can count his gains in abundant living for others, he must carry with him the ultimate in spiritual satisfaction.

Dr. Thomas J. Beasley, who died at 78, had such a life, lived patiently in pursuit of health and comfort for those afflicted with fearful diseases. He also lived to see undreamed progress in the control of dread tuberculosis and was the founder of the old Rockwood Sanitarium in Danville, one of the first hospitals in the Midwest to be devoted exclusively to the treatment of tuberculosis.

Dr. Beasley began early in his devotion to the stricken. And he began in the thick of one of the world's worst diseases, leprosy, in

Continued



PROTECTION AGAINST LOSS OF INCOME FROM ACCIDENT & SICKNESS AS WELL AS HOSPITAL EXPENSE BENEFITS FOR YOU AND ALL YOUR ELIGIBLE DEPENDENTS

ALL PREMIUMS COME FROM
PHYSICIANS SURGEONS DENTISTS
ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS
OMAHA 31, NEBRASKA
Since 1902

Handsome Professional Appointment Book sent to you FREE upon request.

Allergy-free...all day... with this much medication



Typically, the allergic patient can enjoy a whole day's freedom from symptoms with just one Pyribenzamine Lontab in the morning—a whole night of restful sleep with just one Lontab in the evening.

The outer shell of the unique Lontab actually contains an effective dose of Pyribenzamine which is released minutes after the Lontab enters the stomach. Thereafter, medication is released uniformly and continuously from the specially formulated inner core of the Lontab—sustaining antiallergic effect as long as 12 hours.

For patients who need only periodic medication, regular Pyribenzamine tablets provide fast, dependable action, with a minimum of undesirable side effects.

SUPPLIED: Pyribenzamine Lontabs—full-strength—100 mg. (light blue). **Pyribenzamine Lontabs**—half-strength—50 mg. (light green); for children over 5 and adults who require less antiallergic medication. **Pyribenzamine** Regular Tablets, 50 mg. (green, scored) and 25 mg. (green, sugar-coated).

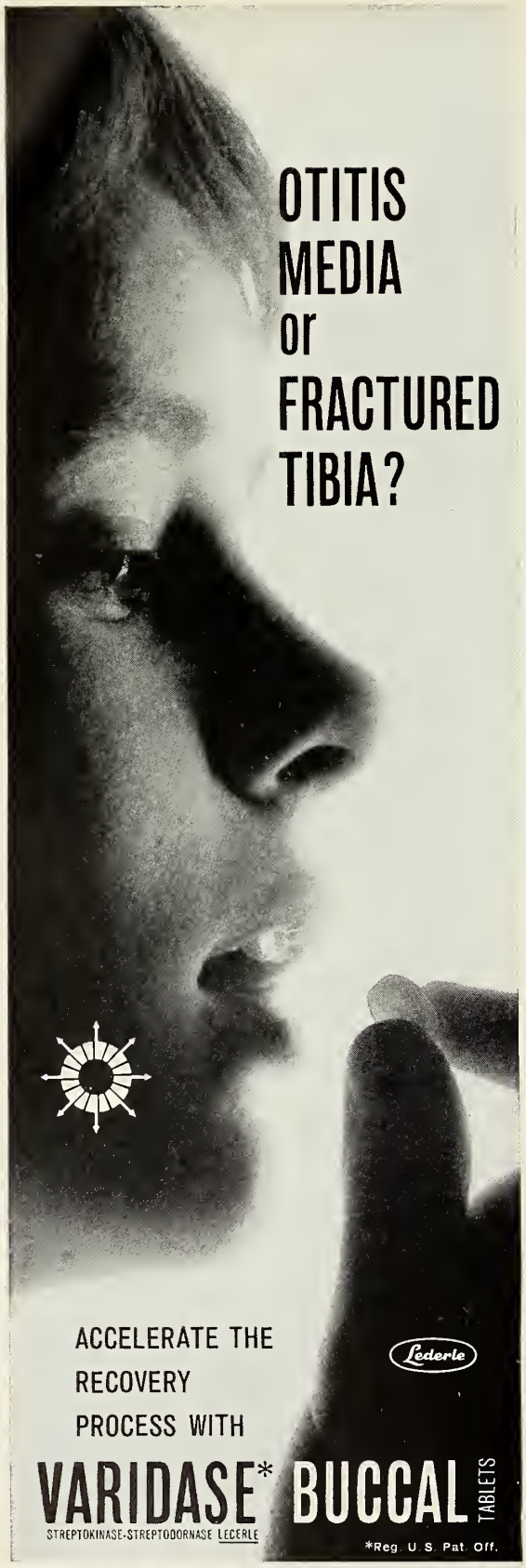
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JUST ONE KEEPS YOUR ALLERGIC PATIENT ON A 12-HOUR THERAPEUTIC PLATEAU



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY,
Pearl River, New York

a colony in the Philippine Islands. There he learned control of contagion, and the rich rewards of complete devotion to those who were at the time, for the most part, the "living dead."

In adding precious years and hope to the afflicted, Dr. Beasley's life was an inspiration both to the medical profession and to all mankind.

—*Indianapolis Times*
January 2, 1959

A Look at Radiation

A group of scientists has made a proposal which, if acted upon, could do much to substitute facts for speculation about the effects of natural—so-called background—radiation on the health of Americans. A committee of the National Academy of Sciences proposes that there be a 20-year study of perhaps as many as two million persons in key points about the country.

Such an undertaking would be of great importance, especially because man has introduced a new factor—the radioactivity from bomb tests and other nuclear activities. We simply do not know enough, at present, about the effects of radiation from these sources coupled with the normal radiation that has always been present.

The study proposed might cost as much as $1,500,000 a year. This would be a small sum, however, in exchange for knowledge which could eventually be a buffer against the dangers that go with entrance into the nuclear age. The sooner we learn how to handle the atom with safety gloves, the less trouble there will be.

—*Kokomo Tribune*
January 15, 1959

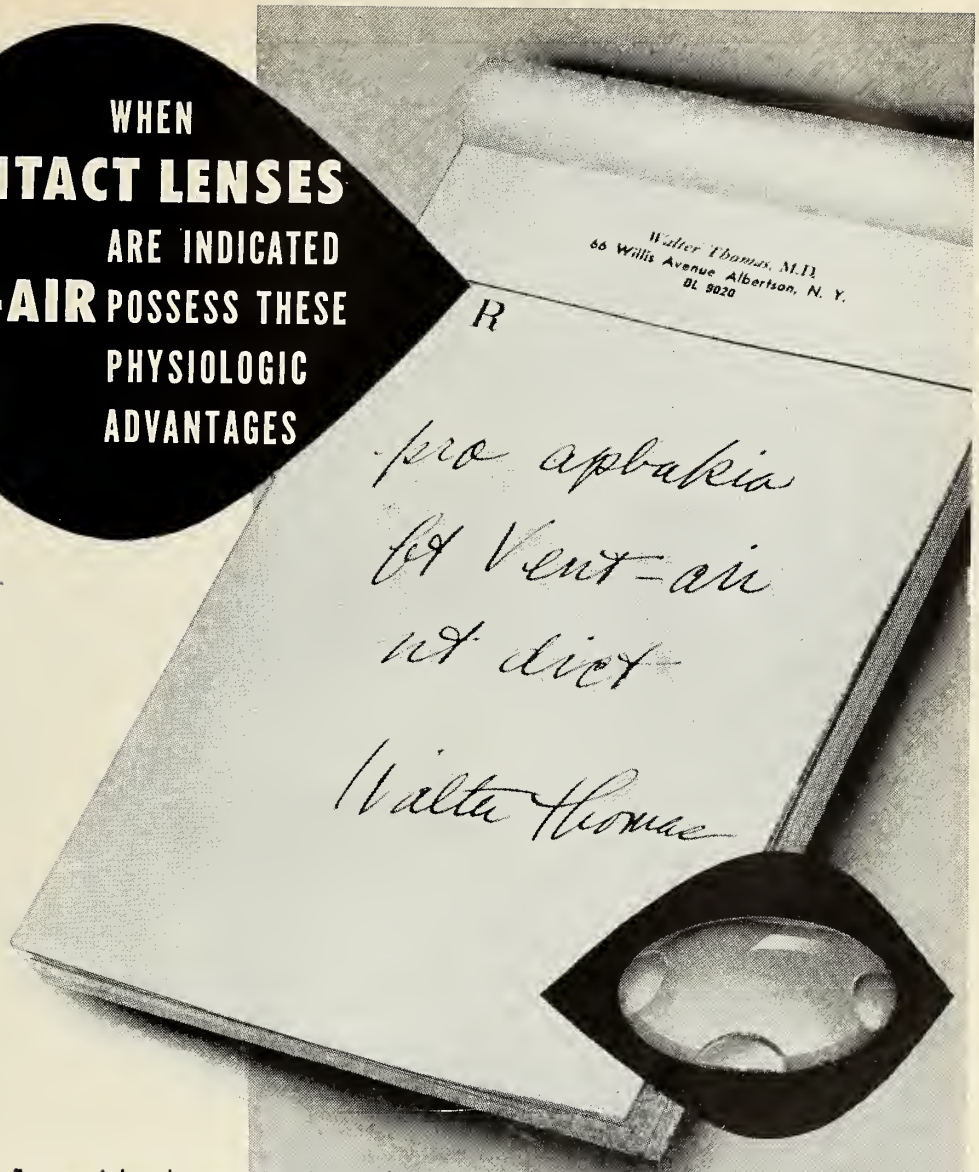
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WHEN CONTACT LENSES ARE INDICATED VENT-AIR POSSESS THESE PHYSIOLOGIC ADVANTAGES



Four peripheral vents	Permit topical circulation of lachrymal and glandular secretions without excessive motility
Corneal apical clearance	Favors normal corneal metabolism and oxygenation
Ultra-Smoothness of Inner and Outer Surfaces	Avoid limbal epithelial and tarsal conjunctival exacerbation
Highly absorptive methyl-methacrylate composition	Simulates "wetting" and moisture-retention properties of cornea (of military specification)
Precision-ground	Prescriptive qualities exact to ± 0.12 D. with precise allowance for vertex refraction and lachrymal factor (exact to .02 mm radius in inner curvature)
Custom-fitted	In uni-, bi-, or tri-curve radii conforming to corneal peripheral asphericities
Hyper-thinness of edge or center	Maintains uniform thickness in high myopia or hyperopia approximating .20 mm irrespective of power
Widest range of inner radii	From 5.0 to 10.00 mm providing for extremes of keratoconic and megaloglobic dimensions
Cosmetic, pin-hole and tinted effects	For leucomatous, polyopic, iridodialytic and albinic conditions or other corneal or media anomalies.

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Wanted: PHYSICIANS LOCATIONS

Following are the latest requests received by the Physicians Placement Service of ISMA:

OAKTOWN—Knox County, population 900. Located 13 miles from Vincennes where hospital facilities are available. One physician in the town. Large surrounding territory. Contact Elmer Howard, president of the Town Board, Oaktown, for further information.

INDIANAPOLIS—Marion County, the office of the late Dr. U. B. Hine, 4808 E. Michigan Street, is available. Contact Mrs. U. B. Hine, 810 N. Arlington Avenue, Indianapolis, for details.

WALDRON—Shelby County, population around 800 with a large surrounding rich farming community. The town is without a physician since the death of Dr. S. B. Coulson. Doctor Coulson's office is available. For further information, contact Mrs. S. B. Coulson, Waldron.

SOUTH WHITLEY—Whitley County, population 1,500. Located 26 miles west of Fort Wayne. Nearest hospital is located at Columbia City. One doctor in the community. Office building available. Contact Mrs. Paul Garber, Sigma Nu Fraternity, Greencastle, or Mr. Ray Walton, druggist, South Whitley.

FOUNTAINTOWN—Shelby County, population 250. Located on Road 52, seven miles from Greenfield where hospital facilities are available. Large surrounding farming community. Contact Mrs. V. B. Hungate, Fountaintown, for details.

Physicians Seeking Locations

Following is a list of physicians who have made inquiry at the ISMA office during November and December, 1958 and January and February, 1959 concerning openings in our state for general practice:

Robert Stone, M.D., 3319 Wilcox Street, Indianapolis 22.

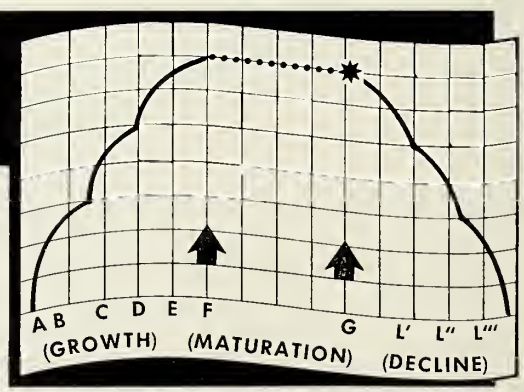
Hal R. Rhynearson, M.D., Springfield City Hospital, Springfield, Ohio.

Donald L. Boucher, M.D., 1990 Antietam, Lexington, Ky.

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Far patients aver 40, The G POINT (paint af declinatian in life) can be pastpaned!

Praperly balanced Andragen — Estragen — nutritianal therapy may prevent premature aging and damage af ganadal decline and nutritional inadequacy.

Camplaints af symptams such as muscular pain, fatigue, irritability, and paar appetite in the patient aver 40 may be the first indicatians af three major stress factars in the aging process: (1) Ganadal Harmonal Imbalance, (2) Nutritianal Inadequacy and (3) Emotianal Instability. GERITAG is especially farmulated ta guard against premature damage and ta delay the degenerative pracess.

Rx GERITAG in preventive geriatrics.

*Chappel, C.C., J.A.M.A., 162: 1414, (Dec. 8) 1956

Write for Latest Technical Bulletins.

Each Magenta Soft Gelatin Capsule contains:

Methyltestosterone	2 mg.	Thiomine Hcl.	2 mg.
Ethinyl Estrodiol	0.01 mg.	Riboflovin	2 mg.
Ferrous Sulfate	50 mg.	Pyridoxine Hcl.	0.3 mg.
Rutin	10 mg.	Niocinomide	20 mg.
Ascorbic Acid	30 mg.	Mongonese	1 mg.
B-12	1 mcg.	Mognesium	5 mg.
Molybdenum	0.5 my.	Iodine	0.15 mg.
Cobolt	0.1 mg.	Potossium	2 mg.
Copper	0.2 mg.	Zinc	1 mg.
Vitomin A	5,000 I.U.	Choline Bitortrote	40 mg.
Vitomin D	400 I.U.	Methionine	20 mg.
Vitomin E	1 I.U.	Inositol	20 mg.
Col. Pontothenote	3 mg.		

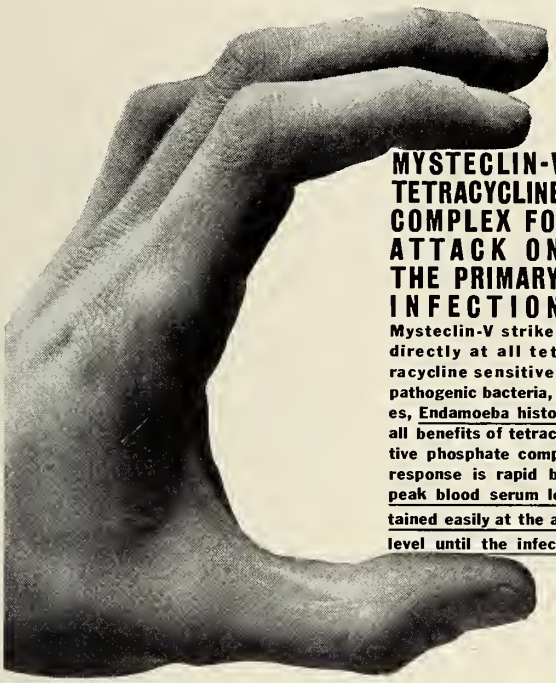
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MYSTECLIN-V CONTAINS TETRACYCLINE PHOSPHATE COMPLEX FOR A DIRECT ATTACK ON THE PRIMARY INFECTION

Mysteclin-V strikes directly at all tetracycline sensitive organisms—most pathogenic bacteria, certain large viruses, Endamoeba histolytica. It provides all benefits of tetracycline in the effective phosphate complex form.[1] Patient response is rapid because initial high peak blood serum levels may be maintained easily at the antibacterial attack level until the infection is conquered.

MYSTECLIN-V CONTAINS MYCOSTATIN FOR A SPECIFIC DEFENSE AGAINST SECONDARY MONILIAL SUPERINFECTION

Mysteclin-V protects patients against antibiotic induced intestinal moniliasis and its complications, including vaginal and anogenital moniliasis. This protection is provided by Mycostatin, the antifungal antibiotic, with specific action against Candida (Monilia) albicans.[2]

BOTH ARE OFTEN NEEDED WHEN BACTERIAL INFECTION OCCURS

MYSTECLIN-V

SQUIBB TETRACYCLINE PHOSPHATE COMPLEX (SUMYCIN) AND NYSTATIN (MYCOSTATIN)

Capsules (250 mg./250,000 u), bottles of 16 and 100.
Half-strength Capsules (125 mg./125,000 u), bottles of 16 and 100.
Suspension (125 mg./125,000 u per 5 cc.), 2 oz. bottles.
Pediatric Drops (100 mg./100,000 u per cc.), 10 cc. dropper bottles.

References: 1. Crunk, G. A.; Naumann, D. E., and Casson, K.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia Inc. 1958, p. 397. 2. Newcomer, V. D.; Wright, E. T., and Sternberg, T. H.: Antibiotics Annual 1954-1955, New York, Medical Encyclopedia Inc., 1955, p. 686.

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Wanted

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Michael D. Finegold, M.D., 134 Glenridge Place, Cincinnati 17, Ohio.

Walter Able, Jr., M.D., Box 64, Mescalero, New Mexico.

Robert Gayne, M.D., R. R. 2, Waynesboro, Va.

Nobutake Azuma, M.D., Lutheran Hospital of St. Louis, 2639 Miami Street, St. Louis 18, Mo.

John R. Ware, M.D., Box 503 Balboa Heights, Canal Zone.

Carl R. Dudeck, M.D., Butler Co. Memorial Hospital, Butler, Pa.

D. Diazgrandados Bell, M.D., Health Center, Utuado, Puerto Rico.

G. Vazquez Gonzales, M.D., Health Center, Utuado, Puerto Rico.

Harry E. Mayhew, M.D., 1628 Robert T. Longway, Flint 3, Mich.

John E. Finger, M.D., 19th Medical Detachment, APO 46, New York, N. Y.

William M. Sermonte, M.D., 3156 Jefferson Avenue, Cincinnati 20, Ohio.



Kenneth D. Miller, M.D., 537 Hayes Street, Gary, Ind.

Richard S. Latta, M.D., New Milford, Pa.

Edgar A. Hanson, M.D., USVA Hospital, Iowa City, Iowa.

Robbert V. L. Seglin, M.D., 51 State Street Hammond, Ind.

Cornelius N. Stover, M.D., U.S.S. Glacier, FPO, New York, N. Y. (locum tenens for 1 year—available August 1959)

Specialists

Harry E. DeHaven, M.D., 1110 Yale St., Santa Monica, Calif., **Urology.**

John E. McGee, M.D., 1732 Red Bird Cove, Brentwood, Mo., **OB-GYN.**

Charles N. Tarkington, M.D., St. Louis City Hospital, 1515 Lafayette Ave., St. Louis, Mo., **OB-GYN.**

Ray J. Gratz, M.D., 1930 Oakdale Ave., Richmond 27, Va., **General and Thoracic Surgery.**

Charles R. Willman, M.D., 7636 Poe St., Detroit 6, Mich., **General Surgery.**

Joseph Brozda, M.D., 720 South Wolcott St., Chicago, Ill., **General Surgery.**

Robert J. McKenna, M.D., 1558 Sevilla, Coral Gables, Fla., **Surgery.**

Benjamin M. Rush, M.D., 108 Willow, Monroe, La., **General Surgery with Proctology.**

David M. Berkson, M.D., 2052 Lincoln Park, Chicago, Ill., **Internal Medicine—Cardiology.**

William J. Alt, M.D., 922 High St., Madison, Wisc., **Internal Medicine.**

Gerald T. Havey, M.D., 9128 Mansfield, Detroit, Mich., **Internal Medicine — Gastroenterology.**

James A. Marvel, M.D., Henry Ford Hospital, Detroit, Mich., **Internal Medicine.**

Jerome L. Handler, M.D., 8635 N. Trumbull, Skokie, Ill., **Internal Medicine — Hernatology.**

Herbert Hillemeier, M.D., Madison Apts. South St., Red Bank, N. J., **Orthopedic Surgery.**

Donald J. Killelea, M.D., 417 Addison Road, Riverside, Ill., **Radiology.**

Revelle Russell, M.D., 537 Flagg Ave., San Jose, Calif., **Urology.**



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Improve appetite and energy
with ample amounts of vitamins—B_1, B_6, B_{12}.

strengthen bodies with needed protein
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discourage nutritional anemia
with iron in the well-tolerated form **of** ferric pyrophosphate.

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delicious cherry flavor— no unpleasant aftertaste

Average dosage is 1 teaspoonful daily. Available in bottles of 4 and 16 fl. oz.

Each teaspoonful (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

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Medical Benefits and Health Insurance

E. T. EDWARDS, M.D., Chairman
Commission on Medical Economics and Insurance

TODAY 71% of Americans have hospital insurance, 63% have surgical coverage, but only 43% have medical benefits!* With the prolongation of life increasing the incidence of degenerative diseases, combined with the increasing complexity of medical diagnostic and treatment procedures, it is not surprising that several resolutions concerned with medical benefits were introduced at the 1958 Indiana State Medical Association meeting.

These resolutions urged broader, more realistic benefits and greater sales activitiy by Blue Shield. The various medical societies had hoped to influence the only "Insurance" company in which they are considered to have any direct control. The executive secretaries of both the "Blue Plans" reported to the ISMA Reference Committee that such a plan was their "Comprehensive Policy" which was more expensive and required a maximum fee schedule adopted by the local medical society, and was not selling widely. They said that "out-patient diagnostic payments" were desired more by union leaders than "in-hospital medical benefits" at the industry-wide purchasing centers. The conclusion could be drawn that the medical man, by his small daily charges, has enabled the patient to believe the installment payment delusion that "if the payments are small, anyone can buy anything." Obviously, 30 times $3.00 or $5.00 makes $90 or $150 which is comparable to surgical fees! Perhaps, the medical man must create a demand for "insurance" for this particular group of charges.

Before we attempt to create this demand, a study of the market (the public) and the different insurance plans would be wise. Historically, in so-called health insurance activities, there are 3 types of organizations: (1) private insurance companies, (2) the Blue Plans, (3) the independents, e.g., Kaiser Foundation Health Plan, Hospital Insurance Plan of New York (HIP), union plans. In the past there have been fundamental differences between these programs.

Private insurance companies offered insurance against the cost of hospital and surgery with freedom of choice of doctor and hospital. Any individual passing a physical exam could buy the policy and would be paid benefits in cash. Group policies were also offered.

Early Blue Plans

Early Blue Cross and Blue Shield plans were called insurance, but were considered by many to be prepayment. Low income groups were the first to be covered. They had freedom of choice of hospital and doctor. Payment was in the form of services, i.e., paid-up hospital or surgical care—not cash. Whether it was the indemnity type of private insurance and some blue plans or service plans of the other blues, costs were curbed by fee schedules, maximum limitations and other restrictions.

Most independent plans offered comprehensive coverage at higher cost, few limitations and little free choice. This was really a method of budgeting the costs of most illnesses.

When the National Labor Relations Board ruled that health insurance was a fringe benefit in labor wage negotiations between 1947 and 1949, there was a rapid growth of hospital coverage and this has continued.

Continued

Written to provide background information for commission members. Published for information of all ISMA members.

* Health Insurance Council, 1958.

"It is concluded that the addition of buffering agents to acetylsalicylic acid in the concentrations used serves no clinically detectable useful purpose."[1]

[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:183, August, 1958.

Nonbuffered Material Used—Bayer® Aspirin.

Medical Benefits

Continued

Accompanying this growth there has been an increasing number of complaints by all concerned. Costs have gone up, desire for increased benefits has developed; abuses by patients, doctors, union and management representatives, hospitals and insurance companies have been revealed.

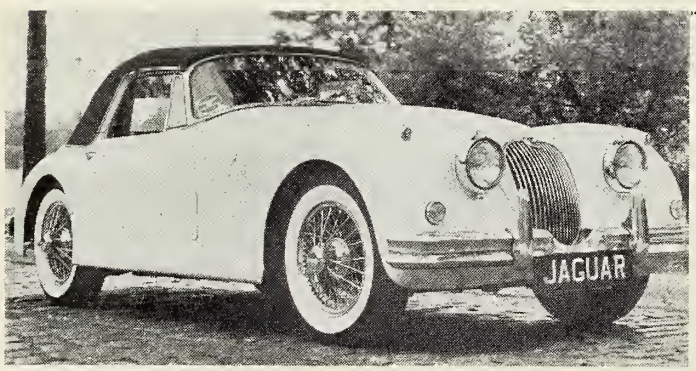
The Michigan State Medical Society found in a survey that most people were not primarily interested in lower premiums, but wanted more protection. At least this was true before the last economic slump.

Many experiments have been conducted in this field by the Blue Plans and the insurance companies. One of the most popular, Major Medical, was characterized by a deductible feature, by co-insurance requiring the policy holder to pay part of the expense, by large benefits and no fee schedule. Some of these companies are now finding that they must add a fee schedule. Unions, we are told, do not favor deductible plans! Furthermore, there is a demand by unions to provide coverage for small medical expenses (office, home, and drugs) as well as the large hospital bills.

G. E. Plan Favored

The General Electric Comprehensive Plan was designed to provide protection against large and small bills, with freedom of choice of physician, deductible and co-insurance provisions, no fee schedule, out-patient diagnostic services, mental care, home and office visits at a cost of $4.00 per month per individual or $14.00 for the employee and his family. When put to a vote of its employees, 99% favored the G. E. Plan. After the first year, costs were as predicted. The good record was attributed to extensive employee education and cooperation. More recently, the Wisconsin Physicians Service (a Blue Plan) has offered a service type comprehensive policy without fee schedule, with free choice and no limit on income. At the present time, there is an intense conflict within that State Society over their two Blue Plans.

The office of the Insurance Commissioner of Indiana has ruled that all insured members are entitled to the same benefits, which does



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Medical Benefits

Continued

not permit the double coverage feature of paying an assistant's fee in addition to the surgeon's fee for some patients and not for others. Indiana Blue Shield does pay for medical care prior to surgery in some plans.

Insurance actuaries in the past have stated 4 conditions are necessary to qualify an event as an insurance risk. These are (1) the loss must be substantial in order to be insurable, (2) it must not recur at regular intervals, (3) there must be a definable amount and (4) the loss must be beyond the control of the insured. In terms of a medical illness this would mean: a high total fee of a fixed amount, covering diagnosis which would be documented and having a statistical incidence over which the patient had no control. Thus, coronary occlusion, new diabetics, meningitis and rheumatic fever would qualify. Perhaps flat rate, comprehensive fee schedules should be adopted for such medical conditions.

Commission has Obligation

Certainly the problem of the medical man's fees as related to Third Party Payers is not simple in the light of the above discussion. The ISMA Commission on Medical Economics and Insurance has an obligation to the physicians of Indiana to seek a feasible solution.



"You'd better call the doctor! That fellow in 17 is really sick . . . he just proposed to me!"

A suggestion to increase the demand for medical benefits would be discussions with small groups of local union men regarding their satisfaction with their present health insurance coverage with the subtle suggestion that they initiate a grass roots program within their respective unions for medical coverage. This has been done successfully by our local Public Service Committee in reference to community medical service needs as noted by union members, business leaders, etc. We can hardly, as attending physicians, address patients with the advice to "buy better insurance because you have hypertension and will probably have a stroke, a coronary, or renal failure, and that costs like hell." The patient might seek a physician who has more optimism in his therapy.

The above might help with those persons covered by group insurance, but for the individual plans and particularly the retired or social security persons, the total cost has to be kept in mind else we price the entire policy out of his reach.

"Do you really love her?"

"Love her? Why I worship the ground her father struck oil on!"



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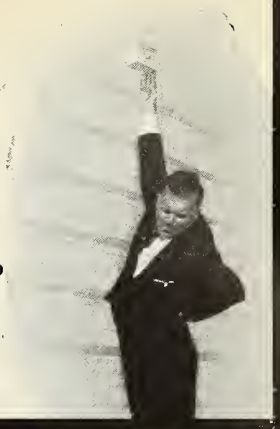
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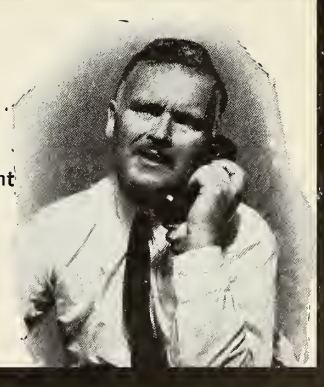
REACHING FOR THOSE 9B's NEARLY PUT ME ON THE SHELF...



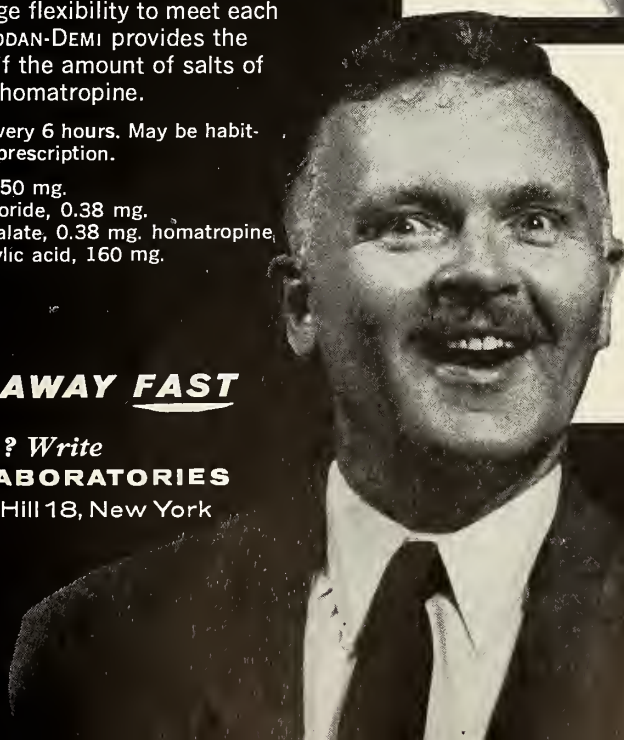
Reaching for 9B shoes and other top shelf sizes is no joke . . . it gave me a terrible kink in my back.



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I called my doctor that night and picked up the tablets he prescribed.



The pain went away fast—in just 15 minutes—and I was back on the job the next morning! But not one 9B customer came in the whole day!

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AND THE PAIN WENT AWAY FAST

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*U.S. Pat. 2,628,185

℞ for Society Ills

(Following is a copy of a letter which has been sent to the secretaries of the component county medical societies of the Fifth and Ninth Councilor Districts by Dr. Robert K. Webster, Council of the Fifth District, and Dr. Kenneth O. Neumann, Councilor of the Ninth District. The letter is published at the direction of the Council for the information of all ISMA members.)

There are a few matters which I wish to call to your attention and to the members of your society. Some of these are local, some district and some state.

In the next few weeks you will choose officers and committees for 1959. It is imperative that these selections be men who will *work!* In view of the recent election results, this is especially true. Therefore, the county officers must be willing and able to do their job. The chairman of the legislative committee and his members must study proposed legislation and see that their legislators and congressmen know how we doctors feel about legislation. Next the delegates must attend the entire session of the Indiana State Medical Association and be available for attendance at committee meetings and caucuses. The districts which accomplish their wishes have been there and organized.

The recent meeting of the Indiana State Medical Association was unfortunately rather unsuccessful. The attendance was poor for several reasons.

1. The program was not sufficiently interesting to attract doctors.

2. There were many specialty meetings in October.

3. There was a marked lack of interest in the exhibit, both commercial and scientific.

4. The instructional courses were not well attended.

5. There was and is a "don't give a dam attitude" and lack of interest in our meeting by the members at large.

The lack of interest in local and district meetings is quite evident. Several of us who are new councilors have begun a study to find out what is wrong in the societies in our districts. In the first place the councilors have been largely at fault because of their failure to visit the component societies and help to keep them informed of Indiana State Medical Association activities. In this connection please read the enclosed material concerning the duties, responsibilities and other requirements of a Councilor.

DO NOTHING BUT RAISE——

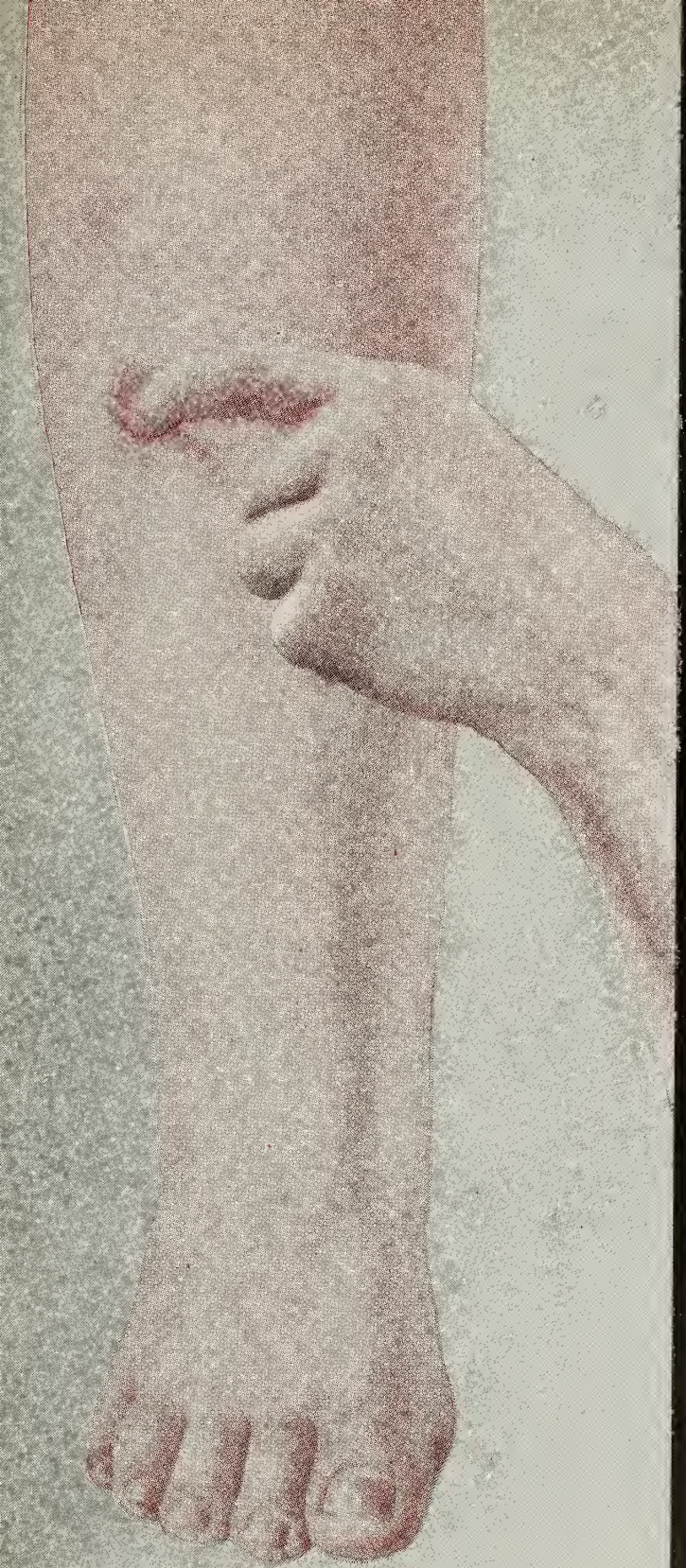
Secondly, there is a marked tendency to leave society affairs—county, district, and state—to a few and for the rest to do nothing but raise hell. The president-elect will ask some of you to serve on commissions and committees. For this you will receive mileage to Indianapolis and your dinner and NOTHING for your time, money and effort but your own personal satisfaction. We councilors receive mileage and meals for the meetings in January, April and July—*that is all.* Frankly, I estimate that two state meetings and four other meetings the last year have cost me a minimum of $1200.

It costs the president of the Indiana State Medical Association thousands of dollars to be president. He, too, receives only mileage, meals and some travel expense, the rest coming out of his own pocket. So far none has put up a kick but everyone should know the score.

Let's all see if we can't do a little more next year. In order to further increase my share, I will be glad to attend two or three meetings of your society next year if you will notify me of the time and place.

The discussion at the recent state meeting indicated that there was a great deal of mis-understanding and mis-information regarding the councilor district activities and the duties and responsibilities of the councilor and component societies.

Continued on 336



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1. Landes, R. P. and Peters, M.: Postgrad. Med. 23:648, June 1958.

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Continued from page 332

The change in the by-laws, as adopted at the 1958 meeting, will help clarify many of these problems. I am enclosing a copy of the By-laws regarding Councilor District Medical Societies. In addition, there are some additional comments I think are in order to clear up any confusion still remaining.

Contrary to opinions frequently expressed, the councilor receives no pay, no allowance and has no expense account from the state, district or local societies. He does receive mileage to and from the three council meetings held each year, but none for the state meeting.

There are thirteen councilor districts in the state —the Fifth District is composed of Vigo, Clay, Putnam and Parke-Vermillion societies with a total membership of approximately 175 doctors. A councilor is elected from each of the thirteen districts for a 3-year term, staggered so that one-third can change each year. They may serve only 2 successive terms. An alternate councilor is elected in each district in a year other than the year the councilor is elected and also serves 3-years. Your present councilor was elected in May, 1957 at the suggestion and on the motion of Dr. M. C. Topping who was the preceding councilor and also president-elect of the Indiana State Medical Association. My time of office was to begin in October 1957 instead of January 1958. This was at the Council meeting at French Lick.

An alternate councilor, Dr. V. Earle Wiseman, continued his duties. The duties of the councilor are covered in Chapter VII of the By-laws of the Indiana State Medical Association.

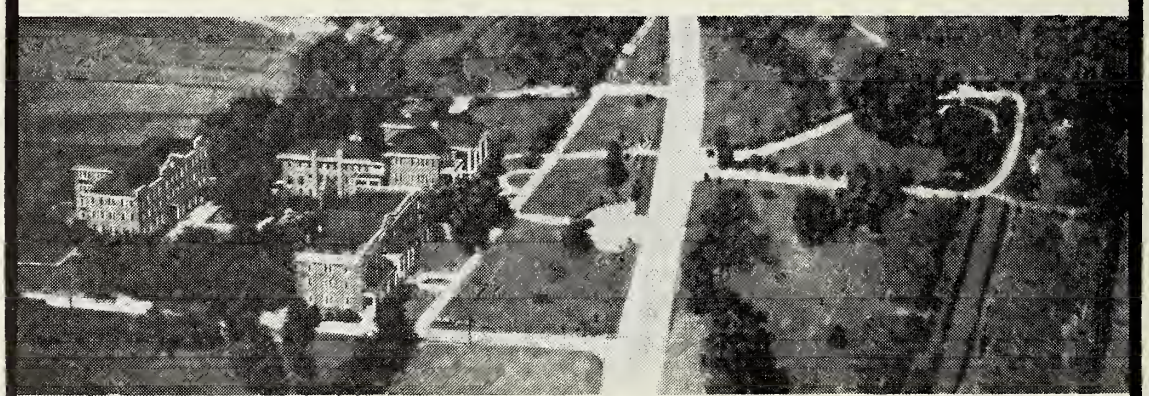
SUGGESTIONS FOR DOING!

In order that the councilor and the councilor district medical society may be more effective in the activities of the state society and perhaps to overcome some of the "power politics" in the state society (which has recently evoked so much disapproval in this district), the following suggestions are offered for your consideration.

1. In the event one of the component societies has some matter to present to the council, such information should be in the hands of the councilor by the first of the month preceding the meeting—namely, January 1, April 1, July 1 and October 1. It would be helpful if the facts were

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forwarded in writing, but it is hoped that many of these matters can be discussed at times when the councilor visits the various societies.

2. Each county society should carefully study the resolutions to come before the House of Delegates and instruct their delegate. If any society has a resolution to present to the House of Delegates, their delegate or alternate should appear before the reference committee to which the resolution is assigned. If the society's representative fails to appear and speak for the resolution, it receives little or no attention. If the councilor appears before the reference committee and the society's delegate does not, it appears as if the society has already lost interest in the resolution and nothing is accomplished.

In this connection it should be noted that much is accomplished between the meetings of the House of Delegates, and if effective representation is to be given to the societies, it is necessary for the delegates to be on hand during the entire session—not just the 2 meetings of the House—so that the district members can caucus and perhaps present a united front and at least be in a position to make their ideas and desires understood. It is trite to say that "silence often gives consent." It would be a good idea for the delegates to meet with the councilor in September after having studied the resolutions, etc., to be considered in the House of Delegates. Furthermore, they should meet during the state meeting.

3. An attempt is made to allocate memberships on commissions on a basis of population and interests of the various members. Each district has one representative on each commission. The presidents-elect in the past few years have made every effort to have each society indicate to them their members who have a special interest. Of course, not all can be appointed, but each society should recommend those members who are interested in a specific problem. It would be most helpful to provide the councilor a copy of these recommendations. If they are appointed, they owe it to their societies, as well as the district, to make every effort to attend and participate in every meeting of their commission.

Many of you have felt that your representation on reference committees was woefully inadequate. The suggestions made in regard to the commissions apply equally to the reference committees. It should be remembered that these are wholly the prerogative of the president and he must appoint those he feels will be most helpful to him.

4. Legislature meeting in 1959 will have important impact on the medical profession in licensing, chiropractic problems, registration fees, etc. It is imperative that each society designate one or two men who know and who can influence the thinking of legislators from their counties. This problem must be fought out on the local basis—you cannot expect the Legislative Committee and society officers to do the whole job. The legislators listen most to the people who can vote for them. After election, please notify the state office and the councilor of the names of these important contacts. Help them with letters, telegrams and personal contacts when requested.

QUIT 'DO NOTHING' ATTITUDE

5. The officers, field men, commissions, and councilors cannot do the entire job. It will take the active participation of each member and



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Rx for Society Ills

Continued

each society. Let's quit the "do nothing" attitude and all get to work and share some of the work and responsibility. If you are asked to do a job or are appointed to a job, please accept the responsibility and do it. If you cannot help, please let us know.

6. The next district meeting will be held in Terre Haute on May 20, 1959. The next Fifth District meeting is the responsibility of the Vigo Society. Good officers have been chosen. Let's hope they have your support and attendance.

It has been the custom in the Fifth District to rotate the meeting places on a regular schedule and permit the host society to name the district officers. We have no district dues, but in my opinion a nominal sum is in order, possibly only a dollar or two per year. This should be collected by the county secretaries and given to the district secretary-treasurer.

I should like to hear suggestions from each of the county societies as to the make-up of the Constitution and By-laws for the district society before January 1, 1959. A rough draft will then be drawn up and forwarded to each of the societies before the annual meeting.

NOTE: The above is the letter and material sent out by Doctor Webster. Doctor Neumann sent similar matter to his District, making it applicable to his district.

CHAPTER XXVI of BYLAWS
COUNCILOR DISTRICT MEDICAL SOCIETIES

SECTION 1. A Councilor District Medical Society, hereinafter called the District Society, shall be a society whose members consist of the members of the County Medical Societies in the Counties which constitute the Councilor District, provided such members of County Medical Societies have paid their membership dues in the District Society.

SECTION 2. The State shall be divided into thirteen (13) Councilor Districts.

SECTION 3. Each District Society shall adopt a Constitution and By-laws which shall not conflict with the Constitution and By-laws of the State Association, and only one District Society shall exist within any one Councilor District. The authorized District Society in each Councilor District shall receive a charter from the State Association, and the Secretary of the District Society shall have custody of the charter.

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SECTION 4. Each District Society shall organize by electing a President, a Secretary, and a Treasurer and a Councilor and Alternate Councilor as the current Councilor term and Alternate Councilor term for the District expires, and such others as may be provided for in its Constitution and By-laws. The office of Secretary and Treasurer may be held by the same physician. The Councilor shall continue to have the same duties and terms as are set forth in the Constitution and By-laws of this Association.

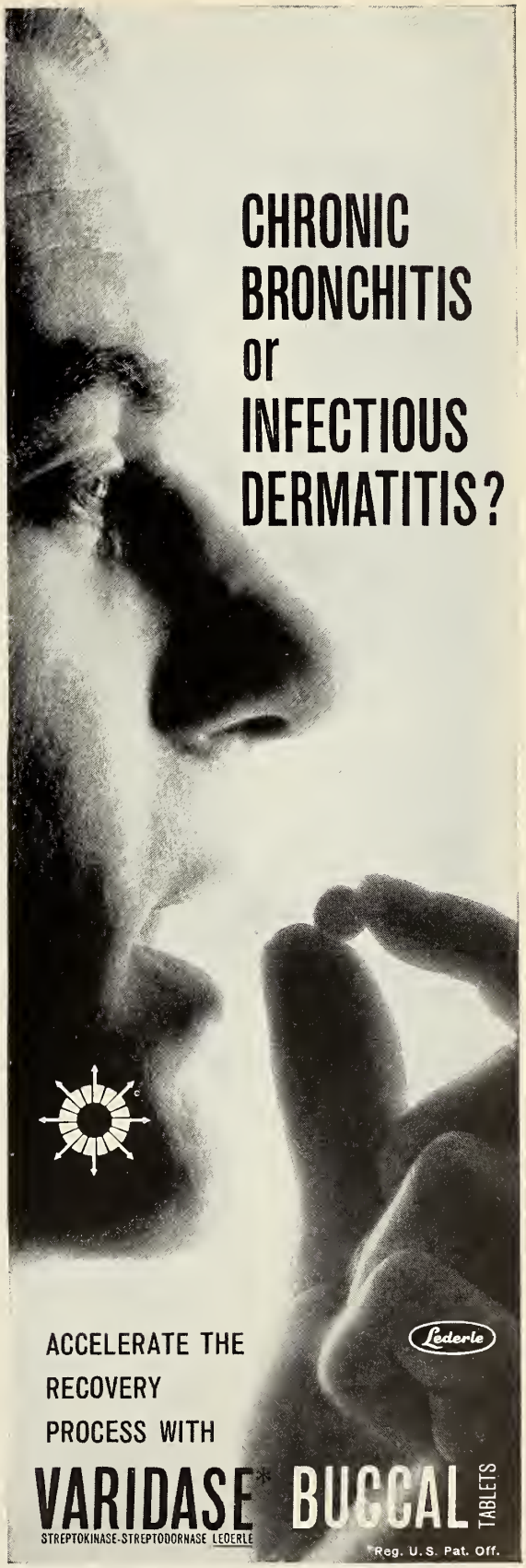
SECTION 5. The dues of the District Society in an amount fixed by the District Society to meet the District Society needs, shall be collected by the Secretaries of the component County Societies and delivered to the Treasurer of the District Society. The Secretary of each District Society shall report to the office of the State Association the names and addresses of the members of his District Society, together with a copy of the minutes of each meeting of the District Society.

SECTION 6. Each District Society shall meet at least once each year at a time and place to be fixed by the District Society. On or before January 1st of each year each District Society shall notify the headquarters of the State Association of the time and place of the annual District meeting for that year; but if no such notification has been received in the headquarters on or before the January meeting of the Council, the Councilor shall fix the time and place of the District meeting, and notice of such meeting shall be sent to the members of the county medical societies in such District.

SECTION 7. Whenever a District Society is to elect a Councilor and/or Alternate, the headquarters office of the State Association shall so notify the individual members of such District Society not later than the first of March of the year in which the election is to occur.

SECTION 8. The District Society shall send to the headquarters office of the State Association a copy of its program showing the time and place of its meetings, early enough that the headquarters office may notify all members within the District of the meeting at least thirty (30) days prior to the date thereof.

It's a strange world: Sometimes a man who is too scared to visit his doctor will still race a train to a crossing!



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

to the editor:

December 30, 1958

We wish to call your attention to an error in the current (December, 1958) issue of the *J.I.S.M.A.* under the treatise "Pharmacologic Treatment of Geriatric Mental Patients" by Elwood Phipps and Frank Hogle.

Our product Metalex, supplied for the study, does not contain nicotinamide, but rather nicotinic acid. We have found that the flushing effect experienced with the latter is far superior than that experienced with nicotinamide.

There is a definite synergistic action between nicotinic acid and pentylenetetrazol, which will not be evident when nicotinamide is substituted. Metalex has been on the pharmaceutical market for 4 years now and has always contained nicotinic acid.

We sincerely appreciate your publishing this article and trust that a correction can be made to coincide with the product that so many Indiana physicians are using effectively.

Kindest personal regards.

Gratefully,

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Tom E. Fleming

About August 1 every year an Arizona church puts this sign on its bulletin board:
"You think it's hot here?"



"Now, as I understand it, your false teeth have been chattering ever since you went under the polar icecap with the Nautilus."

Abstract:

THE INFLUENCE OF AN ANDROGEN-ESTROGEN-THYROID MIXTURE ON NITROGEN BALANCE AND CLINICAL STATUS OF OLDER PERSONS, by Thomas H. McGavack, M.D., Winnifred Seegers, M.D., Hans Bauer, M.D., Maria Krawzoff, M.D., Helmut Haar, M.D., Josef Enzinger, M.D., and Herley Fujiy, M.D.

The West Virginia Medical Journal

January, 1959 Vol. 55, No. 1

Although declining endocrine function is not the primary cause of aging, it is frequently associated with the aging process. The administration of gonadal and thyroid hormones has been suggested, with considerable enthusiasm by many observers, for the prevention and palliation of certain phenomena associated with senescence.

This group of investigators studied 74 aging individuals who were apparently free from acute disease and endocrine dysfunction. The therapy used was a tablet containing: Methyltestosterone 2.5 mg; ethinyl estradiol 0.01 mg; and thyroglobulin ¼ gr.

Eight patients (4 men and 4 women) were subjected to detailed metabolic and endocrine studies. In general there was an increase in nitrogen retention of from 1.1 Gm/day to 2.5 Gm/day in both men and women. There was a decrease in 17-ketosteroids in all men studied, but no change occurred in the 17 ketosteroid excretion in the women.

All of the subjects gained weight but basal metabolism was not significantly altered. The color of the skin, became a deeper pink in all eight subjects, and all of women patients showed significant increases in scores of psychometric tests during periods of the therapy, while no change occurred in the men.

Clinical observation only, of 66 patients revealed 75% experienced some improvement in mental activity and a general sense of well-being after 3 to 9 weeks of treatment. The younger subjects appeared to improve more than the older individuals. If no benefit occurred after 9 weeks of therapy, longer treatment was ineffective.

Some untoward effects were noted in hyperthyroid patients and patients with advanced marked cardiac disease and extensive arteriosclerosis. Vaginal bleeding occurred in two women.

This study indicates that therapy with androgenic, estrogenic and thyroid hormones benefits some aging individuals but is by no means to be considered to be a fountain of youth.

David A. Bickel, M. D.

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Clinical Pictures of Body Fluid Imbalances

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Evansville

SINCE the emergence of medicine as a scientific discipline the approach to the diagnosis and management of disease has been chiefly clinical. Our introduction as medical students to such disease entities as rheumatic fever, appendicitis, diphtheria, lobar pneumonia, the contagious diseases, and indeed, to almost all disease states, was an introduction to "clinical pictures." Each clinical picture was a sort of composite that included, in general, the natural history and clinical causes of the disease plus the clinical findings, which included such *subjective* findings as symptoms and such *objective* findings as physical findings and laboratory data.

The approach to the study of imbalances of the body fluids has, in general, been quite different. Body fluid imbalances have been regarded as a sort of "biochemical appendage" of disease states. The study of body fluid imbalances has been chiefly incidental to the study of other disease states. There are thousands of disease listings in the standard disease nomenclatures, and many of these have body fluid imbalances that accompany them. These body fluid imbalances are by no means stereotyped for each disease state even though some disease states have imbalances that are fairly characteristic.

To learn body fluid imbalances as incidentals to disease states imposes a task that is too great for any but the expert or the physician who spends most of his time working in the area of fluid balance. The futility of the approach can be seen when one considers that such a condition as burns, for example, or diabetes mellitus or infantile diarrhea can be accompanied by almost any body fluid imbalance or almost any combination of imbalances at various stages in their respective developments. Stimulated by the basic suggestions of Moyer, the author has attempted

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Figure 1—Body fluid imbalances represent disease states, usually caused by disparities between intake and output of water and electrotypes.

to analyze body fluid disturbances and classify them as clear-cut, clinical pictures on the basis of a systematic classification.

Body fluid imbalances represent disease states that are usually caused by disparities between intake and output of water and electrolytes. In health there is a balance between gains and losses of these substances. In disease one may have an abnormal decrease or increase in either intake or output of either water or electrolytes. See Figure 1.

In addition to abnormalities in intake and output of either water or electrolytes, some disease states are characterized by immobilization of water and electrolytes within the body. As an example, certain electrolytes may be immobilized in pooling that occurs in certain disease states as ascites; or, an imbalance may result from increased utilization of water and electrolytes, or both, that characterizes other disease states such as infectious disease with high fever. Various derangements in the volume, composition and concentration of the body fluids can be caused by mal-functioning of the organs of homeostasis, chiefly:

- The Lungs
- The Kidneys
- The Heart
- The Vascular System
- The Adrenal Glands
- The Pituitary Gland (anterior and posterior)
- The Parathyroid Glands

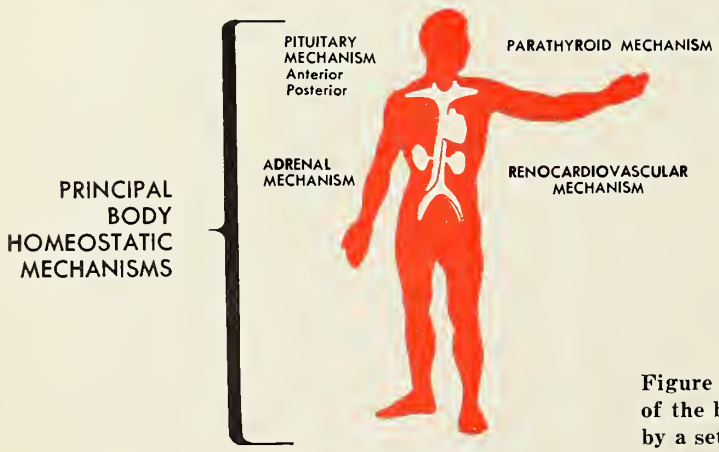
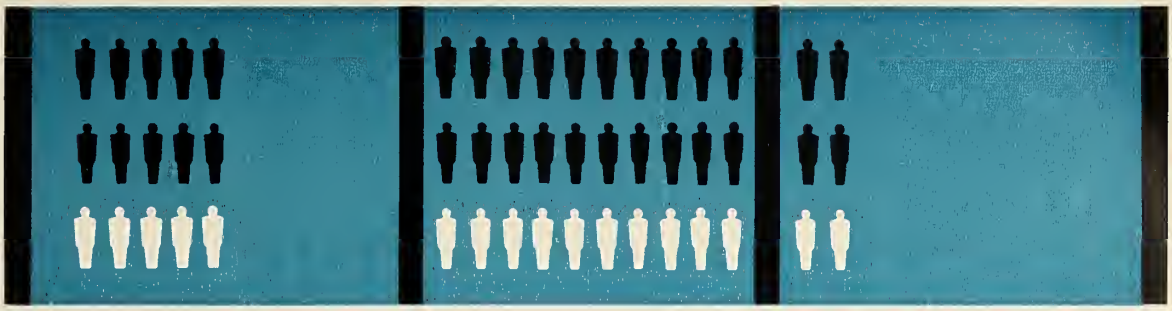


Figure 2—The physico-chemical constancy of the body fluids are maintained in health by a set of automatic controls

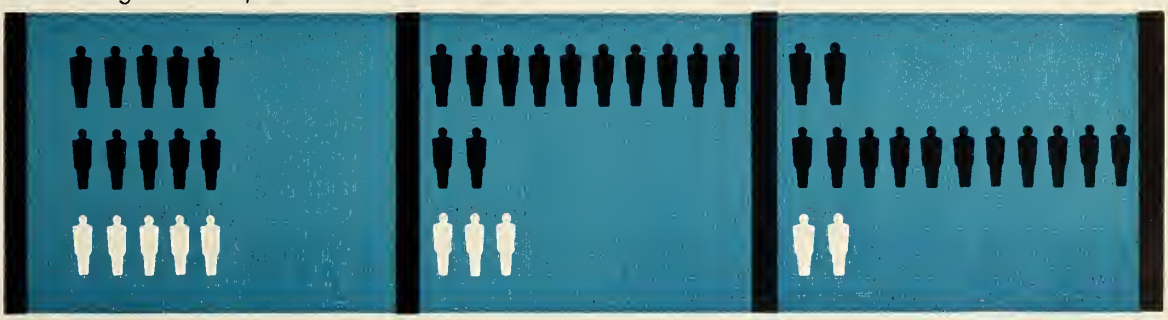
• Changes in concentration of electrolytes



Changes in electrolyte concentration correspond to changes in population density.

Figure 3

• Changes in composition



Changes in electrolyte composition correspond to changes in racial cross-section.

Figure 4

Fortunately, this group of imbalances represents a minority group. See Figure 2.

Systematic Classification

In view of the great number and variety of factors which may lie at the root of imbalances of the body fluids it might seem at first glance that an attempt at systematic classification is doomed to failure. Such, fortunately, is not the case, for the body fluid imbalances can be logically divided into 17 imbalances, each with its own clinical picture. Some of these imbalances may exist alone; for example, electrolyte concentration deficit. Others are chiefly secondary to primary disease states; for example, primary base bicarbonate deficit. Some pictures may exist chiefly alone as more or less "pure" imbalances. Others may exist in combination. Not infrequently a succession of imbalances may follow one another. For example, a child with an acute severe diarrhea who is untreated may first suffer from an extracellular fluid volume deficit. A little later he develops, in addition, a primary base bicarbonate deficit. To these may be added a potassium deficit, and finally, an electrolyte concentration excess.

In a real sense body fluid imbalances can be regarded as *clinical entities;* like other clinical entities, they modify and are modified by coexisting pathologic states. The fact that imbalances are frequently mixed does not relieve the clinician of the necessity of recognizing the individual clinical pictures of specific imbalances any more than it relieves medical students of the necessity of learning the individual clinical pictures of pulmonary tuberculosis, viral hepatitis or ulcerative colitis. Such clinical entities, like those of fluid imbalances, may be confusingly intermingled.

For the many practitioners who have few or no laboratory facilities available, familiarity with the clinical approach is especially valuable. It is also helpful to those who do not have emergency 24-hour laboratory service at hand and who must assess a patient, make a diagnosis and proceed with therapy while awaiting a laboratory report.

Basic Imbalances

Of the 17 basic imbalances, each with its own clinical picture, 12 of the imbalances stem from changes in *properties* of extracellular fluid. These properties include volume, electrolyte con-



Figure 5

centrations (that is, total concentration of electrolytes per liter) and electrolyte composition. The imbalances in properties include:

- VOLUME IMBALANCES
 - Extracellular Fluid Volume Deficit
 - Extracellular Fluid Volume Excess
- CONCENTRATIONAL IMBALANCES
 - Electrolyte Concentration Deficit
 - Electrolyte Concentration Excess
 - (See Figure 3)
- COMPOSITIONAL IMBALANCES
 - Potassium Deficit
 - Potassium Excess
 - (See Figure 4)
 - Calcium Deficit
 - Calcium Excess
 - Primary Base Bicarbonate Deficit (metabolic acidosis)
 - Primary Base Bicarbonate Excess (metabolic alkalosis)
 - Primary Carbonic Acid Deficit (respiratory alkalosis)
 - Primary Carbonic Acid Excess (respiratory acidosis)

Perhaps in the not far distant future imbalances involving magnesium and other electrolytes may be included.

There is a second type of imbalance characterized by changes in *position* of extracellular fluid. Normally, one-fourth of the extracellular fluid exists as plasma, and three-fourths as interstitial fluid. Under varying clinical conditions there are two types of shifts which may develop:

- Plasma to interstitial fluid shift (Shift of water and electrolytes from plasma to interstitial fluid)
- Interstitial fluid to plasma shift (Shift of water and electrolytes from plasma to interstitial fluid)

(See Figure 5)

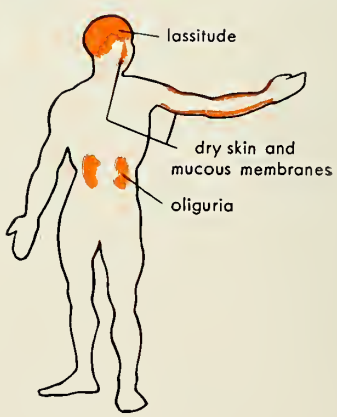
Finally, there are three imbalances characterized by changes in *position* of extracellular fluid. body. These are all in the nature of *deficits,* and they include:

- Protein Deficit
- Calorie Deficit
- Vitamin Deficit

The following discussion will present thumbnail sketches of clinical pictures of the 17 basic fluid imbalances. These sketches provide informational hooks on which to hang the considerable body of information required for practical mastery of the subject.

Volume Deficit

The first of the imbalances characterized by changes in properties of extracellular fluid is EXTRACELLULAR FLUID VOLUME Deficit. This deficit results from decreased intake of water and electrolytes, as in infectious disease, or from acute loss of water and electrolytes, as in vomiting. KEY CLINICAL FINDINGS include lassitude, dry skin and mucous membranes, and oliguria. There is weight loss.



CHANGES IN PROPERTIES OF EXTRACELLULAR FLUID

Figure 6—Volume Deficit

A laboratory finding is elevated hemoglobin, since the volume of the plasma is decreased. See Figure 6.

Volume Excess

The next imbalance is VOLUME EXCESS, caused by excessive retention of water and electrolytes, when so-called "Normal Saline" is given in excessive quantities or when excessive retention of water and electrolytes occurs in congestive heart failure. KEY CLINICAL FINDINGS include puffy eyelids, moist rales in the lungs and pitting edema. There is rapid weight gain. A laboratory finding is decreased hemoglobin, since the plasma volume is increased. See Figure 7.

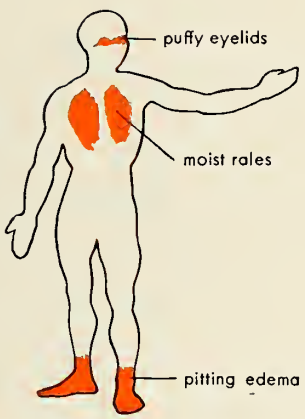


Figure 7—Volume Excess

Electrolyte Concentration Deficit

The next clinical picture, ELECTROLYTE CONCENTRATION DEFICIT, is caused by loss of water and electrolytes replaced by water only. Excessive sweating followed by drinking of water may bring it on. So may drinking water while gastrointestinal suction tubes are removing water and electrolytes. The imbalance may result from excessive loss of electrolytes from the body as in adrenal insufficiency. KEY CLINICAL FINDINGS include apprehension, abdominal cramps and diarrhea. The plasma sodium level is characteristically below 137 mEq./L. and the specific gravity of the urine below 1.010. See Figure 8.

Electrolyte Concentration Excess

ELECTROLYTE CONCENTRATION EXCESS results when water intake is decreased or when there is excessive loss of water through

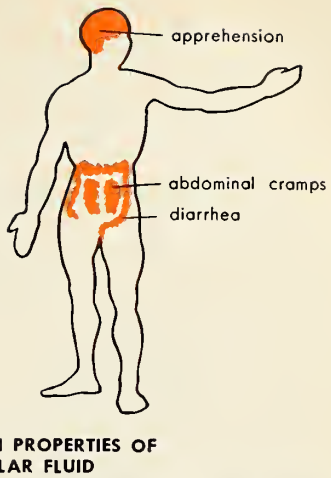


Figure 8—Electrolyte Concentration Deficit

rapid and deep breathing as in tracheobronchitis. It may also result when water in excess of electrolytes is lost in copious, watery diarrhea or in the urine of untreated diabetes insipidus. KEY CLINICAL FINDINGS include excitement progressing to mania; dry, sticky mucous membranes; and oliguria. The plasma sodium may rise above 147 mEq./L. and the specific gravity of the urine above 1.030. See Figure 9.

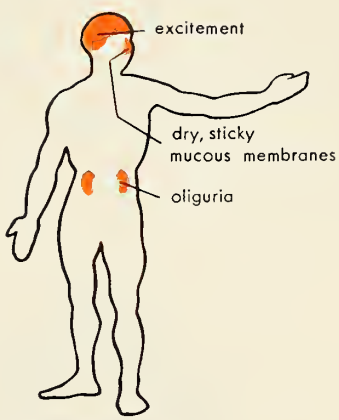


Figure 9 — Electrolyte Concentration Excess

Potassium Deficit

POTASSIUM DEFICIT results when there is excessive loss of potassium-rich secretions as in severe vomiting, ulcerative colitis or infantile diarrhea. It may occur when there is increased utilization of potassium as in the healing phase of burns and in recovery from diabetic acidosis.

The KEY CLINICAL FINDINGS include anorexia, muscles soft (like half-filled water bottles) and silent intestinal ileus. The plasma potassium is usually below 4 mEq./L. See Figure 10.

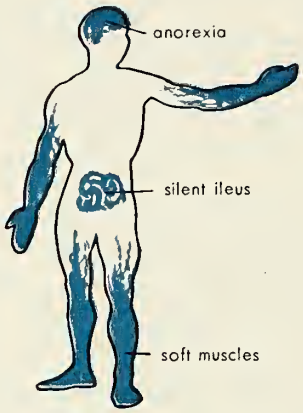


Figure 10—Potassium Deficit

Potassium Excess

POTASSIUM EXCESS results from retention of potassium in the body and may occur in severe kidney disease, excessive release of potassium due to burns or crushing injuries, or with excessive parenteral administration of potassium. It may be caused by excessive retention of potassium due to adrenal insufficiency. KEY CLINICAL FINDINGS are oliguria progressing to anuria, intestinal colic and diarrhea. The plasma potassium is usually above 5.6 mEq./L. See Figure 11.



Figure 11—Potassium Excess

Calcium Deficit

CALCIUM DEFICIT is caused by excessive loss of calcium from the body as in the steatorrhea of sprue. It also occurs when calcium from the body fluids is immobilized in acute pancreatitis, massive subcutaneous infections or generalized peritonitis. It may occur when the parathyroid glands become hypoactive as with excessive surgical removal. It may result from the inactivation of calcium by excessive administration of citrated blood. The KEY CLINICAL FINDINGS include tetany, tingling of the fingers and muscle cramps. The plasma calcium is characteristically below 4.5 mEq./L. and the Sulkowitch test on urine fails to show precipitation. See Figure 12.

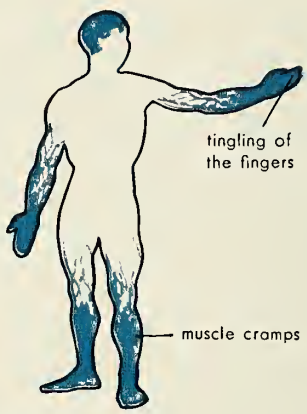


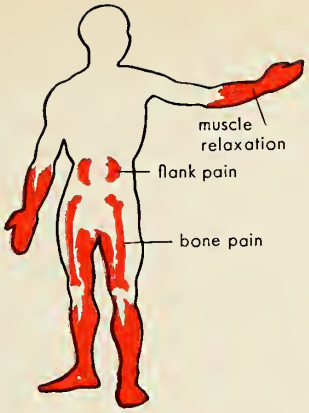
Figure 12—Calcium Deficit

Calcium Excess

CALCIUM EXCESS results from excessive mobilization of calcium because of overactivity of the parathyroid glands, tumor of the parathyroid glands, or with excessive administration of Vitamin D. The KEY CLINICAL FINDINGS include relaxed muscles, flank pain from kidney stones and deep bony pain; for example, in the thighs. The plasma calcium is characteristically above 5.8 mEq./L. and the urinary output of calcium as evidenced by the Sulkowitch test is greatly increased. See Figure 13.

Acid-Base Imbalances

The next 4 changes in composition of extracellular fluid include DEFICIT and EXCESS of CARBONIC ACID and BASE BICARBONATE. They are usually designated the ACID-BASE IMBALANCES. In their inti-



CHANGES IN PROPERTIES OF EXTRACELLULAR FLUID

Figure 13—Calcium Excess

mate chemistry they result from abnormalities in hydrogen ion concentration of the extracellular fluid. The cation hydrogen is present in extracellular fluid in such tiny quantities that we do not include it in our classification, but the concentration of hydrogen is immensely important from the standpoint of health. When this concentration lies within certain narrow limits, the patient's extracellular fluid is physiologically neutral.

When the concentration of hydrogen ions is abnormally increased, the extracellular fluid becomes relatively acidic and the patient is said to be in acidosis. When the concentration of hydrogen ions is abnormally low, the reaction of the extracellular fluid becomes alkaline, or basic, and the patient is said to be in alkalosis. What is it that determines this concentration? Carbon dioxide unites with water in the extracellular fluid to form CARBONIC ACID. The cation sodium balances the anion bicarbonate to form an extracellular fluid complex known as BASE BICARBONATE.

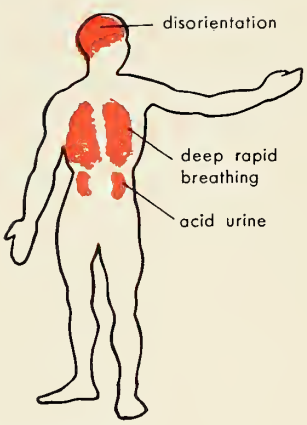
Now it is the ratio of the carbonic acid to the base bicarbonate of the extracellular fluid that determines the concentration of hydrogen ions in the extracellular fluid.

As long as there is one unit of carbonic acid for each 20 units of base bicarbonate in the plasma the hydrogen ion concentration lies within limits of normal. Visualize a mythical acid-base teeter-totter with one unit of carbonic acid resting on the left side and 20 units of base bicarbonate on the right. Any condition that tilts the teeter-totter to the left causes acidosis. Anything that tilts it to the right causes alkalosis.

Let us now examine the 4 acid-base imbalances as they appear clinically. Two general types of disturbances tilt our teeter-totter. Metabolic disturbances affect the base bicarbonate or right side.

Primary Base Bicarbonate Deficit

The first metabolic disturbance is BASE BICARBONATE DEFICIT, usually called METABOLIC ACIDOSIS. It is caused by any clinical event which decreases the amount of base bicarbonate. Thus, the acidic ketones of uncontrolled diabetes mellitus displace base bicarbonate, disturbing the ratio and tilting the teeter-totter to the left. When excess chloride is introduced into the body, base bicarbonate is similarly displaced. The KEY CLINICAL FINDINGS include disorientation, shortness of breath on exertion, deep rapid breathing and acid urine. The plasma bicarbonate, which reflects the amount of bicarbonate on the teeter-totter, is depressed below normal. See Figure 14.



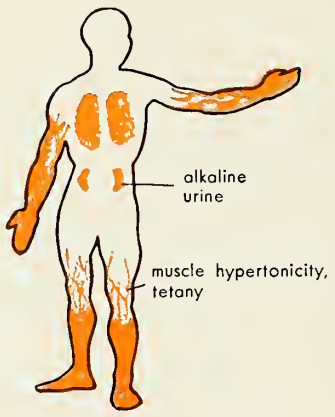
CHANGES IN PROPERTIES OF EXTRACELLULAR FLUID

Figure 14—Primary Base Bicarbonate Deficit

Primary Base Bicarbonate Excess

BASE BICARBONATE EXCESS, usually called METABOLIC ALKALOSIS, is caused by any clinical event which weights the base bicarbonbate side of the balance. Excessive ingestion of sodium bicarbonate causes such a weighting. When chloride is lost as in vomiting or gastric suction, the bicarbonate anions must increase in compensation since the total cations must always equal the total anions. Either situation tilts the teeter-totter to the right. Alkalosis is present. KEY CLINICAL FINDINGS

include tetany, muscle hypertonicity and alkaline urine. Plasma bicarbonate is usually elevated. See Figure 15.



CHANGES IN PROPERTIES OF EXTRACELLULAR FLUID

Figure 15—Primary Base Bicarbonate Excess

Primary Carbonic Acid Deficit

Respiratory disturbances affect the carbonic acid or left side of the teeter-totter. Consider, first, CARBONIC ACID DEFICIT, caused by any condition which results in increased rate and depth of breathing with blowing off of carbon dioxide. Recall that carbonic acid of the extracellular fluid is the source of carbon dioxide blown off in the lungs. Excessive blowing off of carbon dioxide reduces the amount of carbonic acid in the extracellular fluid and causes the teeter-totter to tilt to the right. Alkalosis is present. Clinical conditions causing increased rate and depth of breathing include oxygen lack, fever and high temperature. KEY CLINICAL FINDINGS include tetany, deep rapid breathing and alkaline urine. The plasma bicarbonate is depressed from the normal. See Figure 16.

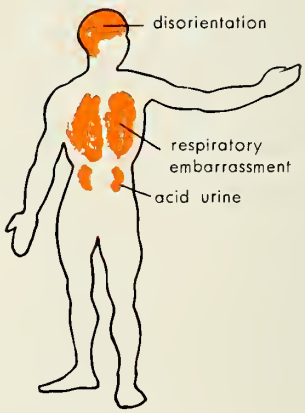


CHANGES IN PROPERTIES OF EXTRACELLULAR FLUID

Figure 16—Primary Carbonic Acid Deficit

Primary Carbonic Acid Excess

CARBONIC ACID EXCESS results when carbon dioxide is retained with a resultant retention and increase of carbonic acid in the extracellular fluid. It is caused by conditions which suppress respiration such as pneumonia, emphysema and morphine poisoning. There is a weighting of the carbonic acid side of the teeter-totter, which tilts to the left. Acidosis is present. KEY CLINICAL FINDINGS include disorientation, respiratory embarrassment and acid urine. The plasma bicarbonate level is above normal. See Figure 17.



CHANGES IN PROPERTIES OF EXTRACELLULAR FLUID

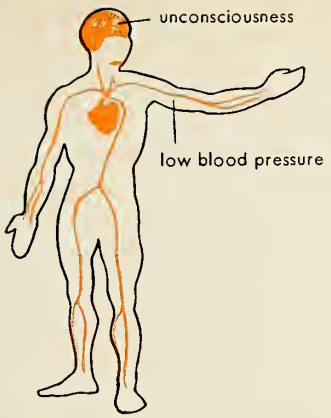
Figure 17—Primary Carbonic Acid Excess

Plasma-to-Interstitial Fluid Shift

Now let us consider changes in POSITION of extracellular fluid. The first involves a shift of water and electrolytes from the plasma into the interstitial fluid, a PLASMA-TO-INTERSTITIAL FLUID SHIFT. The mechanism of this shift is not known, but is probably neurogenic in nature. It includes such clinical occurrences as burns, massive crushing injuries and perforated peptic ulcer. KEY CLINICAL FINDINGS include pallor, low blood pressure and unconsciousness. The hemoglobin is elevated since water and electrolytes have shifted FROM the plasma. See Figure 18.

Interstitial Fluid-to-Plasma Shift

An INTERSTITIAL FLUID-TO-PLASMA SHIFT of water and electrolytes can re-



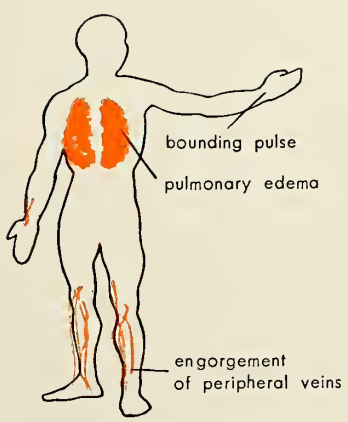
CHANGES IN POSITION OF EXTRACELLULAR FLUID

Figure 18 — Plasma-to-Interstitial Fluid Shift

sult from excessive intravenous administration of hypertonic solutions such as serum albumin, plasma or dextran. The osmotic effect of such solutions draws water and electrolytes from the interstitial fluid. It can occur in recovery from a plasma-to-interstitial fluid shift. One may have an interstitial fluid-to-plasma shift which is compensatory in nature following the internal or external loss of whole blood. KEY CLINICAL FINDINGS include pulmonary edema, engorgement of peripheral veins, and bounding pulse. The hemoglobin is decreased in interstitial fluid-to-plasma shift, since there is an excess of water and electrolytes in the plasma. See Figure 19.

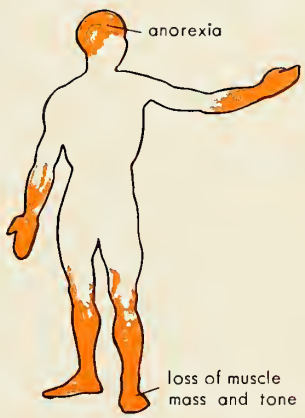
Protein Deficit

Finally, let us consider 3 changes in the nutritional status of the body. The first is PROTEIN DEFICIT and is caused by any condition involving loss of protein from the body such as severe hemorrhage, burns, draining ulcers, by increased utilization of protein as in severe trauma, or by inadequate intake of food as in starvation. KEY CLINICAL FINDINGS include fatigue, loss of muscle mass and tone and anorexia. There is also loss of weight. The plasma albumin level may be below 4.0 Gm./100 ml. See Figure 20.



CHANGES IN POSITION OF EXTRACELLULAR FLUID

Figure 19 — Interstitial Fluid-to-Plasma Shift

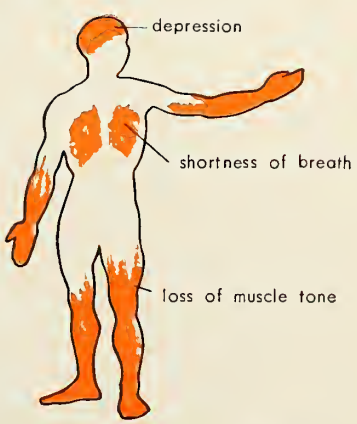


CHANGES IN NUTRITIONAL STATUS OF BODY

Figure 20—Protein Deficit

Caloric Deficit

CALORIC DEFICIT results from decreased intake of calories as in starvation or from increased utilization of calories. Automatically, caloric deficit leads to protein deficit as body tissues are burned for energy purposes. KEY CLINICAL FINDINGS include mental depression, shortness of breath and loss of muscle tone. Acetonuria may be found. See Figure 21.

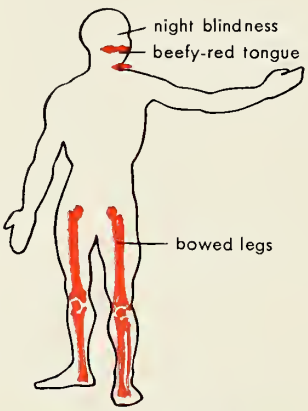


CHANGES IN NUTRITIONAL STATUS OF BODY

Figure 21—Caloric Deficit

Vitamin Deficit

VITAMIN DEFICITS result from decreased intake of vitamins as in starvation or from increased utilization of vitamins as in chronic infectious disease or severe injury. KEY CLINICAL FINDINGS may include the night blindness of Vitamin A deficiency, the beefy-red tongue of B deficiency and the bowed legs of rickets. The x-ray findings on examination of the bones in Vitamin C deficiency and Vitamin D deficiency are characteristic. See Figure 22.



CHANGES IN NUTRITIONAL STATUS OF BODY

Figure 22—Vitamin Deficit

It should be borne in mind that the thumbnail sketches just presented are indeed **sketches** in the sense of being extremely *sketchy*. The clinical pictures have been presented in detail in the following references:

- Snively, W. D., Jr. and Sweeney, M. J.: *Fluid Balance Handbook for Practitioners,* Springfield, Illinois, Charles C Thomas, 1956.
- Snively, W. D., Jr. and Wessner, M.: The A B C 's of Fluid Balance, *J. Ind. State Med. Assoc.* 47:957-972 (Sept.) 1954.
- Snively, W. D., Jr. and Sweeney, M. J. and Wessener, M. L.: Systematic Approach to Fluid Balance, *GP* 13:74-86 (Jan. and Feb.) 1956.
- Snively, W. D., Jr. and Brown, B. J.: In the Balance, *The Am. J. of Nursing* 58:55-57 (Jan.) 1958.

In analyzing the symptomatology of the clinical pictures it is interesting to note that actually a relatively small number of findings are responsible for the various clinical pictures.

Systematic Diagnosis

When the physician is familiar with the clinical pictures of fluid imbalance, he is then in a position to analyze a patient with potential disturbances of the body fluids in a systematic manner, evaluating him from the standpoints of extracellular fluid volume, electrolyte concentration of the extracellular fluid, electrolyte composition of the extracellular fluid, possible shifts of water and electrolytes from plasma to interstitial space and vice versa, and from the standpoint of nutritional deficits. The physician then is possessed of a rational "three-dimentional" diagnosis, and such a diagnosis is a logical prelude to effective therapy.

Armed with knowledge of the several clinical pictures of fluid imbalances, the physician is in an excellent position to approach the diagnosis in the case of any ill patient suspected of having an imbalance of the body fluids. Suppose he has a patient whose intake of water and electrolytes has been abruptly decreased because of infectious disease. At the same time his output, through vomiting and losses through the skin, has increased. The physician knows that this patient is a likely candidate for an extracellular fluid volume deficit. Knowledge of the clinical findings of this deficit, plus information concerning acute weight loss and laboratory findings, helps make the diagnosis certain indeed.

Suppose the physician has a patient with a history of excessive losses of potassium-rich secretions, such as might occur in ulcerative colitis. From the history of the disease he knows that this patient is a candidate for potassium deficit, particularly if the patient's intake of food has decreased. Clinical findings of this deficit, plus laboratory findings, confirm his suspicions based on the history.

Given a patient with a massive crushing injury who is pale, has low blood pressure and is perhaps unconscious, the physician has the clue to a plasma-to-interstitial fluid shift. The diagnosis would be corroborated by an elevated hemoglobin.

The patient who has been breathing unduly deeply, perhaps due to hysteria, oxygen lack or high temperature, will immediately be considered by the physician as a candidate for primary carbonic acid deficit because of his excessive blowing-off of carbon dioxide.

The patient with acute pancreatitis will immediately be suspected of having a calcium deficit, since the physician knows that this is one of the causes of acute calcium deficit. The physician's suspicions will be corroborated if the patient has tingling of the fingers, muscle cramps and laboratory findings typical of calcium deficit.

Again, the patient who has lost large quantities of a chloride-rich secretion such as gastric juice will, the physician knows, be a candidate for base bicarbonate excess since with loss of chloride the base bicarbonate increases in compensation. The physician will also recall that such a patient is a candidate for potassium deficit, too, and when he corrects the base bicarbonate excess by giving chloride, he will give potassium at the same time.

A physician familiar with the clinical picture concept will, confronted by a patient who has suffered repeated severe hemorrhages, burns, draining ulcers or severe trauma, be on the alert for protein deficit. Given such key clinical findings as fatigue, loss of muscle tone and anorexia, his suspicions will be corroborated. If there has been loss of weight and the plasma albumin level depressed also, there can be no question concerning the diagnosis.

The patient who has perspired excessively and then drunk water is a likely prospect for electrolyte concentration deficit. Given a positive history and key clinical findings such as apprehension and abdominal cramps, the physician immediately has a basis for a diagnosis. . . .

And so, one could go through the several imbalances. It should be borne in mind that imbalances are frequently compounded by other imbalances. For example, an infant with acute diarrhea that is not properly treated can progress from acute extracellular fluid volume deficit to a primary base bicarbonate deficit. Grafted on these two, after a few days, can be a potassium deficit, and a little later, an electrolyte concentration excess due to the loss of watery diarrhea secretions. The physician with knowledge of clinical pictures of fluid balance will not permit the situation to advance to such a sad state.

A patient with diabetic ketosis frequently presents a number of imbalances including extracellular fluid volume deficit, primary base bicarbonate deficit and potassium deficit. A patient who is unwisely given an excessive quantity of isotonic solution of sodium chloride can present the picture of extracellular fluid volume excess. If an infectious process has been present, excessive saline can well tip the scales in favor of a base bicarbonate deficit by imposing an excessive chloride load on the kidneys.

A systematic approach to diagnosis is of first importance in properly evaluating the patient with fluid imbalances. First, a careful clinical history should be taken, jotting down facts suggestive of specific imbalances. The past intake and output of fluid should be reviewed with particular emphasis on the previous one or two days. Answers to such questions as the following should be obtained:

- Has the patient been eating and drinking normally?
- Have therapeutic fluids been given by tube, rectum or parenterally?
- Have abnormal losses of body fluids occurred as of normal perspiration, vomiting, gastric or intestinal suction, enterostomy, drainage, liquid stools, wound or burn exudate?

Sometimes a rough estimate of the intake-output record can be obtained from the history. In carrying out the physical examination the physician should list findings that may indicate a specific clinical picture. Laboratory findings should be studied. Now, with pertinent data available from the clinical history, physical examination and laboratory values, the patient has a *solid basis* for a systematic diagnosis, which should include both the imbalances present and their approximate severity. For example, the diagnosis on a given patient might read as follows:

- Changes in properties of extracellular fluid
 Moderate fluid volume deficit
 Slight electrolyte concentrate excess
 Slight base bicarbonate deficit
- Changes in position of extracellular fluid
 None
- Changes in nutritional status of the patient
 Moderate protein deficit

Conclusion

We have now sketched the 17 basic clinical pictures of imbalances of the body fluids. While a patient whose body fluids have been disturbed may suffer from only one fluid imbalance, most patients will manifest a combination of 2 or more imbalances. Just as knowledge of the clinical characteristic of individual diseases is required for the diagnosis and treatment of a patient with

a combination of pathologic states, so is knowledge of the specific fluid imbalances necessary for the diagnosis and treatment of the patient with combined disturbances of the body fluids. Such knowledge, plus the facts gleaned from the clinical history, physical examination and laboratory tests, greatly facilitates diagnosis of combined imbalances and makes possible effective therapy.

Therapy lies outside the purview of this article. It has been presented in the follow references:

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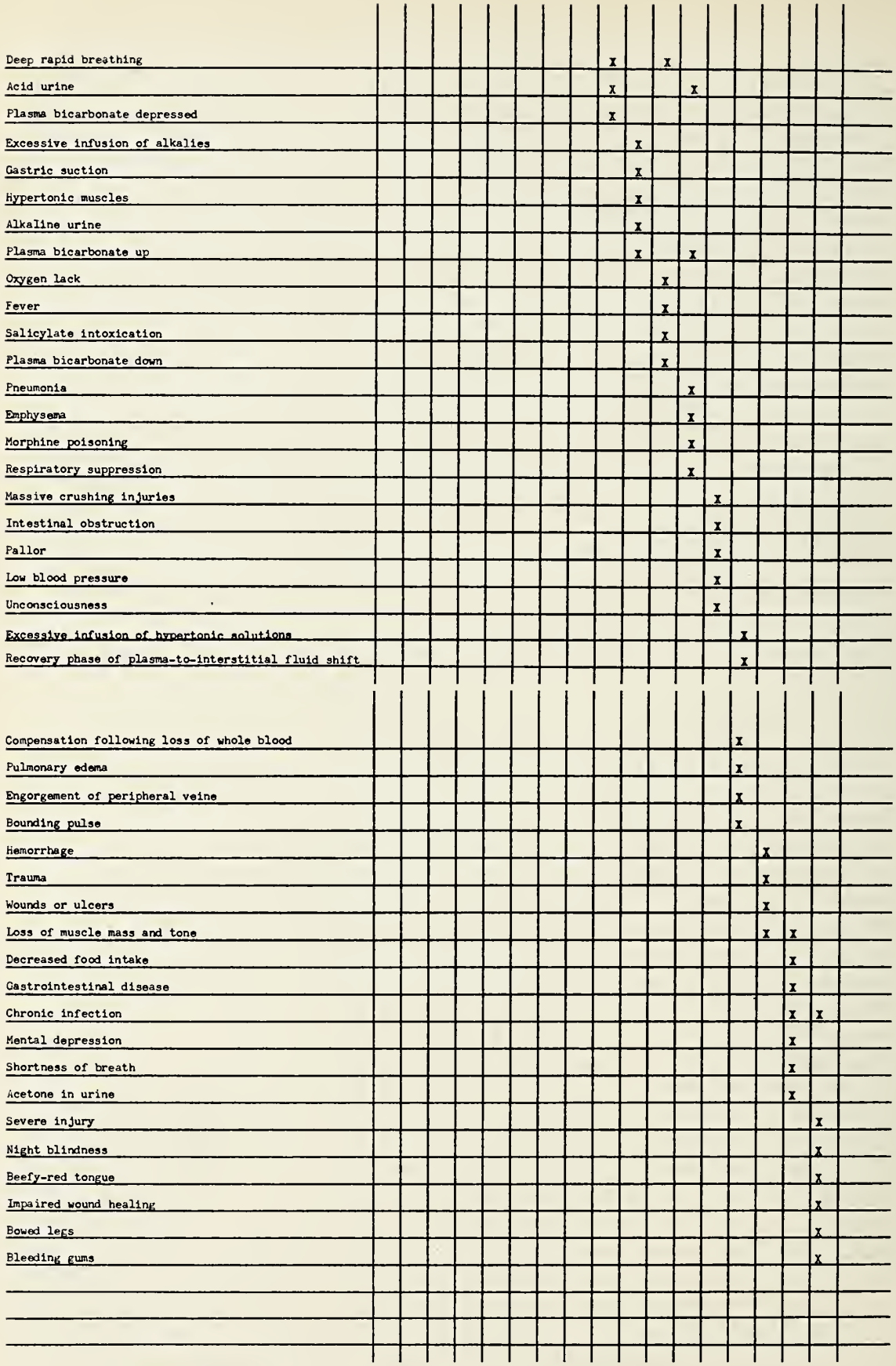
Figure 23 gives a sort of general bird's-eye view of clinical events and specific fluid imbalances with which they may be associated. Specific clinical pictures of fluid imbalances are listed across the top from left to right. Clinical events which are usually parts of these clinical pictures are listed at the left in the vertical column.

Suffice it to say, the only rational basis for effective therapy is accurate, systematic diagnosis. Such diagnosis is facilitated by employment of the "clinical picture" approach to understanding the imbalances of the body fluids.

Figure 23

CLINICAL EVENTS AND SPECIFIC FLUID IMBALANCES WITH WHICH THEY MAY BE ASSOCIATED	SPECIFIC FLUID IMBALANCES	EXTRACELLULAR FLUID VOLUME DEFICIT	EXTRACELLULAR FLUID VOLUME EXCESS	ELECTROLYTE CONCENTRATION DEFICIT OF EXTRACELLULAR FLUID	ELECTROLYTE CONCENTRATION EXCESS OF EXTRACELLULAR FLUID	POTASSIUM DEFICIT OF EXTRACELLULAR FLUID	POTASSIUM EXCESS OF EXTRACELLULAR FLUID	CALCIUM DEFICIT OF EXTRACELLULAR FLUID	CALCIUM EXCESS OF EXTRACELLULAR FLUID	PRIMARY BASE BICARBONATE DEFICIT OF EXTRACELLULAR FLUID	PRIMARY BASE BICARBONATE EXCESS OF EXTRACELLULAR FLUID	PRIMARY CARBONIC ACID DEFICIT OF EXTRACELLULAR FLUID	PRIMARY CARBONIC ACID EXCESS OF EXTRACELLULAR FLUID	PLASMA-TO-INTERSTITIAL FLUID SHIFT OF EXTRACELLULAR FLUID	INTERSTITIAL FLUID-TO-PLASMA SHIFT OF EXTRACELLULAR FLUID	PROTEIN DEFICIT	CALORIC DEFICIT	VITAMIN DEFICIT
CLINICAL EVENTS																		
Abruptly decreased intake of water and electrolytes		X																
Vomiting		X										X						
Diarrhea		X				X												
Dry skin and mucous membranes		X																
Oliguria		X			X		X											
Weight loss		X														X		
Hemoglobin up		X												X				
Excessive infusion of isotonic saline			X		X						X							
Chronic kidney disease			X															

Puffy eyelids		X																
Moist rales in the lungs		X																
Pitting edema		X																
Rapid weight gain		X																
Hemoglobin down		X												X	X			
Excessive sweating plus drinking water			X															
Excessive infusion of carbohydrate and water			X															
Gastrointestinal suction plus drinking water			X															
Apprehension			X															
Abdominal cramps			X															
Plasma sodium level down			X															
Specific gravity urine down			X															
Tracheobronchitis				X														
Copious, watery diarrhea				X														
Dry, sticky mucous membranes				X														
Plasma sodium up				X														
Specific gravity urine up				X														
Ulcerative colitis					X													
Recovery from diabetic acidosis					X													
Anorexia					X										X			
Muscles soft					X													
Silent intestinal ileus					X													
Plasma potassium down					X													
Burns						X							X					
Crushing injury						X												
Kidney disease						X												
Excessive infusion of potassium solutions						X												
Intestinal colic						X												
Plasma potassium up						X												
Sprue							X											
Acute pancreatitis							X											
Hypoactive parathyroid glands							X											
Excessive infusion of citrated blood							X											
Tetany							X			X	X							
Tingling of fingers							X											
Plasma calcium down							X											
Tumor of parathyroid glands								X										
Excessive vitamin D for therapy								X										
Multiple myeloma								X										
Relaxed muscles								X										
Flank pain								X										
Deep thigh pain								X										
Plasma calcium up								X										
Diabetes mellitus									X									
Disorientation									X			X						
Shortness of breath on exertion									X									


Deep rapid breathing
Acid urine
Plasma bicarbonate depressed
Excessive infusion of alkalies
Gastric suction
Hypertonic muscles
Alkaline urine
Plasma bicarbonate up
Oxygen lack
Fever
Salicylate intoxication
Plasma bicarbonate down
Pneumonia
Emphysema
Morphine poisoning
Respiratory suppression
Massive crushing injuries
Intestinal obstruction
Pallor
Low blood pressure
Unconsciousness
Excessive infusion of hypertonic solutions
Recovery phase of plasma-to-interstitial fluid shift
Compensation following loss of whole blood
Pulmonary edema
Engorgement of peripheral veins
Bounding pulse
Hemorrhage
Trauma
Wounds or ulcers
Loss of muscle mass and tone
Decreased food intake
Gastrointestinal disease
Chronic infection
Mental depression
Shortness of breath
Acetone in urine
Severe injury
Night blindness
Beefy-red tongue
Impaired wound healing
Bowed legs
Bleeding gums

Diabetes Insipidus Following Closed Intracranial Trauma

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DIABETES INSIPIDUS is a syndrome characterized by intense thirst (polydipsia) and by excretion of large quantities of dilute urine (polyuria). The syndrome is caused by a deficiency of anti-diuretic hormone of the posterior pituitary gland. It is commonly accepted that the polydipsia is secondary to polyuria. (There is, however, evidence for the existence of a "drinking center" in the hypothalamus which may be involved in thirst production). The mechanism of water control by the kidneys is through the release of antidiuretic hormone from the posterior pituitary gland. The hormone acts upon the renal tubules facilitating resorption of water. Any lesion along the neuropathway from the supraoptic nucleus of the hypothalamus involving the tuber cinerum, pituitary stalk, or pars nervosa of the posterior pituitary gland, may cause a deficiency in the circulating hormone and be responsible for the production of diabetes insipidus. The syndrome may be inherited or it may be caused by infection, neoplasia and open or closed intracranial injuries.

Case Reports

CASE 1: A 24-year-old, white, unmarried female was admitted to Reid Memorial Hospital on Jan. 26, 1952. She had been severely injured in an auto accident. There were lacerations of the forehead, tongue and nose and she was in shock. Although unconscious she responded to painful stimuli. An x-ray of the skull revealed a Y-shaped fracture in the right frontal area. She was given immediate blood transfusions and the lacerations were repaired. Neurologically there was a fast pulse and fast, shallow respirations with bilateral positive Babinski signs and evidence of impaired motion in both upper extremities. For 2 weeks her condition was considered to be critical but during the next 2 weeks she improved and began to show evidence of returning rationality. During the first 4 weeks intravenous fluid administration was maintained at 1800 cc. daily and the urinary output ranged from 1200 to 1400 cc. daily. A specific gravity of the urine recorded 2 days after injury was 1.014. The following data refers to the subsequent post-injury period:

Twenty-six days	—Quantities of liquid by mouth.
Thirty-one days	—Complete mouth feedings.
Forty-three days	—Urinary output 5900 cc.
Forty-seven days	—Intense thirst had developed. Urinary output 8550 cc. Specific gravity of urine 1001.
Forty-eight days	—Pitressin tannate in oil 5 units I.M. (5 units per cc.) daily begun.
Fifty days	—Necessary to increase pitressin tannate to 20 units daily to keep urinary output at 2500 cc. or less.
Fifty-six days	—Pitressin tannate reduced to 10 units with urinary output maintained at 1000 to 1500 cc. daily. The patient was released to her home where her mother administered the pitressin tannate 10 units daily.
Five months	—Pitressin tannate reduced to 5 units daily.
One year	—Requiring pitressin tannate 5 units daily.
Two years	—Requiring pitressin tannate 5 units every other day.
Three years	—Requiring 5 units bi-weekly to maintain 1500 cc. output.

Three years and six months —Off all medication with urinary output 1500 cc. There was no nocturia, she was working in an office and planning to enter business school. There was a complete loss of smell but otherwise the neurological recovery appeared to have been complete.

This patient presented moderately severe diabetes insipidus which was controlled by pitressin tannate. Recovery was accomplished in 3½ years from the time of injury. It is interesting to note that she had completely lost her sense of smell which would indicate injury to the olfactory nerves in the region of the anterior-inferior surface of the brain and in proximity to the hypothalamic-pituitary area.

CASE 2: A 16-year-old white male was admitted to Reid Memorial Hospital on May 6, 1956. He was unconscious at admission. The diagnosis was that of cerebral concussion with severe lacerations of the face and tongue. Shortly after admission his blood pressure was 82/54, pulse 136 and respirations 36. He became conscious during the few hours after admission but was disoriented and restless for about 24 hours. X-ray revealed no evidence of skull fracture and there were no other positive neurological findings. Four days after injury the patient was taking fluids by mouth and had an intense thirst. He insisted upon having water to drink. His urinary output for 24 hours was 4625 cc. The specific gravity was not recorded. Six days after injury his urinary output was 2100 cc. He did not exceed that amount in subsequent days and his excessive thirst disappeared. While hospitalized he developed an acute appendicitis and appendiceal abscess. Surgical treatment resulted in recovery.

This patient represents a very transitory diabetes insipidus similar to some of the cases which have been reported. A demand for large quantities of fluids in the patient who has just sustained a moderately severe head injury and in whom one would hope to limit the fluid intake, presents a considerable problem.

A Survey of Previous Reports

Willis is credited with first reporting the syndrome of diabetes insipidus in 1674. Since then there have been cases reported that have been caused by closed head injury. Most of the cases have been individual case reports. (I was able to find 14 individual case reports in American and foreign literature.) More recently groups of 3 to 7 cases have been reported, and only in a relatively few reports.[1, 2, 3] Bottrell and Horsey[4] reported that there were only 7 cases in the records of the Toronto General Hospital. Actually the total number of cases reported have been so few and the follow-ups beyond hospitalization so incomplete that one could hardly assemble significant statistics. Most observers feel that the syndrome from closed head injury is more frequent than is generally reported. Although some cases had an onset of polyuria as early as 2 to 3 days after injury, the majority of cases reported had an onset from 7 to 14 days after injury. Some of the cases were transitory (2 to 3 days duration) while others persisted from a few days to several months, with recovery. There are a very few cases recorded of persistence of the syndrome after several years.

Treatment

The treatment of diabetes insipidus due to trauma is the administration of posterior pituitary extract in one of two forms. The most simple administration is by the insufflation of dessicated powdered posterior pituitary lobe into the nostrils. A more definitive dose, however, can be administered by pitressin tannate in oil. Either of these methods is highly effective and may be adjusted to the urinary output. The intervals of administration should be lengthened and if the patient appears to be improving, medications should be discontinued for intervals of at least a week to note the amount of recovery that has occurred. Either fairly abrupt or gradual diminution of thirst and urinary output should be noted in the case that is recovering and dosages adjusted accordingly.

Summary

Diabetes insipidus may be caused by closed intracranial injury. The time of injury to the onset of symptoms varies from 3 or 4 days to a few weeks. The period of recovery may be only a few days or may extend over a period of a few years. Symptoms persist indefinitely in the occasional case. Two cases are presented which illustrate different extremes of onset and recovery. Symptomatic treatment with posterior pituitary extract is effective and simple.

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Sea Gulls and Diuresis

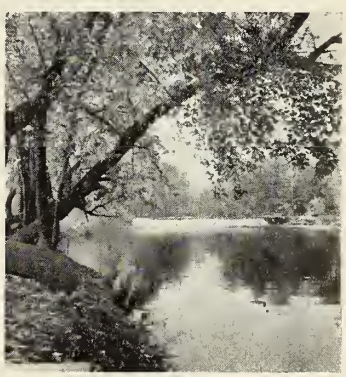
Sea gulls and other marine birds ingest large quantities of salt from sea water. The salt load would be far too great for the kidneys to handle. But salt-retention edema is prevented by unusual functioning of the nasal (supraorbital) gland, which secretes sodium chloride at higher rates and concentration than the kidney. A cholinergic innervation mechanism similar to that of salivary glands, is believed responsible. The nerve reflex is thought to depend on a central osmoreceptor, sensitive to the osmotic concentration of the blood. Researches have found this unusual extrarenal salt excretion in petrels, gulls, penguins, marine ducks and other birds and marine reptiles. (From DIURETIC REVIEW, specialty publication dealing with cardiorenal subjects, from Lakeside Laboratories, Inc., for the profession.)

Things Dreams Have Wrought

To live in a dream world can cause some serious psychological problems; or is it the other way around? Yet, the dreamers wrought progress, for they dreamed of new and better things, and, sometimes against all the antagonistic pressures of an unbelieving society, they surged ahead in work to prove their dreams valid. Thus man has progressed.

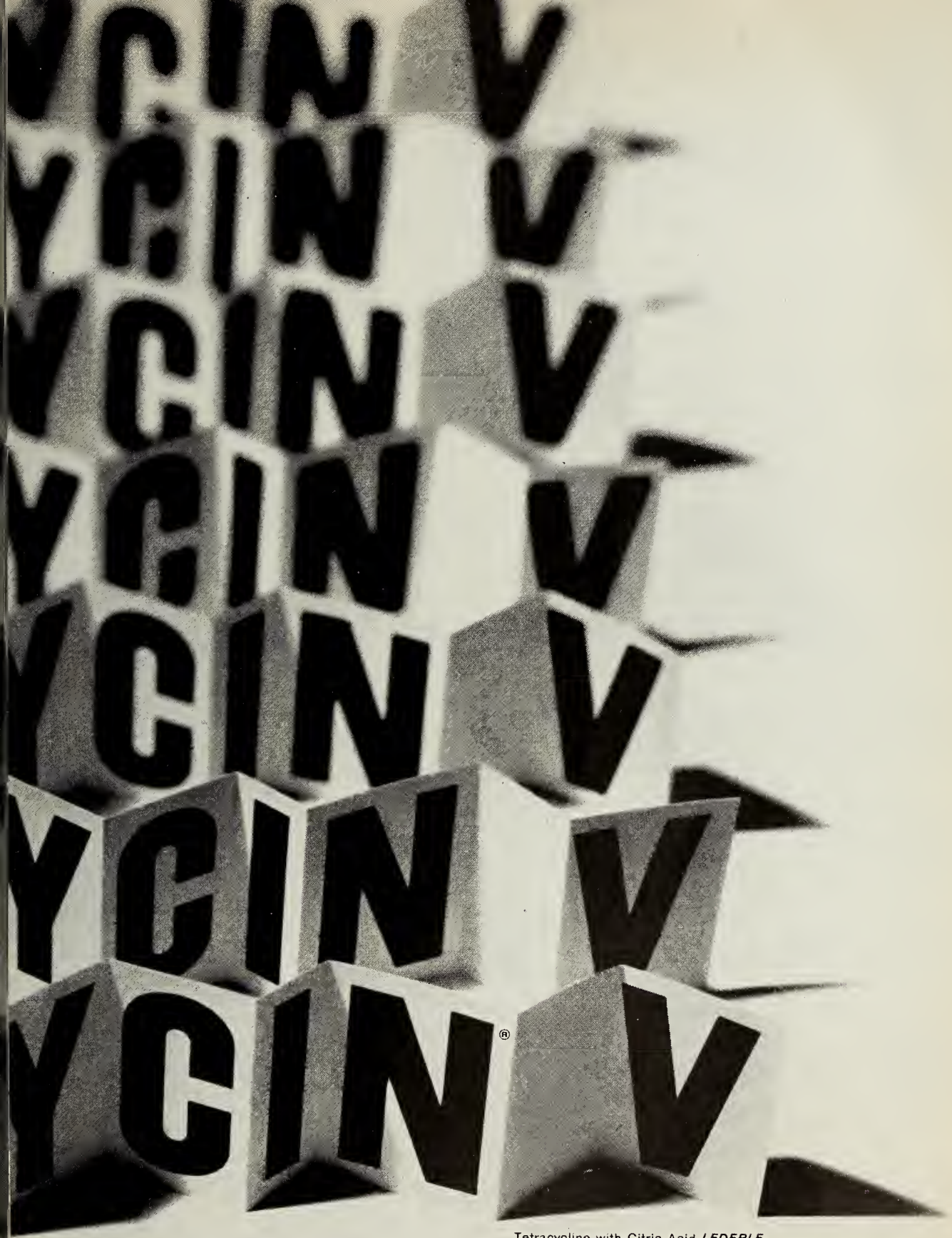
Our "dream" cover picture comes after a cold winter that has been too long. And, in March, when there is a whisper of spring in the air at odd moments, what better time to dream of summer with its green loveliness, its boat and swimmer laden lakes and streams, the great out-of-doors' life under the warmth of a summer sun?

Our March cover is that dream. It won't change the capriciousness of March, or the advent of an early spring snow; but it can warm us in thoughts of the summer that nears as we shiver in winter's last-minute blasts.



(Photo, by Henry S. Wood of New Palestine, shows Blue River at Freeport in Shelby County. According to Mr. Wood, it was this site which inspired Early Smith to write the words to "Down By the Old Mill Stream.")


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Anesthetic Problems of Tranquilizer Drugs in Surgery and Obstetrics

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A GREAT AMOUNT of interest has developed in a new group of drugs known as tranquilizers or ataraxic agents. The latter term was coined by Fabing and is derived from the Greek noun ataraxia, meaning "peace of mind." An estimated 140 million dollars was spent by the public to purchase these drugs in 1956.[2] Approximately 10,000 or more publications concerning the ataraxics have appeared in the literature,[3] but despite these voluminous reports, an element of danger accompanies their use. They remain new drugs and comparatively few long-term clinical or laboratory studies have been performed.

The tranquilizing drugs are rather loosely grouped under this somewhat nebulous term. They are very dissimilar not only in their pharmacological actions and chemical structures, but also in their varying side effects. Because of these diverse side effects, it is important for the physician to have a working knowledge of these drugs.[2]

The Phenothiazine Derivatives

The parent substance phenothiazine has only a minimal depressant effect on the central nervous system and no anti-histaminic action. Its derivatives, however, have both a depressant and antihistamine action plus ataraxic effects. They all have an additive effect with the barbiturates, the narcotics and the anesthetic agents.

Chlorpromazine (Largactil, Thorazine) results from the substitution of a dimethyl-amino n-propyl group as well as a chlorine atom attached to the phenothiazine nucleus. It differs from phenothiazine pharmacologically in that it has very little antihistaminic action, but a marked effect upon the central nervous system. It has a diffuse action upon the central nervous system involving many different areas. These include the hypothalamus and thus secondarily the anterior pituitary as well as the mesencephalic alerting system which consists of the reticular formation and the thalamic diffuse cortical projections. It is believed that control of basal metabolism, body temperature, vasomotor tone, emesis, the sleep-wakefulness cycle and hormonal balance are centered in these latter areas and are affected by the drug. These activities are inhibited in some manner by the phenothiazine derivatives and, therefore, affect the psychic and physiological functions dealing with the somatic and autonomic nervous system. The drug causes adrenergic blockade, a reduction in blood pressure due to decreased peripheral resistance and a variable effect on cardiac output. Large doses administered to animals over a period of one to two hours produce ventricular tachycardia.[2]

Chlorpromazine has an adrenergic blocking effect and hypotension developing during its use may be very difficult to control. A fall in blood pressure of this nature does not respond to ordinary doses of vasoconstrictor drugs. Five milligrams of chlorpromazine has been demonstrated to block the pressor effect.[5] This hypotensive side effect may also occur under general

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anesthesia, and it has been advised by some to discontinue the drug on any patient who has been receiving prolonged therapy for a few days before administering a general or spinal anesthesia.

Chlorpromazine is felt by some to be a valuable adjunct to anesthesia; however, it is becoming increasingly clear that the drug is quite inconsistent in its multiple actions. The drug does not assure adequate drying of secretions nor can it be relied upon to eliminate excitement at the beginning of the anesthetic period.[5, 6] In some patients sedation is not only absent or minimal but induction to inhalation anesthesia is frequently slow and stormy.[5] The effect of the drug on any one patient is unpredictable. Its use in the postoperative recovery room is also equivocal. A few patients with emergence delirium have responded quite effectively to the drug, while others have developed a prolonged depression. Tachycardia and hypotension may develop within a few minutes after administration of the drug.[5]

The value of chlorpromazine in obstetrics is also questionable as illustrated by numerous conflicting studies.[7, 8, 9] Since the drug has an additive effect with opiates and barbiturates, it was hoped that depression of the newborn might be lessened by its action of decreasing the amount of narcotics required for analgesia. Some authors feel that it is useful in this respect while others report no detectable differences. It is questionable in the face of its multiple potential hazards whether or not the possible lessening of newborn depression is offset by the risk of even more serious complications.

Multiple adverse effects of chlorpromazine have been reported in the literature and have involved practically every system of the body. The great majority of these have occurred during high dosage or long-term therapy with the drug. Mental changes varying from mental depression to delusions or hallucinations have been reported. Toxic effects on the central nervous system have included classic signs of Parkinson syndrome; toxic confusional states, some of which terminated fatally; syndromes resembling myasthenia gravis, tabes, and bulbar palsy; hyperthermia resembling heat stroke; and hypothermia. Toxic effects on the autonomic nervous system are due to an adrenergic blocking action and also an anticholinergic action. These include hypotension, tachycardia, blurred vision, pallor and constipation. Allergic reactions include obstructive jaundice, agranulocytosis, purpura, dermatitis of a wide variety and asthma. The metabolic effects include lactation, transient weight gain, polydipsia and impotency.[10]

Promazine (Sparine) is identical in structure to chlorpromazine with the exception that the chlorine atom is absent. This change is thought to probably diminish such undesirable side effects as hypotension, tachycardia and pain at the site of injection. Its site of action and physiological and pharmacological effects are, in the main, identical to chlorpromazine. Due to the close structural similarity to chlorpromazine it is possible that all of the untoward reactions attributed to the latter may occur after promazine therapy.

Promethazine (Phenergan) results from the addition of a dimethyl amino isopropyl group to the phenothiazine nucleus. It is a central nervous system depressant although its ataraxic properties are milder than the previously described phenothiazine derivatives. It is a powerful antihistamine. Intravenous administration has no significant effect on blood pressure, pulmonary blood flow or pulmonary artery pressure.[2] It does not significantly alter renal blood flow, glomerular filtration rate or renal electrolyte excretion. No reports of jaundice, severe hypotensive reactions or blood dyscrasias have been associated with its use.[14] It is useful as a preanesthetic agent and as a sedative the night before surgery. Postoperative restlessness is rare and it has a drying effect on the respiratory tract.

Promethazine appears of much greater value in obstetrical analgesia than does chlorpromazine. Studies of fetal cord blood in obstetrical patients who received 50 mgm. intravenously 5 to 10 minutes before delivery failed to reveal demonstrable amounts of the drug in cord blood despite a level of 200 gamma in maternal venous blood. The drug does not appear to cross the placental barrier and may be of value in reducing fetal respiratory depression if used in place of barbiturates or narcotics for obstetrical sedation.[15] Promethazine may be used as a sedative during spinal, regional and local analgesia; in reducing the amount of intravenous barbiturates during general anesthesia; in the prevention of and treatment of postoperative vomiting; the control of postoperative excitement; and pro-

longed relief of pain when combined with the narcotics.[16]

Sadove and Frye have used promethazine in conjunction with meperidine and scopolamine as preoperative sedation in children.[17] They feel this combination of drugs facilitates induction of anesthesia and inhibits postoperative nausea and vomiting.

Promethazine has fewer objectionable features than the other previously described phenothiazine derivatives. Its sedative effect may be highly variable and it may cause prolonged drowsiness postoperatively.[16] Other adverse effects noted have included inadequate bedtime sedation, over-medication prior to anesthesia, cough with rapid injection intravenously, restlessness and wildness on awakening, and occasional post-operative depression and slow awakening, particularly when used with thiopental.[14] It appears that this drug will be the most useful and least objectionable of the phenothiazine group.

Three other compounds derived from phenothiazine are undergoing clinical investigation. These drugs are known as NP 207, Prochlorperazine and Mepazine.

NP 207 (Sandoz) apparently resembles chlorpromazine in its clinical effects. Toxic retinitis has been reported in a high percentage of clinical subjects and this has delayed its introduction into modern therapeutics.

Prochlorperazine (Compazine) is less toxic than chlorpromazine and appears to be a good anti-emetic. The drug has had little trial clinically and thus a complete evaluation is not yet possible.

Mepazine (Pacatal) has been used as a preanesthetic medication. Dryness of the mouth, constipation and blurring of vision have been reported.[2]

Meprobamate (Miltown, Equanil) is developed from the drug myanesin. It possesses pharmacological properties similar to this drug in addition to actions at the supraspinal levels. The drug is given in the oral form since intravenous preparations cause thrombosis, hemolysis and possible glomerular damage. It has 3 main pharmacological actions, namely: (1) a muscle relaxing property of greater potency and duration than myanesin; (2) an anticonvulsant action which protects experimental animals from toxic doses of metrazol; and (3) an ataraxic effect. Its site of action is believed to be the thalamus and perhaps the internuncial neurons.[2] Meprobamate, though studies are far from complete, seems to be more effective in neurotic than psychotic conditions.[18]

The drug has been used for preoperative sedation without any effect on respiration and circulation. A type of reaction representing a probable idiosyncrasy to meprobamate has recently been reported and is charatcerized by a purpuric or erythematous rash, pruritic, with fever· chills and edema lasting one to 3 days. Shock and severe anuria has occurred in patients receiving dosages ranging from only 4 to 8 hundred milligrams daily for one month.[20] Shaking chills and fever have been reported on as little as a single 400 mgm. dose of the drug. Other side effects have been gastric discomfort, paradoxical excitement, intestinal hyperperistalsis with cramping and flatulance, severe diarrhea and palsy of extraocular muscles.[21] There also appears to be increasing evidence that the drug may be addictive in nature and it has been suggested by some authors that it be withdrawn slowly from chronic users and used with caution in known narcotic and barbiturate addicts.[21, 22]

The *Rauwolfia Preparations* are used chiefly as antihypertensive agents, but are also classed and used as ataraxics. They have the advantage of easy oral or parenteral administration and relatively low toxicity. Their sites of action are believed to be upon the hypothalamus and the mesodiencephalic alerting system where their actions resemble chlorpromazine with the exception that reserpine stimulates rather than depresses this activating system.[2] The drugs act through the central suppression of vasoconstrictor impulses and thus lower blood pressure. They also slow the pulse, an effect which is probably not entirely vagal in origin, since atropine only partially blocks the bradycardia. Reserpine has been noted to produce a sedative effect on laboratory animals and appears to promote a reduction in nervous tension in humans which is more prominent than somnolence, although both may occur. Excessive salivation; bradycardia; generalized cutaneous and mucous membrane flushing; vomiting and diarrhea and severe hypotension have been reported in patients receiving rauwolfia derivatives. Reserpine

appears to activate peptic ulcers by increasing the volume and acidity of gastric secretions. Premature ventricular contractions have been reported[23] in patients receiving extractions of rauwolfia, suggesting a potential danger of producing cardiac arrhythmias. The drug should probably be used with some caution in patients with a known tendency to ventricular arrhythmias.[10] Muscle aching and severe mental depression may occur in patients receiving reserpine.[10, 2] Nasal stuffiness is the most common complaint associated with use of the drug.

Severe hypotension in patients on rauwolfia drugs during and after surgery has been described by Coakley, *et al.*[24] In 40 unselected cases, 16 had significant hypotensive episodes during surgery with continuous electrocardiogram tracings showing such changes as sinus bradycardia, absence of P waves, heart blocks, depression of ST segment and inversion of T waves. The response to all vasopressor drugs is undependable; however, vagal blocking drugs are of val e in correcting the disturbance of hypotension in these patients. Patients receiving rauwolfia therapy should not receive the drug for 2 weeks prior to elective surgery. Emergency surgery can be safely carried out on patients receiving the drug by an awareness of medication and by using agents which block the vagus in preventing and treating vagal circulatory responses.

Phenglycodal (Ultran) is a butanediol and has been classified as a tranquilizer because of its ability to allay tension and anxiety with only minimal dulling of mental acuity. It is said to have an action similar to mephenisin and other internuncial neuron blocking agents since it produces muscle relaxation. There has been no clinical evidence presented at present indicating that the drug has any synergistic actions with other medications. The drug is said to be useful in the treatment of neuroses, but has shown little value as a medication for the more severe psychoses.[2] Toxic reactions to this drug have not been reported, but few clinical studies have been done.

Dioxolane has been used as a tranquilizer in anxiety states, dysmenorrhea and alcohol withdrawal syndromes. Its site of action may also be at the internuncial neuron level in the brain stem and spinal cord. It has been used clinically as a muscle relaxant for spasm or tremors. The drug is said to have the ability to cause transient paralysis of voluntary muscle without respiratory depression in therapeutic doses and death from asphyxia in toxic doses.[2]

2-Ethylcrotonyl Urea (Nostyn) is a ureide which is reported to have a very low toxicity and minimal side effects in therapeutic doses when used as a sedative. It is said to cause less hypnosis than meprobamate when used for tranquilizing effects; however, little is known about its pharmacology or site of action. It is reported not to depress respiration or blood pressure in therapeutic dosages. There has been no evidence of tolerance or cumulative effects developing with its use. It has been described as useful in the treatment of epileptic patients in combination with diphenylhydantoin.[2]

Pipradol (Meretran), like the remaining drugs to be discussed, is a derivative of piperidine. It differs from the previously described drugs in that it has a stimulating rather than depressive action and has been classed as a sympathomimetic drug since its actions are believed to be on the subcortex and evidence of sympathetic stimulation has not been observed. It has a low toxicity and no withdrawal symptoms.

Piperidylacetate (Phenidylate, Ritalin) resembles Meretran and has also been classed as an analeptic rather than an ataraxic agent due to its mild cortical stimulating action. This drug has the action of overcoming the sensation of fatigue. It also has an anti-lethargy and antidepressing effect. Ritalin has been used in combination with antihistamines and rauwolfia drugs to combat depressive side effects. It is said to have no significant central or peripheral side effects. The drug has been demonstrated to have the ability to antagonize the depressant central nervous system effects of thiopental and other barbiturates.[2] This effect has led to recent reports[25] of its possible value in the postoperative recovery room.[1] Evidence has been presented which indicates that it is the central nervous system stimulating effects of Ritalin rather than any direct antagonistic action to thiopental, which accounts for a more rapid awakening and increase in minute volume when it was administered in recovery room. The drug is said to have no significant hypertensive effects.

Azacyclanol (Frenquel) is similar chemically

to pipradol but differs in its pharmacological effects, since it is not a central nervous stimulant. It has been used in the treatment of severe anxiety states, obsessive-compulsive syndromes and depressive reactions. The drug is also thought to be inactivated by the sulfonamides, since patients receiving both drugs simultaneously have been observed not to react to azacyolonal.

Hydroxyzine (Atarax) is similar to meclizine and has antihistaminic and tranquilizing properties with a low incidence of toxicity. Little in the way of controlled laboratory studies has been performed on this drug. One study indicates that it may be of value in paroxysmal auricular tachycardia. It may be of value as an adjunct in preoperative medication due to a hypnotic and anesthetic potentiating property as well as possible coronary artery dilating effect.

Summary

The various drugs which are rather vaguely and loosely classified as "Tranquilizer or Atraxic" agents are described briefly as to chemistry, pharmacology and common therapeutic indications. Possible uses as well as objectionable features are considered. These agents are quite dissimilar in nature and effects, and it behooves the physician to be familiar with their variations of actions since they are being widely used by a great number of people. These drugs produce hazardous combinations when used with certain anesthetic agents, and thus raise the morbidity and mortality. Certain of these agents may prove to be of definite value in the field of anesthesiology if used with precaution. It is obvious that a more restrained usage of these drugs by the entire medical profession at present is indicated, and that more detailed and controlled laboratory and clinical studies are needed to properly evaluate and classify them.

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The Journal

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MALPRACTICE SUITS

MR. ED KLINGLER, associate editor of the Evansville Press, presents some extremely valid observations on the phenomenon of malpractice suits. His column on this subject is reproduced in our "Fourth Estate." It was written for laymen and should be assigned reading for everyone, non-medical and medical alike.

Increase in the frequency of malpractice actions and increase in the size of judgments obtained in some of them have understandably become a matter of concern to all physicians. Other considerations, apart from the financial and emotional impact on the doctor, are now being pointed out. Mr. Klingler has wisely deduced that the growing prominence of this problem has already or may in the future affect the treatment which the patient receives.

The practice of medicine is an art. It is based on scientific observations, but, as every medically trained man knows, the results cannot be predicted or guaranteed. The most basic definition of living matter—the one point which differentiates it from inanimate matter—is that its reactions cannot be accurately predetermined.

Everyone should realize this as a fundamental fact. Everyone should realize that in choosing a method of treatment a doctor

never has a choice of something that is certainly safe—he is limited to a choice of the safest treatment, one which is safer than the malady for which it is prescribed, but never certain of success.

The tendency of courts in some states to depart from the rule that the claimant must prove that the physician was negligent and substitute a rule that an unfavorable result is evidence of negligence, if universally adopted, will place further limitations on the art of medicine.

Such considerations as these constitute an indirect menace to the practice of medicine. They can reduce the healing art to an impotent hodge podge. They can make the study of medicine unattractive to intelligent young men and women.

This, most certainly, is a subject which should be discussed far and wide.

PHYSICIANS FOR TOMORROW

THE UNITED STATES now has approximately 230,000 licensed physicians, or about 132 physicians per 100,000 population. By 1970 the population will have increased by at least 26% and perhaps by more. To maintain the present physician ratio will require by 1970 the graduation of 1900 more doctors than are graduated now, and a doubling of the 750 foreign educated doctors who are now licensed each year.

These startling figures were given by Dr. Leroy Burney, Surgeon General of the Public Health Service, in the Martin Memorial Lecture which he delivered before the American College of Surgeons last October. Dr. Burney's discussion did not attempt to determine how many physicians will be needed in the future, although he outlined several considerations which would indicate that the need is increasing.

Secretary Folsom's consultants on Medical Research and Education has recommended the construction of 14 to 20 new medical schools, together with the expansion of existing facilities, as a minimum effort to maintain the supply of adequately trained physicians for the future. This many new schools will be required, in their opinion, to graduate the 1900 additional physicians and to supply doctors for medical research which they expect will double in personnel and treble in cost.

The consultants also pointed out that a new medical school would require an investment of between 35- to 50-million dollars, and that usually 10 years will elapse between the decision to establish a school and the graduation of its first class. Such data as these emphasize that the task of maintaining our present ratio of physicians is not a small one.

Dr. Burney reviewed the indications that there are constantly increasing demands for physicians. On the average Americans see a doctor twice as often now as they did 25 or 30 years ago. Hospitalization is at 3 times the rate of 1940. Disability rates are higher and the proportion of elderly citizens increases the need for medical care.

The mental hospitals of the country would require 6,000 more psychiatrists to bring their staffs up to standard. Health departments, federal health services and medical schools today have vacancies which total to over 10,000.

These specific shortages together with the obvious fact that many practicing physicians today are overworked, makes a telling point for the view that maintenance of the present physician ratio is not enough, and will not be enough for the future.

Expansion of medical care services in the rest of the world may decrease the number of foreign graduates who have bolstered our own graduates in providing interns and residents for our voluntary general hospitals which are growing larger and more numerous. There are now twice as many approved internships as there are graduates.

Since Dr. Burney delivered the address he has appointed a Consultant Group on Medical Education. He has asked them to appraise the existing data, plans and proposals con-

cerned with our medical schools and the nation's need for physicians, to sift out areas of agreement and the areas that require further study, and to recommend the action which all groups must take to achieve reasonable and acceptable goals in the next decade.

In the words of Dr. Burney: "In the pursuit of our professional aims we do not always realize the new position of leadership to which medicine is being called in society today. It is not in the local community alone that the physician's advice and cooperation is needed—in acquiring a new hospital, a nursing home, a program for the aged. In a state or region, also, and the nation as a whole, the physician's judgments and his actions have an impact that extends far beyond the exclusively medical problems which confront him in his patients and their families. President Eisenhower has given medical leadership an even wider area of responsibility by making health a central factor in his plan for world peace.

"If American medicine is to live up to these great expectations, it must accept a broader view of the nation's needs and the profession's leadership role. As a profession, our first obligation is to medical education."

Medical Essay Contest Instructions

Entries for The Journal's Medical Essay Contest for interns and residents should be submitted prior to May 1, 1959. The manuscript itself is to be identified only by the title. Author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.

FREEDOM IN MEDICAL SCIENCE

EARLY last year the Superior Court of Alameda County, California, awarded two children damages for poliomyelitis infections allegedly resulting from the use of Cutter vaccine in spite of the finding of the jury that Cutter Laboratories was not negligent.

It would be an understatement to say that such a decision will place a damper on all investigative work in therapeutic and biological sciences. All therapeutic agents have been introduced and pioneered with a knowledge of their inherent risks. All potent therapeutic agents, even after years of careful use and study, still carry with them a small and irreducible risk.

The case has been appealed. The American College of Physicians has filed an amicus curiae (friend of the court) brief, which in part is quoted:

"the creation of an absolute liability concept would greatly impair future progress. The introduction of new products and procedures would be stifled and mankind would be denied the continual advancement of medical science. We believe that when, as in the cases before the court at this time, a biological is made according to strict government specifications and complies with the best scientific and productive knowledge available and when the manufacturer is absolved of all possible negligence by the jury, as this defendant was, no liability should be incurred when an injury occurs because of the user's own peculiar susceptibility or because of insufficient scientific knowledge at that time. To

create such an absolute liability would be to saddle the world of medical science with an unfair burden We in no way feel that we are over-dramatizing these results, for its is clear that researchers would be unwilling to try new drugs on patients, practicing physicians would be afraid to avail themselves and their patients of the new wonder drugs and pharmaceutical houses would not be willing to manufacture new products should this concept be applied, for it holds the defendent liable without fault and liable for the unknown.

"Since the fact is self-evident that certain treatments will save lives or alleviate suffering, it is unrealistic and unreasonable to say that there must be no unknown untoward effects. If we take this position, then the conquering of disease in the future will be far slower, as neither manufacturers nor insurance companies can afford to insure against the unknown and the unpreventable. Thus, the liefsaving drug or biological that may save thousands of lives every year from cancer which might be available tomorrow would probably, under the absolute liability situation, be withheld for another ten years of testing and 'wait and see' and 'make sure' periods. To be sure, a statistically small number of hypersensitive or hypersuseeptible individuals will thus be saved from harm, but in the meantime thousands who might otherwise live, or live without suffering, will necessarily be denied medical care.

"How can any scientist, physician, hospital or pharmaceutical producer become involved in any forward steps in medicine, no matter how surrounded by standards, if he is to be held responsible for knowledge that does not, and cannot, exist until the future unfolds."

MEDICAL SCHOOL ALUMNI DAY

ALUMNI DAY at the medical school will be held early this year to coincide with the dedication ceremonies of the new Medical Science Building. Both functions will center on Wednesday, April 22, with some preliminary and also some postcelebration functions on the 21st and 23rd, according to present plans.

Medical School alumni will hold their customary Alumni Day meetings on the morning of the 22nd and then will join in the dedication program that afternoon. Representatives from other medical schools, prominent medical educators and other distinguished guests have been invited.

The newly completed seven million dollar Medical Science Building has already been "initiated." In this, its first year, it is accommodating the entire 4 years of medical school instruction, and also is being utilized for basic science courses for the School of Dentistry and the School of Nursing.

The building has made possible the long dreamed for unified medical school. It is the culmination of years of planning by the university and the state medical association. It provides teaching facilities of which the state of Indiana and the medical profession can be very proud. Its dedicatory program may be enjoyed by all the physicians of Indiana.

President's Page

Have you ever asked yourself the question: How much am I personally contributing to the better health of the people?

This question has become an important one to me since I have been actively engaged and interested with legislation currently pending in the State Legislature and the Congress. A few minutes of reflection on this subject by each of us, in light of many of the bills which are pending in the legislative halls, makes one seriously question just what we are doing in the interest of better health for our people.

It is not enough for physicians to solace their thinking and conscience by believing that just doing the dedicated duties of administering to the sick is sufficient. The complexities of medical practice and their relationship to matters affecting the lives and health of the public necessitates a broader area of action and interest for each physician.

We have had many of the age-old problems in the 1959 session of the State Legislature, the one of longest standing being the chiropractic issue. While this issue has been before every session for years, it is disappointing to learn how little interest is taken in this matter by the individual practicing physician. We have a responsibility to the public to do all we can to protect them from being victims of healing technics which have no scientific basis for their existence, nor scientific proof of providing cures which are claimed.

While, as an organization, we cannot enter into active legislative action, the individual physician can and has an obligation as a citizen to actively participate in legislative matters. As physicians, we have an obligation to have a practicing physician in the legislative halls, who would have a voice in legislative matters having a bearing upon the health of the people. It behooves the physicians of Indiana to look over our ranks and make a strenuous effort to bring about representation of our profession, not only in our state legislative halls, but also, in Congress. All of us should evaluate our abilities and our available time to endeavor to find at least a few of us who can enlist the support of our colleagues and friends in seeking election to legislative office.

In addition, we have a responsibility to lend our support to electing the best qualified people available in our community as our representatives in the legislative chambers.

We, as physicians, are involved by law more and more, so that besides continually striving to improve our medical knowledge, we must not neglect the political influence upon the public—our patients and ourselves. Passing resolutions by our County and State Society without continuing individual and group action is futile, and only tends to give a false feeling of having done our duty. We have a dual responsibility as a physician and as a citizen. Will there be a physician in the 1961 General Assembly?

Kenneth L. Olson M.D.

The Changing Picture of Orthopedic Practice

A Review of Medicine with Emphasis On the Strong Trend Toward 'Third Party Medicine' and the Possible Loss of Private Practice Privileges.

GEORGE O. EATON, M.D.

Baltimore, Maryland

IN THE same quarter of a century that has seen such tremendous change in electronics, air transportation, nuclear research and industrial automation, not to mention the growth of the automobile tail fin, there has occurred a great, if not so dramatic, change in the practice of medicine generally and orthopedic surgery in particular. I have in mind not so much the development of new technics and therapeutic agents, which certainly has been dramatic enough, but the change in that which is the very essence of medical practice, the relationship between the physician and his patient.

When I entered private practice 25 years ago, orthopedic surgery was a much more comfortable occupation than it is at present. In most of the larger urban centers of which I had some knowledge, there was no hospital shortage. Beds were always available, and the patient even had a choice of accommodations to fit his purse and sense of position. There was no waiting period for general hospital admissions. There were no attempts by doctors to get patients admitted through an emergency room at night because by day the admitting office had no available beds.

In those days, the orthopedist frequently found that a primary part of his practice was convincing patients that an operation would be safe and beneficial. The era was past when hospitals were considered to be places where one went to die, but there was not as yet general acceptance that a stiff knee, for example, was within the powers of man to correct. The orthopedic surgeon was not widely known. Exactly how many such specialists there were in this period before the organization of the specialty boards would be difficult to state, but communities of less than 100,000 population rarely had one in local practice.

Many of the orthopedic surgeons acquired their training by means of a preceptorship arrangement. Nearly all the teachers of orthopedic surgery in medical schools were part-time instructors busily engaged before and after teaching hours with their own private practices. When it came to combating infection, there were very few specific remedies, and the main reliance was on multiple transfusions, vaccines and general supportive measures.

Many of the larger urban centers had their hospitals for crippled children which were in effect orthopedic hospitals. The cases consisted almost exclusively of tuberculosis of bones and joints, poliomyelitis in the subacute and chronic stages, osteomyelitis and pyogenic infection of joints. Here, unlike general hospitals, there were waiting lists, so much so that the less acute and

Presidential address prepared for presentation at the Seventy-first Annual Meeting of the American Orthopaedic Association and the Joint Meeting of the Orthopaedic Associations of the English-Speaking World, Washington, D. C., May, 1958.

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SEARLE

Changing Picture

Continued

not so alarming conditions, such as brain damage, speech defects, hemiplegia and cerebral palsy were not allotted much hospital space.

Today the situation of 25 years ago is reversed. The orthopedic surgeon finds it necessary to exercise his powers of persuasion not to convince patients, as of old, that an operation is advisable, but to convince them that non-surgical measures will suffice. Instead of patients being reluctant to undergo hospitalization, the pendulum has swung to the opposite extreme under the influence of prepayment plans and the surgeon is confronted with patients expecting hospital care when their complaints and anxieties could just as well be remedied in a doctor's office.

Whereas the field of the orthopedist was once confined in most cases to treating chronic diseases and derangements of the musculoskeletal system, his specialty now cuts a broad swath through all medical care. During World War II and the Korean Conflict, the orthopedic service was usually the largest of the surgical specialties in terms of the number of casualties requiring treatment just as psychiatry was the largest branch of internal medicine. In the more peaceful present, the orthopedic surgeon is entrusted throughout much of this country with the major responsibility in acute trauma of the spine and extremities. As in wartime, the daily casualty lists continue to show a high percentage of orthopedic cases as cars clash on the highways, and the legion of blue-collar workers goes about its hazardous pursuits and an ever larger army of the elderly stumbles and falls. With such cases mounting, we may view with concern the efforts on the part of some prominent general surgeons to recapture, as it were, the field of trauma to the extremities.

The orthopedic sugeons have grown with their field. Since their specialty board was established in 1935, some 2,400 trained practitioners have been certified. While their percentage distribution among medical specialists has not changed significantly since 1935, the number of specialists of all types has shown a sharp increase. The results have been more orthopedic surgeons more widely distributed, so that where once it was rare to find one in a city of less than 100,000 population, it is accepted that communities of 40,000 and even 25,000 can support their own orthopedic specialist.

The orthopedic surgeon also has seen great changes in the tools and technics of his special calling. He has materials and metals with which to work that were unknown a quarter century ago, and a far broader knowledge of how they may be applied most effectively. He has bone banks at his disposal and all that has been learned about bone-grafting. He has chemical and antibiotic weapons against infection that, together with improved surgical technics, have all but eliminated osteomyelitis as a fatal disease and sharply altered the prognosis in tuberculosis of bones and joints. Children and young adults are limping less today because of the technics developed to equalize leg lengths. The once common complaint of sacroiliac pains, only recently a part of the American middle-aged way of life, has dropped from everyday vocabularies as we have learned to recognize the lesions of the intervertebral disc. The open surgical treatment of certain fractures has improved the outlook in many types of cases and the whole field of reconstruction and rehabilitation has undergone a revolution.

We orthopedic surgeons are the first to admit the continuing room for improvement. We acknowledge that research has not been pressed as hard and as broadly as it should be. We know that our specialty gets less than its deserved attention in many medical schools. Yet nobody can review, even briefly, the past 25 years without a sense of pride in the progress made to date and the groundwork that has been laid for improvements yet to come.

Great strides have been made, not by government dictation, not through the waving of monetary wands by philanthropic groups, not because prepayment plans assured physicians of their financial rewards. Basically the progress has come through the free initiative of medical men pursuing their own life interests, motivated by solicitude for their own patients.

With so many new ways to meet the needs of patients, the orthopedic surgeon's life should be a more satisfying one than ever before. But, as I indicated earlier, private practice is not the comfortable occupation it once was. Just getting a patient into a hospital these days takes far too much of the physician's time and ingenuity. Hospitals are badly overcrowded in many cities, and no small proportion of the patients who jam

clinical facilities and who cause others to wait for beds represents unnecessary admissions.

As great a blessing in many ways as the prepayment insurance programs have been, they have done much to foster the rush of patients to hospitals for treatment and diagnostic studies that are as readily available in doctors' offices. Hospitals, as a result, are hard put to meet their duties to the community in the care of true emergencies. Deserving patients suffer harassing delays and physicians suffer for their patients.

Another result, equally telling, is that hospitals swamped with patients are beset by ever-mounting costs, which require higher insurance rates to meet them. Yet when Blue Cross and Blue Shield agencies go before their local insurance commissioners to get the added income they must have to meet the added costs, a public howl ensues; enterprising politicians, labor organizations and others begin a chant for an investigation and for more control over costs, which, in the final analysis, means control over the practice of medicine.

Blue Cross and Blue Shield are fine as long as they are medically oriented. But in some states the Blue Shield organization is not controlled by physicians, and the situation is likely to worsen if the protests over costs lead to increased demands that there be more public representation in the large prepayment insurance program.

Twenty-five years ago this was no problem. Less than a million persons had health insurance. Today some 110,000,000 persons are covered for hospital charges, 92,000,000 for physicians' charges for surgery, 55,000,000 for physicians' medical charges in hospitals, and 10,000,000 for physicians' home and office charges. This is private voluntary health protection, and it is essential that it remain private.

Even while we talk of private practice, however, and the benefits that have been derived from it, the practice of medicine becomes increasingly less private. Pressing in from one side are the extensive medical services of the Federal Government. From another side comes the pressure from organized workers for completely prepaid group medical plans. And a third factor in the decline of private practice is the fact that many doctors no longer are working as independent physicians.

To take the last trend first, between 13,000 and 14,000 doctors are now government em-



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Changing Picture

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ployed, counting those on military duty. Another 11,000 are employed by hospitals as specialists or administrators, and these salaried doctors are in a statistical group apart from some 23,000 hospital interns and residents. Then there are about 7,000 doctors who work for health plans, industry, other doctors and miscellaneous employers. Finally, there are the combinations of doctors that in the most extreme form reduce private practice to treating a predetermined group of customers at so much a head.

Any doctor may have his own views on the various aspects of changing medical practices. But the change itself cannot be denied. A quarter of a century ago and right on up to World War II, an overwhelming majority of American doctors had their own independent one-man practices. Patients came to them of their own free choice, and the physicians set their own fees for the services performed, taking into consideration all the intimate details that were once so much a part of the relationship between the doctor and his patient.

Today little more than half our doctors are working by themselves. No special virtues are attached to the one-man practice. No ethical or medical principles are breached when doctors join together to provide easier consultation service, better facilities and more efficient coverage when one doctor is away. When, however, the group-practice movement extends to the point at which doctors hire their own orthopedic specialist on a salaried basis, certainly the fee-for-service policy has suffered a setback; and when a group of practitioners contract with a large block of patients on a yearly flat-rate basis, it is quite obvious that the independent physician is confronted with a form of competition unknown only a few years ago.

Similarly, no criticism can be leveled at doctors who become clinical faculty members in medical schools. Our medical schools need experienced teachers. If the teaching schedule is such that faculty members can maintain private practices in their own private offices, they are doing no more than continuing the tradition of the part-time teacher, part-time practitioner. When, however, the salaried faculty members conduct their private practices from their medical-school offices, in some instances using tax-supported facilities for their own gain, and in other instances letting the institution handle the fees, then a situation develops that rightly concerns the truly private physician.

As for the second large factor affecting the private practitioners—the ever-expanding governmental programs in this country—the inroads here already are heavy and constitute a continuing threat. Take the Veterans Administration and its more than 120,000 hospital beds for one example. The original purpose of its medical-care program was to provide for veterans whose disabilities were the direct result of military service to their country. That was and still is a sound humanitarian purpose and a legitimate obligation of our Government. Back in 1924, however, Congress under Coolidge opened the Veterans Administration hospital doors an extra few inches by authorizing the Veterans Administration to admit indigent veterans with non-service-connected disabilities, when spare beds were available. The exceptions soon become the rule.

Today, the tail wags the dog. The veterans whose ailments are in no way attributable to service to their country represent more than two-thirds of the Veterans Administration case load. Instead of their occupying just the beds not immediately needed by others, the non-service-connected disability patients receive the lion's share of the benefits of a program that, in the last fiscal year, cost more than $700,000,000 for in-patient and out-patient care. If any group suggests that this exploitation of the nation's obligation toward military casualties is wrong, as the Hoover Commission did a few years ago, it is greeted with howls and abuse from veterans' organizations.

The medical care provided by the armed services has undergone a somewhat similar expansion, having been extended, 2 years ago, to cover the dependents of servicemen whether they live at a military post or in their own civilian communities. Requested by President Eisenhower as an inducement to men considering military careers, the dependent benefits authorized by the Congress have opened military medical facilities to parents and parents-in-law of members or retired members of the armed forces, if they are living in the members' households and are dependent on them for more than half their sup-



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1. Wright, W. T., Jr.; Pokorny, C., and Foster, T. L.: Kansas M. Soc. *57*:410, 1956. 2. Gilchrist, A. R.: Brit. M. J. *2*:1011 (Nov. 3), 1956. 3. Terman, L. A.: Illinois M. J. *3*:67, 1957.

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Changing Picture

Continued

port. Also included are widows and dependent children of members whose death occurred on active duty or in a retired status, as well as the wives and children of living members, including children over 21 if they are attending college or are mentally or physically incapacitated.

Perhaps of even more significance to private medicine, the Medicare program, as it is called for short, enables the spouse and children of active-duty military personnel to have civilian hospital care at almost no cost to themselves if they live too far from military facilities or if the facilities are overtaxed or do not offer the necessary treatment. This covereage includes semi-private accommodations in civilian hospitals up to 365 days for each admission, all required medical and surgical care incident to hospitalization, complete maternity care, and all diagnostic tests and procedures incident to hospitalization, the only charge to the patient being $25 or $1.75 a day, whichever is higher, for each period of hospitalization.

Medicare has extended the military medical program to the point where it covers more than 2,500,000 dependents and 3,000,000 men in uniform. To begin to see the size of the Federal medical-care program, this figure for military personnel must be added to the more than 22,500,000 veterans who are potential beneficiaries of the Veterans Administration's services. There must also be added the 300,000 beneficiaries of the Public Health Service, the 370,000 Indians and Alaskan natives receiving Federal hospital care, and the 4,000,000 persons who come under the Federal Bureau of Employes' Compensation Act, which covers at-work injuries only.

This is by no means the extent of Government care. The Public Welfare Assistance Program, which continues to grow larger in good times and bad, includes payments for medical services to the needy. Until the amendments of 1956, unspecified Federal-State funds were paid out; an educated guess has put the federal share at between $90,000,000 and $100,000,000 a year. With the amendments, which set up a new category of Federal-State payments for medical care over and above the old subsistence payment limits, costs are expected to more than double and may go as high as $300,000,000 this year.

The 1956 amendments to the Welfare Program provided for direct medical payments by welfare agencies to physicians, hospitals, nursing homes and druggists in behalf of more than 5,000,000 recipients of public assistance. The vendor medical payment provisions were amended again in 1957 to clear up problems created by the 1956 amendments, this time giving states a choice as to how Federal funds for medical payments are applied and also permitting the states to continue to make direct payments to recipients for medical and subsistence expenses.

Whether the doctor sends his bill to the welfare agency or the welfare recipient, he comes up against the same governmental controls over how much will be allowed for house and office visits, how much for an x-ray and how much for this and that. And if the local welfare people are on their bureaucratic toes, he also finds that prescriptions are checked to make sure that an expensive drug is not ordered when a cheaper medication, considered by them to be of equal therapeutic value, is available.

When the more than 5,000,000 public welfare recipients are added to the veterans, servicemen and their dependents, Federal employees, Indi-

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Vaginal Approach to Pelvic Surgery, One Week, April 27
General & Surgical Obstetrics, Two Weeks, March 30

MEDICINE—
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Hematology, One Week, May 25
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ans, Alaskan natives and patients of the Public Health Service, we find that over 37,000,000 Americans are potential beneficiaries of Federal medical services, or one out of every 4.6 residents of the country.

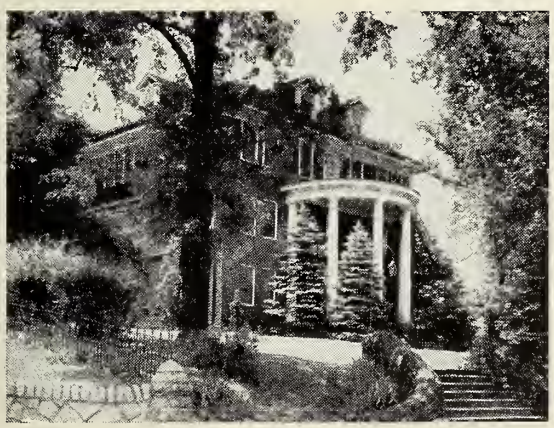
We can all remember the running fight of the 1940's to defeat national health insurance, popularly known as socialized medicine. Politicians and labor leaders teamed up to push hard for the Wagner-Murray-Dingell bill of 1945 and allied schemes in 1946. President Truman was in the White House and his party controlled Congress; but, after extensive hearings, sufficient opposition manifested itself to keep the bills from coming to a vote.

Another big push was mounted in 1947 and 1948, with Oscar Ewing staging a National Health Assembly to build up support for his health insurance program. The assembly, however, could not be stampeded into endorsing socialized medicine, and, in spite of all the pressure from labor and other lobbyists, compulsory health insurance died once again in a Congressional Committee, this time with a Republican Congress offsetting the influence of a Truman administration.

An aroused medical profession in those years was a strong factor in the defeat of a frontal move toward nationalized medicine. Lest we forget, though, that was a decade ago. The doctors may have relaxed since then; their opponents have not. The health insurance program that could not be obtained in one fell swoop has been pushed on a piecemeal basis. Congress enacted bills in 1950, 1952 and 1954 that paved the way for what was a major breakthrough in 1956, the passage by a one-vote margin of the Social Security amendment that authorizes cash disability benefits for workers at the age of 50 if they become permanently and totally disabled, physically or mentally.

As doctors, we know how difficult it is to say with finality that a person is permanently and totally disabled. We know the effect on possible rehabilitation and re-employment that can be produced by labeling a patient as hopeless and assuring him of a monthly income whether he works or not. We also can recognize that payment for physical and mental ailments is a radical departure from the original intent of the Social Security Act to provide old-age and survivors' insurance. But the efforts of organized

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Continued

medicine and others could not turn the tide in 1956. President Eisenhower signed the measure, and it went into effect last July.

The disability payments at the age of 50 are only a first step. Half a dozen bills in the current Eighty-fifth Congress would permit the payment of disability benefits at any age. Other proposed legislation would liberalize the coverage requirements and redefine *disability*. Still others would provide disability payments to widows at the age of 50 and to blind persons of all ages.

A particularly potent scheme now pending is the Forand bill to furnish hospital, nursing home and surgical care for the millions of Americans now receiving old-age and survivors' insurance benefits. Compulsory insurance is back again, sponsored by Messrs. Murray and Dingell, son of the original Dingell. There are also moves to provide Federal aid to medical schools and health insurance for Federal civilian workers. And, among the encouraging proposals, Representative Roosevelt of California has an amendment to the Longshoremen's and Harbor Workers' Compensation Act that would permit injured workers to select their own physician and hospital.

So great is the Congressional interest in the health field that 250 pieces of health legislation were introduced in the Eighty-second Congress, 407 in the Eighty-third, 571 in the Eighty-fourth, and the present outlook is for at least 640 in the current Congress. Not all of this interest is sinister, of course. Yet often the good intentions of Congressmen knowingly or unknowingly pave a road to regimentation for the private practitioner, as in the case of the Forand bill, which provides, among other things, that physicians be paid in such amounts as prescribed in regulations promulgated not by physicians but by the Secretary of Health, Education, and Welfare.

The third large factor in the diminution of private medical practice, along with Government expansion and the shift of doctors to salaried positions, is the drive among organized labor unions to procure full and prepaid coverage of all medical expenses for their members. The threats from Washington in the 1940's have been superseded now by the threats of men with large union treasuries who are not satisfied with Blue Shield plans and with the private physicians who guide those plans. The big labor leaders increasingly want their own medical programs and their own stables of doctors, financed through business contributions to their health and welfare funds.

An article in *Medical Economics* last fall ticked off some of the major labor moves: Walter Reuther and his auto workers, one of the largest of all unions, are pushing ahead with plans for closed-panel medical centers throughout Detroit to provide members with a full range of medical services by doctors on a salaried or per capita basis.

The United Steelworkers, a union that brought over 1,000,000 members into Blue Shield, threatens to withdraw its membership *en masse* when the current contract expires, unless Blue Shield is prepared to offer full benefits regardless of income and comprehensive coverage that includes "early diagnostic and preventive medical care, treatment of the chronically ill, hospital visits, home and office calls, dental, drug, and appliance bills."

The United Mine Workers, whose fiscal report for the year ending June 30, 1957, shows $59,584,594 expended to provide hospitalization in 45 states, the District of Columbia, and Alaska for 93,679 beneficiaries, was one union that at the outset honored the fee-for-service principle and the right of members to choose any qualified physician. Last year, however, 5 state medical societies registered complaints with the American Medical Association that the union has begun to put physicians on a salary or retainer basis and limit the members' choice of physicians.

Instead of licensed physicians being accepted as qualified to perform such services as they and their professional peers believe them competent to perform, and instead of hospitals being judged on their individual performances, the miners' health organization frequently of late has assumed the prerogatives of judging treatment given by physicians, the qualifications of physicians for hospital appointments, the selection of hospitals and the choice of hospital staffs. And as the miners go, so more than likely will go other unions.

Doctors in the mining regions of Pennsylvania have seen clearly enough what happens as a third party comes between physician and patient. The free-choice principle is dropped down an

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abandoned mine shaft as more and more doctors become dependent on union patronage and drift into union control. One young surgeon put it bluntly when he said, "It's up to us who aren't completely dependent on union payments to carry this fight through to its conclusion. One side or the other has to win."

Colorado doctors have also seen the handwriting on the hiring-hall walls. The medical society there has ruled that any physician who knowingly and willingly participates in a medical plan which denies its beneficiaries the right of free choice of physician shall upon conviction thereof by appropriate medical tribunal be found guilty of unethical and unprofessional conduct. But if the price is high enough, even this threat of professional condemnation may not be sufficient to stop some doctors from crossing over to controlled medicine.

Nobody in our profession needs a crystal ball to foresee what is in store for private medical practice in this country. When the monolithic AFL-CIO organization announces the formation of a war chest to help defeat medical opposition to labor health plans, and when its president patronizingly remarks that "we only want to help attract the best doctors and bring out the best in them," the prospects of continued union intervention between physician and patient are perfectly clear.

While Blue Shield is the immediate object of labor's attack, it is only the first target in the union's line of fire, representing the medical profession once removed. This is quite evident when an official of the United Auto Workers levels his verbal gun at Blue Shield for trying, as he says, to "superimpose the concept of prepayment on an archaic system of solo practice." It is made doubly plain when a spokesman for the steel workers says that Blue Shield has deteriorated into what he calls "a collection agency for the medical profession."

The ancient foe of private medicine, Michael M. Davis, whose promotion of compulsory health insurance goes back to the 1920's, has brought forth the prediction that within 10 years only 10% of all payments to physicians will be in the form of fees for service. That may sound fantastic to some of us and, considering its source, a prediction to be classed as the pipe dream of a propagandist. However, Mr. Davis' prophecy does not sound so far-fetched when men from the ranks of medicine, such as Dr. Russell Lee, make similar forecasts.

Dr. Lee, who heads an 80-physician clinic in California, has served as an American Medical Association delegate and was a member of President Truman's Commission on health needs. Interviewed for *Medical Economics,* Dr. Lee said he felt certain that within 25 years almost all the medicine in the country will be practiced in prepayment groups. Comprehensive care on a prepaid basis is presumed to be what the patients want, and men like Dr. Lee are convinced that is what they are going to get. "If organized medicine does not accept the idea, there will be plenty of maverick MD's who will."

We had better fall into line, the closed panelists say, or that other goblin—socialized medicine—will get us for sure. A glance into the future offers no assurance whatsoever that doctors by giving up their principles of fee-for-service and free choice of physicians can thereby keep Government medicine from their office doors. On the contrary, it may be that the doctors who sell short the tried and proved principles of the private practice of medicine only serve to weaken what was once a united front and thereby make the whole profession more vulnerable.

How far the nationalization of medicine will go, I myself would not care to predict. The pressure in Washington is there, that's for certain. Social Security provides a ready tax on the earnings of nearly all working Americans. If it can be twisted into disability payments at the age of 50, as has already happened, or converted into hospital insurance for the aged, as the Forand bill proposes, then there is no guessing what new forms of socialized medicine can be pulled in under the Social Security blanket. The one obvious thing is that new schemes will be proposed and pushed with relentless determination.

Aside from the prospects of compulsory health insurance coming piecemeal under the guise of Social Security governmental care of the medically indigent, military dependents, federal employees, and millions of veterans surely will continue and will be expanded wherever and whenever the empire builders and pressure

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groups see an unguarded opening. Political parties rise and fall on Capitol Hill, but the drive toward socialized medicine goes steadily forward, no matter who occupies the White House or the seat of the Majority Floor Leader.

I, for one, do not minimize for a moment what the opponents of a free and independent medical profession are predicting. I believe that the battle lines are drawn and that, in the next few years, the principles of fee for service and free choice of physicians will have had their conclusive test and either will have been successfully defended by an aroused profession and their patients or will have been swallowed up once and for all time.

The only real question remaining is whether private practitioners will rise to the challenge or simply let their profession, including themselves, be overtaken by groups openly aiming to take medicine out of medical hands. The American Medical Association, as we all know, is alert to the dangers and actively opposes each threat that arises. But what do we mean when we say the American Medical Association? Too often we mean a small band of medical representatives in Washington fighting our battles with only nominal support and a cash contribution from us.

The medical profession is not going to defend itself for long with a small task force instead of a professional army fully equipped with facts, rebuttals and unity of purpose. The doctor who sits in his office and does not know what the Forand Bill proposes to do to the concept of Social Security is a doctor who is not likely to wake up until it is too late to fire a shot. The specialist who feels that the hiring of internists or orthopedic surgeons by the United Mine Workers is some other doctor's worry is a specialist who does not recognize the noose until it begins to tighten around his own neck.

I said at the outset that the practice of medicine 25 years ago was more comfortable than at present. Looking ahead, it appears certain that the practice we have today is likely to be more comfortable than that in the years immediately ahead.

Medicine is highly personal, and if we consistently render good personal care, the public will not turn to the anonymous care furnished by clinics with their long waiting periods and changing personal physicians.

No man seriously devoted to medicine can anticipate with pleasure having to play an active role in winning friends and influencing legislation on behalf of private medicine. No man with a full patient load relishes attendance at meetings which are occupied with discussions not of medicine but of bills pending in Congress. Yet we must either throw our full weight in person behind the organizations trying to defend the private practice of medicine or be held accountable for the defeat of a medical system second to none in public service and technical advances.

If we win, medical practice for those who open private offices 25 years hence may once again be a comfortable profession which allows a doctor to give full and undivided attention to the one main concern of his life, the care of his patient.

NOTE: The author wishes to acknowledge the interest and assistance of the American Medical Association Washington Office in the preparation of this address, particularly in making available the factual material.

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The Third Party—Friend or Foe?

THEODORE WIPRUD*

Washington, D. C.

THE DELICATE nature of my subject is self-evident. In many areas of the country controversy between the medical profession and a third party has been bitter and a solution is still not in sight.

It is my purpose in these observations to relate to you some historical facts about the socioeconomic aspects of the third party in medicine with which I am personally familiar and their significance to the medical profession here and elsewhere.

Third Party Defined

First of all, I should like to explore definitions of the third party. One of the outstanding physicians in Pennsylvania, a Past President of the American Medical Association, gave me this definition, which I for one am willing to accept: "Economically, the third party is anyone or any organization that arranges in any way to pay for professional services rendered a patient by his physician."

In gathering material for this presentation I wrote 31 Washington physicians for their definitions and other pertinent information. Several of them called me on the telephone and wanted to know what the third party was. One asked me if it was a new political party. Some went along with the definition already quoted. Others offered some which were quite unique, such as the physician who would include any one of the following as a third party: nurses; laboratory, X-ray, or physical therapy technicians; the parents of a minor; the adult children of an aged and infirm patient, whether appointed guardians or not; the courts (in psychiatric cases); hospitals; insurance carriers; Public Health officials, and many others.

In a recent newspaper release the Blue Shield Commission insisted that its organization was not a third party because it is "of the profession itself." Personally, I do not agree. The fact is that Blue Shield Plans act as intermediaries, collecting dues from subscribers and paying physicians, usually in accordance with a fee schedule.

Lest I be misunderstood, this is not intended as a criticism of Blue Shield. After all, as secretary of one of its Plans I am well aware of the unique relationship which exists between this organization and the medical profession.

So much for definitions. Being primarily concerned with the economic aspects of my subject, I will accept the first-mentioned definition, that a third party is any individual or organization that assumes the responsibility for paying a physician for his services to a patient.

I need hardly remind some of you older physicians that third party medicine has been on the medical scene a long time. It has been the heart of many controversies, within and without the medical profession, for the past 3 decades or more. For better or for worse, it has flourished and become a major factor to be reckoned with by the medical profession.

Why has this growth occurred? There is no simple answer to that question, but a look into the past will give us some clues.

Medical Controversy in the Making

Just a month before the disastrous stock market crash in 1929 I was employed as an executive secretary of a large county medical society in Milwaukee, Wisconsin, which, as you know, is an industrial city. Although I had had 8 years' experience as business manager of a medical clinic, the larger economic problems of medicine

Presented at the Annual Meeting of the Pennsylvania Academy of General Practice in Pittsburgh, May 24, 1958. Reprinted from *Medical Annals* of the District of Columbia, August, 1958, pp. 425-429.

*Executive Director and Secretary of the Medical Society of the District of Columbia; Professorial Lecturer in Medical Economics, Georgetown University School of Medicine.

were new to me. I soon made some important discoveries.

First, there appeared to be a "revolution" in the making where methods of providing and paying for medical care were concerned. The now historic 5-year study of the Committee on the Costs of Medical Care, headed by Dr. Ray Lyman Wilbur, Past President of the AMA, and underwritten financially by 8 Foundations, had been in progress since early 1928. Several individual studies which would be incorporated in the overall study were being released for publication from time time to time.

It soon became evident from the tenor of these reports that the Committee would not be unanimous in its findings. Of the 50 members of the Committee, 17 were physicians engaged in private practice. The others represented Public Health, social sciences, the public, and institutional and special interests.

In the Committee's final report, released in 1932, the majority recommended among other things that "both preventive and therapeutic (services) should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel, such groups to be organized preferably around the hospital, for rendering complete home, office, and hospital care," and that "the costs of medical care be placed on a group payment basis through the use of insurance, through the use of taxation, or through the use of both these methods."

The principal minority group, representing the viewpoint of private physicians, on the other hand, recommended that Government competition in the practice of medicine be discontinued, that its activities be restricted to the care of the indigent, promotion of public health, support of medical departments of the armed forces, and the provision of medical care to veterans suffering from bona fide service-connected disabilities and disease. There was pointedly no endorsement of voluntary health insurance, although the development of plans for medical care by medical societies was recommended. There were no suggestions offered as to the kind of plans these should be.

Recommendations of both the majority and the minority groups stirred up heated discussions throughout the country and marked the beginning of a controversy which has continued down to the present time.

If any of you have not read the final report of the Committee on the Costs of Medical Care, you should do so because nearly all the economic issues facing medicine today stem from this document.

There were, at that time, other problems of more immediate concern to physicians in Milwaukee. Agitation had nearly reached a boiling point over contract practice. A large number of physicians in this industrial community had an agreement with some industry, mutual aid society, or fraternal organization. Some of the more agitated physicians who had no contracts insisted that the "rascals" who had them be thrown out of the Medical Society. The situation, which was not peculiar to Milwaukee, finally reached a stage where it seemed that the organization would be split down the middle. Fortunately, the strategy developed by officers of the Medical Society in an effort to heal differences worked.

However, contract practice continued to be an irritation to many physicians, who were very vocal about it. In one instance lodge practice reached such a low ebb as to quality that even the men who had accepted these arrangements quit in disgust.

Physicians engaged in so-called ancillary services were especially pessimistic about the situation. The President of the Milwaukee County Medical Society, for example, wrote an article entitled, "Can the Pathologists Survive?" He raised the question which one still hears today: "What is there to prevent the pathologist's present position being recognized as a precedent for hospitals employing surgeons and internists in the same manner in which pathologists and roentgenologists are now employed?"

For some years thereafter there were scattered flurries of excitement among the profession over these issues, but finally things settled down to a simmer. The Depression had deepened, and the New Deal was in the ascendancy. Unemployment increased rapidly, with the result that at one time in Milwaukee a substantial part of the population was on relief. Many physicians and their patients, therefore, were in financial straits.

On the initiative of the Medical Society county authorities agreed to pay physicians caring for the medically indigent on a fee basis. It became a far greater undertaking than was anticipated in the beginning and, of course, lasted much longer.

Third Party

Continued

Early in 1933 it became quite apparent to leaders in organized medicine that several signers of the majority report of the Committee on the Costs of Medical Care and their supporters were preparing to implement their recommendations if at all possible. Articles dealing with medical costs were appearing in newspapers and magazines with increasing frequency.

The New Deal Administration announced it would seek the enactment of compulsory health insurance legislation. This was on its list as a must. Organized medicine was equally determined that such legislation should not be enacted. Surprisingly, the Administration did not press the matter too strongly until 1943, when the first Wagner Compulsory Health Insurance Bill was introduced.

Deeply concerned with these developments were a handful of medical leaders who urged not only the endorsement of voluntary health insurance but that something be done to get prepayment plans into operation.

It must be admitted that there was not much enthusiasm for this proposal among the medical profession. One of the most influential medical leaders of that period was the late Dr. Olin West, then Secretary and General Manager of the American Medical Association. Those of us who knew Dr. West held him in highest esteem. He was a man of convictions, integrity and great courage. It was he who made the statement in the latter 1920's that "one great outstanding problem for the medical profession today is that involved in the delivery of adequate scientific medical service to all the people, rich and poor, at a cost which can be reasonably met by them in their respective stations in life." But Dr. West was no friend of medical society-sponsored voluntary health insurance plans. He was, to put it mildly, opposed to health insurance programs of any kind. I recall discussing the matter with him one time in Chicago. He was vehement in his insistence that voluntary health insurance could only lead to the compulsory variety.

Whether he was correct in his opinion, only time will tell. At any rate, a number of highly regarded physicians at that time disagreed with him, taking the position that a negative stand could not be justified. Leading physicians in such states as Wisconsin, Michigan and California raised their voices in strong support of prepaid medicine on a voluntary basis.

Before the 1930's came to a close, medical society-sponsored prepayment plans had made or were about to make their bow in California and Michigan. Washington State and Oregon had for a number of years a form of prepayment which was quite different from that which came later. Prepayment medicine did not gain real momentum until the 1940's, when Blue Shield came into existence.

These, then, are some of the phases of third party medicine which occupied the attention of the medical profession until World War II, when discussion of the subject ceased for the duration of the War.

With the passing of the Truman Administration and the election of President Eisenhower the fire of controversy again died down perceptibly.

Growth of the Third Party

What is the situation today? Has the third party withered on the vine, or has it flourished? The answer is obvious to all of you present. As I stated in the beginning, it is only too apparent that the third party has gained great momentum, with what effect remains to be seen.

Contract practice, especially as it involves hospitals, is still an issue. Legal proceedings have been instituted in some states to prevent the corporate practice of medicine. In one or two instances these efforts have been successful, the most outstanding being in Iowa.

There is no need to dwell upon the phenomenal growth of voluntary health insurance. Although still in its infancy it is a lusty infant. Dr. Odin W. Anderson, Research Director of the Health Information Foundation, states that in 1957, 40 per cent of the total expenditures for health services was paid for by a third party. One hundred and eighteen million persons now have some form of health insurance. However, most of the present insurance and prepayment plans offer limited protection against the cost of illness.

"The drive for expansion of benefits," Dr. Anderson states, "has proved to be relentless since the costs outside the hospital frequently prove to be unduly burdensome for a family."

Six to 700 insurance companies are writing

Continued



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Buffered Pabirin is formulated to provide high and sustained salicylate blood levels. Each tablet consists of an outer layer containing a buffer (aluminum hydroxide), para-aminobenzoic acid, and ascorbic acid; a core of acetylsalicylic acid.

In the stomach, the outer layer quickly releases the buffer, which protects against nausea, dyspepsia and other gastrointestinal symptoms so frequently encountered with salicylates alone. The core of Buffered Pabirin then disintegrates rapidly, permitting rapid absorption of the acetylsalicylic acid for faster pain relief.

References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. *257*:278 (Aug.) 1957.

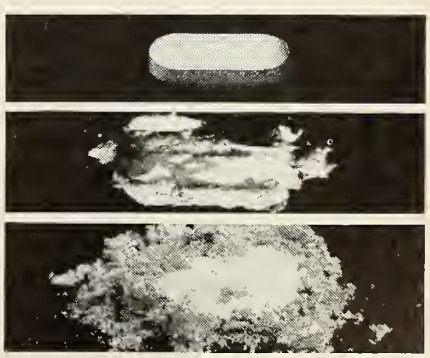
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Each tablet contains:

Acetylsalicylic acid (5 gr.)	300 mg.
Para-aminobenzoic acid (5 gr.)	300 mg.
Ascorbic acid	50 mg.
Dried aluminum hydroxide gel	100 mg.

All Buffered Pabirin is sodium- and potassium-free.

Dosage: Two or three tablets 3 or 4 times daily.



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Third Party

Continued

health insurance. There are about 300 Blue Cross, Blue Shield, and other nonprofit Plans in operation. Most of the Plans providing medical services permit free choice of physicians among those who agree to participate.

In the minds of a large number of physicians Blue Shield Plans are the big hope for the future where the medical profession is concerned. If proper leadership is given them, and if the medical profession cooperates, they are confident of success in meeting the reasonable demands and needs of the people as regards the payment of their medical bills.

As is well known, not all physicians approve Blue Shield Plans. Some say physicians should not engage in the insurance business and should get out of it as soon as they can. Others resent what they consider dictation of their fees. Still others disapprove disciplinary measures by a committee of their colleagues against Participating Physicians. By and large, the protestations of these physicians are looked upon by those who favor Blue Shield as growing pains.

Commercial insurance companies came into the voluntary health insurance picture following the lead of medical societies. When it became apparent to the companies that prepayment was not only feasible but could be made sound actuarially they became actively interested.

It is superfluous for me to tell you that labor unions are and will undoubtedly continue to be a formidable factor in third party medicine. They control vast health and welfare funds. This places them in a strategic position. It is apparent that much patience and good will on the part of both labor and the medical profession will be required to arrive at a mutually satisfactory understanding.

Nothing has been said up to this point about local, state and Federal governments as a third party. Agencies included in this category are Public Health departments, all of which engage to a considerable extent in both curative and preventive medicine; the Veterans Administration, which not only provides all forms of medical care for veterans through its hospitals but in some states home care rendered by private physicians; and a large number of general and specialty hospitals and other medical institutions which make available medical service to a large segment of the country's population. The Government's Medicare program is the most recent arrival upon the third party scene. As you know, this program provides medical care for dependents of personnel in the uniformed forces under agreements with most state medical societies.

This, of course, is only a partial list of organizations and institutions which can be classified as a third party. It is sufficient, however, for the purpose of this discussion.

What About the Future?

Understandably, these developments have deeply concerned many physicians who have grave misgivings about the future of private medical practice. The question uppermost in their minds is: What is the best course for the medical profession to pursue? Is the third party situation the menace it appears to be? What elements in the third party arrangement are essential to safeguard the best interest of patients and physicians? What should be done to win sympathetic public support for the medical profession's point of view? I have discussed these questions with a number of physicians engaged in private practice for whose judgment I have the highest regard. The following, with slight variations, is a consensus of their views.

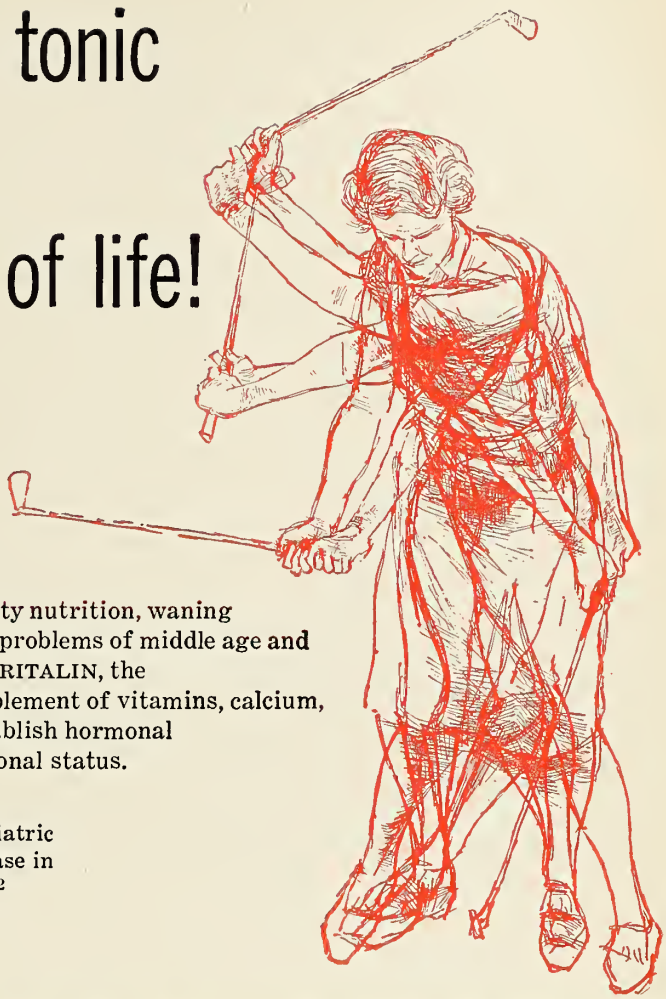
They were unanimous on one point—inroads of third party medicine will continue and will expand. As one physician wrote me, "I believe you will agree that there is nothing on the horizon lessening third party activities. I only hope that we will recognize that we have both friends and foes and will consider each case on its merits. To fight the inevitable on general principle is to fight a losing battle."

Of course, this physician said he did not mean that the profession had to accept anything that was handed it. He did mean that there would have to be some pretty objective thinking in the top echelons of organized medicine about the third party issue. First things, he insisted, will have to come first, and where medicine is concerned that is, as it always must be, the welfare of the patient.

Whether the third party is friend or foe in the minds of most physicians depends upon three things: (1) acceptance of the free choice principle, (2) noninterference in professional matters, and (3) adequate compensation, preferably on a fee basis.

Continued

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methyltestosterone	1.25 mg.
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thiamin (vitamin B_1)	5 mg.
riboflavin (vitamin B_2)	1 mg.
pyridoxin (vitamin B_6)	2 mg.
vitamin B_{12} activity	2 micrograms
nicotinamide	25 mg.
dicalcium phosphate	250 mg.

Dosage: One Ritonic Capsule in mid-morning and one in mid-afternoon.
Supplied: Ritonic CAPSULES; bottles of 100.
References: 1. Natenshon, A. L.: J. Am. Geriatrics Soc. *6*: 534 (July) 1958.
2. Bachrach, S.: To be published.
RITALIN® hydrochloride (methylphenidate hydrochloride CIBA)

C I B A SUMMIT, N. J.

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Third Party

Continued

The best assurance of maintaining free choice, my medical associates insisted, is for the profession to see to it that the quality of medical service is kept at a uniformly high level. Most physicians with whom I talked believe that much more should be done to assure the people that they need have no concern on this score.

At the present time a licensed physician can do as he likes about keeping abreast of medical progress. He may be, and sometimes is, content with what he learned in medical school and through experience in practice. Hospital medical staffs, however, have done much to maintain high standards of practice, but there is very little supervision of them outside these institutions.

Any mandatory requirement that all licensed physicians meet arbitrary standards of practice would undoubtedly meet with strong opposition by the profession. Nevertheless, this factor in the acceptance of the free choice principle cannot be ignored. The American Academy of General Practice recognized this when it required of its members that each year they do a certain amount of postgraduate study.

Another barrier to acceptance of the free choice principle, according to physicians with whom I have discussed the subject, is failure of medical organizations to take effective disciplinary action against wayward members. Grievance committees, in most instances, they say, are soft, cautious, or ineffectual. However, they admit there are a number of exceptions. The State of Washington now has a Medical Disciplinary Law which is being watched with considerable interest by the medical leaders.

The most prized prerogative of a physician is his freedom to exercise his professional judgment without interference. This is something that medicine has fought for with unyielding vigor. It is vitally important to patients as well as to physicians.

There is no question in the minds of students of the subject that in a decade or less voluntary insurance plans, if they are still in existence, will have enjoyed tremendous growth and provide much greater coverage than they now do. In fact, it is certain that most of the people in this country, probably 90 per cent of the population, will be protected by health insurance in some form. This means, of course, that the third party will be largely responsible for their medical bills. Fee schedules or specified payments for various procedures will of necessity have been accepted by the medical profession.

If this situation should come to pass, how satisfactory will the medical profession find it? That depends on how alert they have been and the leadership they have shown. One would think, with all the discussion, all the articles, and all the books that have been written on the socioeconomic aspects of medicine, that much of it would have permeated the doctor's thinking. On the contrary, it is surprising how few are informed, or are very interested in this subject. Happily, there is a group of whom this is not true. They are the ones on whom many of us are pinning our hopes.

It is well known that socioeconomic patterns adopted nationally are never abandoned. One can be certain, for example, that Social Security is here to stay. So is contract practice. So is voluntary health insurance. In this situation it is vital that organized medicine provide constructive leadership.

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Whether the third party is a friend or foe then depends a great deal upon medical leadership. This is especially true where the voluntary health insurance plans are concerned. The medical profession needs to know more about these plans and those who administer them. Without question, they are organized medicine's most valuable instrument in dealing with medical costs.

A few weeks ago Dr. Edward J. Stieglitz, a nationally known authority on the aging and a member of our Medical Society, submitted an article for publication in our medical journal entitled, "Water." In this article he stated he could not recall water being ever mentioned in scientific journals as a nutritional element.

"This blind spot," he wrote, "has often reminded me of the anecdote about the barfly who said to the bartender that blindfolded he could identify all ingredients in any mixed drink which the bartender could concoct. If he failed, he would pay double for the drink, but if he succeeded, he would get it free. The bartender mixed one cocktail after another. The contents of each was identified with unfailing accuracy. In desperation the bartender presented the man with an educated palate with a glass of water. The man tasted it carefully, rolled it about in his mouth, tried another sip, but was obviously puzzled. Finally he said, 'I don't know what this is, but I am sure it won't sell.' "

If the facts presented and the views here expressed are unacceptable to you, I have made no "sale." On the other hand, if what I have said has opened up some new channels of thought on controversial issues, it will not have been time wasted for any of us.

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TO A.M.E.F.

Indiana State Board of Health

DIVISION OF COMMUNICABLE DISEASE CONTROL

A. L. MARSHALL, JR., M.D., *Director*

MONTHLY REPORT - JANUARY 1959

Disease	Jan. 1959	Dec. 1958	Nov. 1958	Jan. 1958	Jan. 1957
Animal Bites	331	227	326	98	127
Chickenpox	622	606	360	602	796
Conjunctivitis	71	61	40	17	19
Diphtheria	0	0	1	0	0
Dysentery, Unspecified	31	29	11	102	7
Impetigo	38	77	61	25	42
Infectious Hepatitis	32	56	11	37	16
Infectious Mononucleosis	22	12	7	3	4
Influenza	730	616	706	665	272
Measles (Rubeola-Ruella)	643	456	270	654	883
Meningitis, Meningococcal	2	5	0	1	2
Meningitis, Other	6	10	13	8	1
Mumps	246	127	147	415	199
Pertussis	186	61	91	27	39
Pneumonia	275	163	148	167	128
Poliomyelitis	0	8	22	0	4
Streptococcal Infections	547	292	232	355	353
Tinea Capitis	13	21	72	32	12
Vincent's Infection	3	4	3	6	3

NEWS NOTES—from State and Nation

Pediatric Postgrad Course Scheduled at Louisville

University of Louisville's Department of Pediatrics is presenting a postgraduate course at Children's Hospital, Louisville, to be held each Tuesday from 9:30 a.m. to 12:30 p.m., April 14 through June 2.

On April 14, the program will consist of comments by the AAP state chairman and KSMA postgraduate committee chairman, Newer Advances in the Care of the Child with TB and The Evaluation of Growth.

A Practical Approach to Allergy in Childhood and The Problem of Low Grade Fevers will be on the April 21 agenda.

April 28 will feature Newer Advances in Therapy and Radiology as a Diagnostic Tool in Pediatrics.

A symposium on Cancer in Children will be presented May 5, as well as Squint, and Management of Head Injuries in Children.

Thyroid and Other Endocrine Problems of the Adolescent and Pediatric Gynecology will be the program on May 12.

May 19 will feature The Well Child, and Medical Care of the Patient with Congenital Heart Disease.

A Re-evaluation of Some Common Poisons will be given May 19, as well as Hearing Defects in Children and Activities of the Hearing and Speech Center, Louisville.

Last of the sessions, to be held June 2, will feature The Newborn and a question period.

Several of the sessions will include conferences. The course is under direction of A. J. Steigman, M.D., chairman, Department of Pediatrics. Programs will be held in Children's Hospital amphitheatre.

The Society of Nuclear Medicine's sixth annual meeting will be held at the Palmer House, Chicago, June 18-20. Additional information may be obtained by writing Samuel N. Turiel, administrator, The Society of Nuclear Medicine, 750 N. Michigan Ave., Chicago 11.

Heart Disease, Hypertension Featured in I.U. Courses

A postgraduate course in treatment of heart disease and one in treatment of hypertension will be presented by I. U. Medical Center April 29 and 30 respectively, registration beginning at 8 a.m. in each case.

In the heart disease course on the 29th, such subjects as pathologic physiology, digitalis, diuretics, low sodium diet, low fat diet, myocardial infarction (first 4 weeks, and after 4 weeks), angina pectoris, auricular fibrillation and indication for surgery will be discussed.

During Thursdays sessions, subject matter will cover blood pressure and its effects upon cardiovascular, central and renal system, hypertension in the older non-systemic patient, treatment of unusual etiology, drug therapy in chronic hypertension, treatment of the hypertensive crisis and a panel discussion on complications of hypertension.

M.G. Symposium Scheduled

The Second International Symposium on Myasthenia Gravis will be held April 18-19 at Los Angeles, Statler-Milton Hotel, under joint auspices of The Myasthenia Gravis Foundation, Inc. and The National Institute of Neurological Diseases and Blindness.

Fifty-seven speakers from Western Europe, Canada, Soviet Russia and U.S.A. will present current work in the field. The symposium will be printed as a monograph by Charles C. Thomas, publisher, Springfield, Ill., and will be available to the medical profession early in 1960.

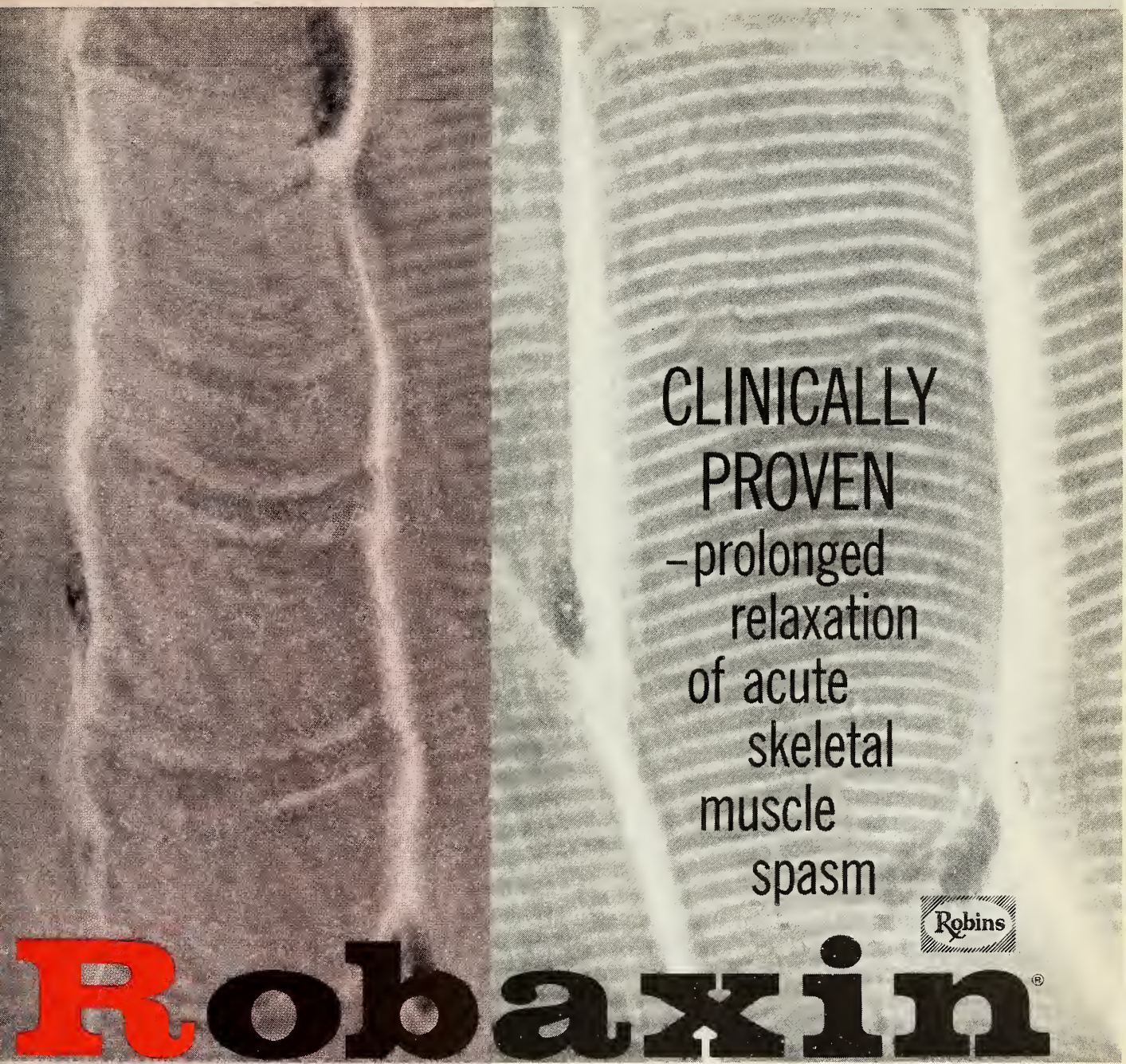
Physicians and students welcome. No registration fee. Write the Myasthenia Gravis Foundation, Inc., 155 East 23rd St., New York 10.

James F. Treon, M.D., Aurora physician for over 50 years, has retired from office practice to continue his practice in his home. He has served as county coroner and at present is physician for the County Home. He is an ISMA senior member.

Continued

Fiber of skeletal muscle in spasm

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TABLETS

Summary of six published clinical studies:

ROBAXIN BENEFICIAL IN 92.4% OF SKELETAL MUSCLE SPASM CASES

	NO. PATIENTS	RESPONSE			
		"marked"	moderate	slight	none
Carpenter[1]	33	26	6	1	—
		"pronounced"			
Forsyth[2]	58	37	20	—	1
		"good"			
Lewis[3]	38	25	6	—	7
		"excellent"			
O'Doherty & Shields[4]	17	14	2	1	0
		"significant"			
Park[5]	30	27	—	2	1
		"gratifying"			
Plumb[6]	60	55	—	—	5
TOTALS	236	184 (78.0%)	34 (14.4%)	4	14

- **Highly potent—and long acting.**[1,2,3]
- **Relatively free of adverse side effects.**[1,2,3,5,6]
- **In ordinary dosage, does not reduce muscle strength or reflex activity.**[1]

REFERENCES: 1. Carpenter, E. B.: Southern M. J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Lewis, W. B.: California Med. 90:26, 1959. 4. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 5. Park, H. W.: J.A.M.A. 167:168, 1958. 6. Plumb, C. S.: Journal-Lancet 78:531, 1958.

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News Notes

Continued

Academy of General Practice Scientific Assembly in April

The American Academy of General Practice will hold its 11th Annual Scientific Assembly in San Francisco on April 6 to 9. Seven thousand doctors and guests are expected to attend. One hundred scientific and three hundred technical exhibits have been prepared.

Twenty-eight prominent physician-authorities will present a scientific program on the subjects of immunology, animal diseases transmissible to man, hypertension, cardiac arrest, burn therapy, obstetrics and complications of abdominal surgical operations, in addition to many others.

Ten $1,000 general practice residency training awards provided by a grant from Mead Johnson & Company will be presented. Two $1,000 awards will be presented for the most significant scientific articles published in GP by academy members, courtesy of Ross Laboratories of Columbus, Ohio.

Dr. Fount Richardson of Fayetteville, Arkansas will be installed as President.

Local Fluid Balance Book Translated into German

The *Fluid Balance Handbook for Practitioners,* by Drs. W. D. Snively, Jr., Evansville, Ind., and M. J. Sweeney, Memphis, Tenn., has been translated into the German and published by Urban and Schwartzenberg, Munich and Berlin. The attractive German edition has 323 pages, 47 illustrations and 27 tables. It includes 4-color plates. The translation was capably done by Dr. Harold Linke of Germany, who included helpful supplementary material.

The translation of a medical text from English to German represents an interesting switch. The *Fluid Balance Handbook* has also been published in Canada, England and other English speaking countries. A Spanish version is in preparation.

Charles C. Thomas published the American edition.

(Above article submitted to the *Journal* by Harold D. Lynch, M.D., editorial board member.)

Diet Manual Published

An "Indiana Diet Manual" has been published by the Indiana Shared Dietitian Project Committee which is represented by the Indiana Dietetic and Indiana Hospital Associations and the Indiana State Board of Health (and approved by ISMA).

Available to physicians and hospitals in Indiana, the manual was prepared and tested by the Dietitian Project Committee as further service in preparation of hospital and special diets, especially slanted for the small hospital with no trained dietitians. It was originated because the planned service of part-time dietitians for all Indiana hospitals has been deemed impossible due to a lack of trained dietitians in the area at the present time.

This manual includes routine hospital diets of general (for adults, older persons, pregnant women, nursing mothers, infants, preschool children, school children and TB patients), soft diets and liquid diets. There are modified diets for residue restricted bland, fat restricted, diabetic, sodium restricted and calorie restricted diets. Exchange lists are provided under the diabetic category.

The appendix includes information on tube feedings, protein content and purine content of foods, gall bladder x-ray test meal and recommended daily dietary allowances of the National Research Council (revised in 1958).

Complimentary copies of the manual have been presented to each hospital in the state. Other copies are available at $1.00 per copy (to cover cost of printing and mailing) from Mrs. Kathryn Sheedy, 122 E. 22nd St., Indianapolis 2. No C.O.D. orders will be accepted.

Krannert Research Lab Dedicated

The new Krannert Research Laboratory was dedicated early in February as a part of the Robert M. Moore Heart Clinic at the Indianapolis General Hospital. The laboratory is equipped for cardiac catheterization, chemical analysis and studies in pulmonary function. Mr. and Mrs. Krannert were honored at the ceremonies by the installation of a commemorative plaque to acknowledge their financial support of the clinic over a period of many years.

Medical Assistants Plan Fort Wayne Convention

Indiana State Medical Assistants Association will have its annual convention April 25-26 at the Van Orman Hotel, Fort Wayne. Workshops, business meetings and social activities have been planned for the two-day affair.

Registration, including cost of a Saturday evening banquet, is approximately $7. Any girl employed by a physician who is a member of the Indiana State Medical Association is invited to attend.

Included in the program will be two workshops, one on trends in medical economics, the other on grooming and hair styling. A social hour is planned to begin at 6 p.m. on Saturday, the president's banquet at 7. Donelly P. McDonald will be guest speaker, presenting the subject, "Self Hypnosis," with Dr. C. H. Warfield, Fort Wayne, giving the Invocation.

Sunday's program will feature a breakfast at 8 a.m. (Invocation by William Bruton, Jr., Fort Wayne), a business meeting and election of officers at 10, luncheon at 1, business meeting and installation of officers at 2:30. Luncheon speaker will be Rev. George B. Wood who will discuss "Religion and Medicine Work Together."

Information and reservations may be obtained from Mrs. Trudy Cleckner, chairman, Registration Committee, 210 Edgeknoll Lane, Fort Wayne. Fee should accompany reservations. Hotel reservations must be made directly with Van Orman Hotel. A recent policy adopted by the Board of Directors prohibits return of registration fees if cancelations are received after April 20.

ISMAA Grows

Indiana's medical assistant organization has grown by the addition of three new constituent societies. Welcomed to the state group are Delaware-Blackford, Bartholomew-Brown and St. Joseph County Medical Assistants Associations.

a thumbnail sketch:

Med Assistant A Hard Worker

An organization still in its infancy, relatively speaking, but one which may in the near future become an important one to the medical profession is that formed by medical assistants, a group which has been taken under wing by the Indiana State Medical Association on the local level.



Miss Theobald

One of the hardest workers in the organization of medical assistants and a charter member of the Indianapolis, the Indiana and the American Associations of Medical Assistants is J. Marie Theobald, medical secretary and receptionist for 12 years to Dr. J. William Hofmann, gynecologist.

Miss Theobald is at present the only representative from the state of Indiana holding office in the national organization, which was formed in 1956 with our Indiana "medic" the first chairman of the Budget and Finance Committee. She held the position in 1956-57, then became a member of the committee the following year. At present she is a member of the board of directors of the national group, a position she is to hold until October, 1960.

Locally, Marie was recording secretary of the Indianapolis Medical Assistants Association from 1952 to '54. She was a member of the Board of Directors from '55 to '57, a position she still holds as an officer in the state group.

State-wise, she was the first secretary in 1957 (it was organized in '56 but no officers were officially in office until 1957). She held

Continued

this job until this year. Now she is on the State M.A.A. Board of Directors.

In addition, she has been active in aiding several local chapters throughout the state in their organization attempts. She also has served the Indianapolis group as chairman of the public relations and publicity committee and currently is responsible for publication of the official *Bulletin* of the state organization.

Previous to her position with Dr. Hofmann, she has been secretary to the director of nurses, Indianapolis General Hospital; secretary to the director of nursing education and director of nurses at Indianapolis Methodist and has worked in medical records at I. U. Medical Center. She is a native of Shelby County. C.W.

Training Program Postponed

A planned "In-Service Training Program" for medical assistants has been postponed until the beginning of the fall semester in September due to an illness of Virgil Hunt, director of the Indianapolis Indiana University Extension Center.

Information regarding this program will be sent to each doctor as soon as the courses have been outlined, and will be presented to medical assistants attending the third anual convention.

I.U. Plans Injury Course

A pre-memorial postgraduate course on common traumatic injuries will be presented at I. U. Medical Center, Student Union Bldg., May 28-29. It will give 7 AAGP credit hours. Fee: $10.

Early treatment will be emphasized although discussion will not be limited to this phase.

Thursday afternoon's program includes subjects on eye, nose and sinuses, abdomen, genitourinary, and burns. Friday morning subject include bones and joints, brain and spinal cord, thorax and heart and blood vessels.

"I never go out with perfect strangers."
"That's okey. I'm not perfect."

Reserve Physicians to Earn Retirement Points at Aero Medical Association Meeting

Retirement point credits may be earned by reserve Medical Corps officers who attend the scientific sessions of the 30th annual meeting of the Aero Medical Association in Los Angeles, April 27-29, 1959, the Department of Defense announced recently. This authorization covers eligible physicians who are Medical Corps officers of the reserve components of the U.S. Army, Navy and Air Force on inactive status.

The wide interest in man's impending venture into space is expected to bring more than 1,500 members of the association and their guests to Los Angeles, according to Brigadier General M. S. White, USAF (MC), Washington, D.C., president of the association. Latest advances and developments in aerospace medicine of nearly 200 scientists from the United States and several foreign countries will be presented. "Space Pilot" Scott Crossfield, Dr. Hubertus Strughold, "father of space medicine," and Colonel John P. Stapp, "the fastest man on earth," are among the speakers.

PHS Exam Deadline March 27

A second series of competitive examinations for appointment to the Regular Corps of the United States Public Health Service will be held throughout the nation May 12-15, Surgeon General Leroy E. Burney has announced. Applications must be filed no later than March 27.

The examinations will cover the following 6 professional health and scientific categories: clinical and public health nursing, bacteriology, entomology, parasitology, health education and social work. The first series of examinations—for physicians, dentists, sanitary engineers, clinical psychologists, biochemists and veterinarians—will be held in April and May, as announced by the Surgeon General on December 15, 1958.

Qualified candidates interested in careers as Regular Corps officers in the Public Health Service Commissioned Corps may obtain application forms and additional information by writing to the Surgeon General, U. S. Public Health Service (P), Washington 25, D. C.



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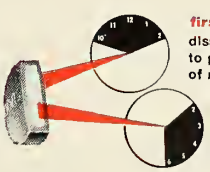
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News Notes

Continued

Guide Issued for Using Simplified Insurance Claim Forms

A guide for physicians on the use of the new simplified claim forms for accident and health insurance policies issued by insurance companies has been published by the Health Insurance Council.

Entitled "Simplified Claim Forms for Accident and Health Insurance—A Report to the Physician," the manual describes the principles of the Council program to reduce paper work for doctors and at the same time provide insurance companies with the medical information they need to process and pay claims. The claim forms—called "Standardized Attending Physician's Statements"—were developed by the Council's Uniform Forms Committee in cooperation with the American Medical Association.

The forms comprise a standard set of questions, in a standard sequence, which are the minimum required to meet the provisions of most insurance companies. Some questions and phrases are optional and in many instances will not be required or used by companies. The questions used, however, will be sufficient to provide the information needed to process routine claims of all types, including initial and continuing proof of disability as well as surgical and medical claims information.

In addition, there are 4 abbreviated forms to be used for surgical and continuing disability statements for group and individual insurance respectively.

Additional copies of this manual may be obtained upon request from the Health Insurance Council, 488 Madison Avenue, New York 22, New York.

ISMA Member Tours USAF

An associate professor of surgery and head of the neuro-surgery section of I. U. School of Medicine, Robert F. Heimburger, M.D., spent a month touring U.S.A.F. medical installations in Europe and the Mediterranean.

He was inspecting Air Force hospital and medical facilities as consultant to the Air Force surgeon general.

Pan-Pacific Surgical Association Plans Congress in Hawaii

The Eighth Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii, September 28 through October 5 in 1960.

All members of the profession are cordially invited to attend and are urged to make arrangements as soon as possible if they wish to be assured of adequate facilities.

An outstanding scientific program by leading surgeons promises to be of interest to all doctors. Nine surgical specialty sections are held simultaneously.

Further information and brochures may be obtained by writing to Dr. F. J. Pinkerton, Director General of the Pan-Pacific Surgical Association, Suite 230, Alexander Young Building, Honolulu 13, Hawaii.

Refresher Courses Offered For Medical Librarians

The second refresher course program sponsored by the Medical Library Association will be given Saturday, June 13, 1959, at the King Edward Sheraton Hotel, Toronto, Ontario, Canada, preceding the Association's 58th annual convention which starts the following Monday.

Twelve courses will be offered covering the most important subjects of special interest to librarians in medicine and related fields. They will be arranged so that those who attend may participate in 4 courses during the day, 2 in the morning and 2 in the afternoon.

Enrollment is limited to 50 for each session, and applications will be accepted as they are received. Advance registration is required, and the closing date for registration is May 15, 1959. Further information may be obtained from Miss Ruth Mann, Mayo Clinic Library, Rochester, Minn.

———

The 1959 meeting of the American Goiter Association will be held in Chicago, at the Drake Hotel, on April 30 and May 1 and 2. The program for the 3-day meeting will consist of papers and discussion dealing with the thyroid gland, its physiology, pharmacology, pathology and therapy. Members of the ISMA are invited to attend.

Ophthalmology Residency Fellowships Announced

Six additional Fellowships for residents in Ophthalmology, to be awarded July 1st, 1959, have been announced by the Guild of Prescription Opticians of America. Applications for these Fellowships must be received by May 15, 1959.

Each Fellowship is for a total of $1,800, payable in monthly stipends over the period of a 3-year residency. The grants are limited to residencies at approved institutions where full 3-year residencies are offered, but residencies which begin anytime during the calendar year are eligible. Application forms and covering information are available by writing to FELLOWSHIPS, Guild of Prescription Opticians of America, Inc., 110 East 23rd Street, New York 10, N. Y.

Ob-Gyn College to Meet

The American College of Obstetricians and Gynecologists will hold its annual meeting in Atlantic City, April 6-8, with general sessions in Convention Hall. An attendance of about 2,000 physicians is anticipated.

Besides the presentation of papers by leading obstetricians and gynecologists from all parts of the country, there will be breakfast and clinical conferences, panels, motion picture programs and scientific exhibits. One panel will deal with radiation hazards in obstetrics and gynecology and another will cover psychosomatic aspects.

A feature will be presentation of 12 research project reports. These will cover the early diagnosis of multiple pregnancy, labor problems, oxygen administration, anesthetics, endocrine functions and other topics.

Continued



Photo courtesy Indiana State Police

Safe Driving Habits:

Death lurks on dark highways; stay alert!

News Notes

Continued

Further information may be obtained by writing to Donald F. Richardson, executive secretary, The American College of Obstetricians and Gynecologists, P.O. Box 749, Chicago 90.

Pathology Course Offered

A postgraduate course in Clinical Pathology will be conducted in Cleveland by the Bunts Institute of the Cleveland Clinic in conjunction with the Cleveland Society of Pathologists on April 2 and 3. The course will be held in the North Clinic Building at Euclid Avenue and E. 93rd St. Members of the ISMA are invited to attend.

Registration fee is $20.00. Detailed program and other information may be obtained by writing Education Secretary, Bunts Educational Institute, 2020 E. 93rd St., Cleveland, 6.

The Membership

Roster

Is Being Made Up

NOW

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VD Conference Next Month

The American Veneral Disease Association will hold its annual meeting April 27-28, 1959 in the Auditorium of Johns Hopkins Hospital, Baltimore, Md., in cosponsorship with the United States Public Health Service of the Tenth Annual Symposium on Recent Advances in the Study of Veneral Diseases.

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Add 1

by corki

Monster growing up? Sometimes I feel that wonderful, miraculous invention of a few years back, hailed and sought by Americans in city, town and country—this wonderful brain child of man called TV—has become a monster. How many of us get filled to the brim with the junk channeled into our homes —and keep right on watching? At times I turn my set off with the horrible feeling that I've wasted too many precious moments of my short span on earth.

It seems to be putting the art of pleasant conversation into the archives—something once enjoyed but no longer known. It keeps families in and apparently together, but, when they aren't fighting over which program to watch, each member of this American family is alone in the TV set (so to speak) and all the warmth and love once gained through doing things together, is lost.

Then I see a program such as the "Red Face of China" mentioned in last month's column and I feel this baby, TV, is, indeed, growing up and contributing something real to our education and understanding of the world around us. And I see the once-in-awhile creation such as Hallmark of Fame's "Berkeley Square" and I turn off my set feeling a little richness has been added to life because the excellent and unusual story material plus talented, sensitive portrayals added up, to my mind, anyhow, to a thing called Art. It was like watching a sunrise in Grand Canyon or looking at a great painting, like hearing a symphony or the roar of the ocean! It was drama reminiscent of the legitimate theater.

Maybe TV producers will eventually tame their monster into a truly worthwhile contribution to American culture and progress. When there are more programs of such quality, I hope I'll be watching.

I might even be glad to stop talking!

The tables are turned! Received an unsigned clipping in the mail the other day that told all about using philosophy instead of griping over cold weather, frozen tootsies and aching ears. Reckon one of my erstwhile friends got a little tired of my less than complimentary remarks about Hoosier weather (And I must admit, Indiana *does* have Weather!). Can't blame said friend. Must get pretty tiring.

But I had the last laugh the other day. Called this friend (I finally found out who the culprit was) during the big fog and got this remark, "OK, you San Franciscan! I sure hope you feel at home in this blasted, *#Q#%* fog!" "I do, I do, it's wonderful!"

Guess she lost her winter philosophy in the fog!

And speaking of winter. Felt happy to see a story on the winter chill table, compiled by the Army and printed in the January *Journal,* was picked up and commented upon by Tubby Toms of the *Indianapolis News.* Maybe that story should have been headlined, "It's colder than you think!" (Ouch!) Mr. Toms called it "No Good Blown by Wind Chill."

Cliniclatter reborn. It's always good to see new publications born, and especially nice to see one reborn. Forty-four weeks ago, after 5 volumes of life, *Cliniclatter,* published by Davis Clinic at Marion, "folded." On February 7 it came out of mothballs and is a thriving medium for communications at the clinic. The editor (is it Thelma Hess?) has a nice sense of humor and, even as an outsider, I got a few good chuckles. So hearty congrats and keep it going this time!

Also liked the "Thought for the Day" in said paper: If you steal from an author, it is plagiarism. If you steal from many, it is research." True!

Two docs in the news! Two more senior members of ISMA were honored by feature stories about them in the *Indianapolis Star* Sunday magazine: Dr. Oscar T. Scamahorn of Pittsboro (Nov. 30), and Dr. John L. Reck of Sheridan (Dec. 7). It's nice to see

Add 1

Continued

such fine tributes given our senior physicians by the newspapers.

Anybody have a cover pic? If you noticed (gads, I HOPE you have!), the *Journal* has a new cover picture each issue. We'd be most happy if some of you docs who are shutter bugs would submit some of your photos of Hoosier scenes for consideration for these covers.

We can't afford 4-color covers unless we can scrounge the plates from someone—but we can do interesting things with what they call duo-tone (2 colors simulating 4 colors) from a black and white—or a good dramatic shot in deep shadows and contrasting whites might go real fine in just black and white.

Contributors whose work is accepted will get full credit for their work and we'd also like to know where the shots are taken and any background material that might prove interesting to our members.

Just be sure the photo will crop appropriately for our off-size cover.

How about those photos???

Something to think about:

The most important thing we have to learn in life is tolerance.—Dorothy Ames, *Hoard's Dairyman.*

(I heartily disagree! The most important thing we have to learn is understanding. Today the more popular connotation of "tolerance," I think, is one of putting up with something or someone — a minority group, a person, etc., with just a slight impression of looking down our noses. If we learn to *"understand"* that person or group, we may find ourselves not *having* to *tolerate!*)



"He was fixing the large clock on our building when he bent over and then one of the hands fell off!"

A supervisor may make rules wisely, but never can he make rules wise. Trying to substitute rules for wisdom turns channels into ruts.—Norman G. Shidle, editorial, *SAE Jnl.*

A laugh cures many ills Dept.:

The taped voice of President Eisenhower proclaiming "peace on earth . . ." from the Atlas satellite set off this talk in political salons: "Lyndon Johnson will be demanding equal time." Wits also claim Johnson will demand: "Tape me to your leader."—Les and Liz Carpenter, *Quote.*

Hear about the 2 little ghosts who drifted into a tavern and asked the bartender, "Do you serve spirits?"—*Wooden Barrel.*

A Memphis woman has discovered fresh evidence of how much our children learn from television.

Her 4-year-old granddaughter likes to serve meals of imaginary hot biscuits and other delicacies to her dolls. But since she's discovered from television what the most popular thing is to serve, she's neglected the biscuits.

Now she serves the dolls nice hot subpoenas—baked, fried or stuffed.—Lydel Sims, *Memphis Commercial-Appeal.*

At the height of the Bernard Goldfine-vicuna coat scandal, Casey Stengel appeared before the Senate Sub-Committee to testify on various aspects of big league baseball.

Later Casey bragged, "Yeah, it got that Goldfine feller off the front page. Maybe he'll send me one of them petunia coats."—*Scholastic Coach.*

Conversation in a London pub: "How did Bill die?"

" 'E fell thru some scaffolding."

"Whatever was 'e doing up there?"

"Being 'anged."—*Pacific Oil-Motive Mag.*

'Anged if it isn't time to write 30 for another month!

Deaths . . .

Farrol Andrew Dragoo, M.D.

Farrol Andrew Dragoo, M.D., 54, a Middletown physician for the past 26 years, died February 1 in the Henry County Hospital at New Castle after a 2-week illness.

Dr. Dragoo graduated from I.U. School of Medicine in 1932 and had served his internship at the Fresno County Hospital, Fresno, Calif.

He was a member of the local, state and American medical societies and the Parker Masonic Lodge.

Don G. Hilldrup, M.D.

Don G. Hilldrup, M.D., 71, retired colonel of the Army Medical Corps, died January 28 in Memorial Clinic, Indianapolis.

Dr. Hilldrup received his A.B. degree at I.U. in 1912 and his doctor of medicine degree from I.U. School of Medicine in 1915.

He was a member of the Indianapolis Medical Society, ISMA, AMA, Paul Coble American Legion Post and the Gyro Club.

Ulis B. Hine, M.D.

Ulis B. Hine, M.D., 61, former Indianapolis Motor Speedway medical staff member and Marion County deputy coroner, died January 26 in Community Hospital.

A graduate of Butler University and the I.U. School of Medicine, Dr. Hine practiced in Indianapolis 30 years.

He was a member of the Masonic Lodge at Whitestown, Murat Shrine, Scottish Rite, American Forestry Assoc., East Side YMCA and a past president of the Irvington Lions Club.

Dr. Hine was also a member of the Methodist and Community hospitals staffs and of Marion County Medical Society, ISMA and AMA.

William F. King, M.D.

Dr. William F. King, a geriatrics pioneer, died at the age of 84 in Methodist Hospital, Indianapolis.

Former Indiana state health commissioner, Dr. King established the first state department of geriatrics in the U.S. and served on the National Plan Commission for the National Conference on Child Welfare during the administration of President Herbert Hoover.

He graduated from the old Ohio Medical University, started practice in 1898 at Columbia City. Dr. King was a member of Marion County Medical Society, ISMA and AMA.

John M. Stalker, M.D.

John M. Stalker, M.D., 76, noted Borden physician and civic leader, died January 11, at his home.

Upon graduating from the University of Louisville School of Medicine in 1906, he practiced in Indianapolis for two years before going to Borden, where he was born and raised.

All Members of the
Indiana State Medical Association
are cordially invited
to attend the

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1. Editorial, New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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County Society and District Reports

Allen

Allen County Medical Society met February 3, 6:30 p.m., at the Shrine Club. Dr. Walter Alvarey presented his paper entitled "Puzzling Types of Abdominal Pain." There were 170 present at this meeting.

Next meeting was scheduled for the Veterans Administration Hospital March 3, 6:30 p.m.

Boone

Witham Hospital was the meeting place, February 3, 7:00 p.m., for the Boone County Medical Society meeting. Seventeen members were present.

March 3 was date selected for the next meeting, same place.

Carroll

Mr. Converse and Mr. Wilson, representatives of Blue Cross and Blue Shield, were present at the December 17 meeting of the Carroll County Medical Society. Election of officers took place at this time.

Roth Park Hotel will be the location for the next meeting January 21.

Clark

Point Inn was the meeting place of 24 members of the Clark County Medical Society, December 17, 6:30 p.m. The newly elected officers as the out-come of this meeting are as follows: Samuel Adair, president; Lee A. Dare, vice-president; David Jones, secretary.

Clay

Clay County Medical Society held their January 20 meeting at the Elks Club, Brazil. The speaker of the evening was Judge Robert B. Stewart, Clay Circuit Court, his subject "Court Examination in Personal Injury Cases." There were 10 members present.

Next meeting was set for February 17, 6:30 p.m., same place.

Elkhart

Doctor Gordon L. Snider, Michael Reese Hospital, Chicago, spoke on Chronic Pulmonary Insufficiency before approximately 60 members of the Elkhart County Medical Society at their January meeting. The meeting was held at the Hotel Elkhart.

February 5 was the date set for the next meeting.

Fountain-Warren

Attica Hotel, Attica, was the meeting place for the Fountain-Warren County Medical Society, February 5, 7:00 p.m.

Next meeting will be March 5 at the residence of Dr. James W. Crain, Williamsport, Ind.

Huntington

A special meeting of the Huntington County Medical Society was held December 2 at the LaFoutaine Country Club. County lawyers, dentists and veterinarians were invited to attend this meeting. Seventeen members, 16 auxiliary members and 47 additional guests enjoyed the entertainment presented by Bob Cocherill, a Fort Wayne vocalist and entertainer. He was accompanied by Miss Ester Howard, pianist.

Knox

The Knox County Medical Society met January 20 at the Vincennes Country Club, Vincennes. Newly elected officers included Nathaniel D. Ewing, M.D., president; Walter R. Vaughn, M.D., vice-president; Charles E. Hendrix, M.D., secretary; and Donald T. Bartlett, M.D., treasurer. The program was presented by Judge C. G. Shake who discussed "The History of Medical Education in Indiana and its First Medical School" which was located in Vincennes in 1837—1838 as part of Vincennes University.

LaPorte

Spaulding Hotel, Michigan City, was the meeting place for 19 members of the LaPorte County Medical Society, January 20, 7:00 p.m. The speaker of the evening was Dr. Aldo A. Luisada, director, Division of Cardiology, Chicago Medical School, whose speech was entitled "Clinical and Experimental Research in Cardiology."

A 7:00 p.m. dinner, February 17 at the Rumely Hotel, LaPorte was the next scheduled meeting.

Lawrence

Dr. Charles Emery spoke on the subject of Gall Bladder Disease at the Feb. 4 meet-

ing of the Lawrence County Medical Society held at the Dunn Memorial Hospital, Bedford. Twenty members were present at this meeting.

Next meeting was set for March 4, same place.

Noble

December 18 the Noble County Medical Society held a luncheon meeting at the Cross Roads Cafe, Ligonier, for the purpose of electing officers and discussing medical-political matters.

Orange

A film on pediatric anesthesia, shown by Mr. Kitch, Wyeth Laboratories, was viewed by 9 members of the Orange County Medical Society at the February 3 meeting, Spring Mill Inn. Following the film the society discussed House Bills Nos. 90 and 250. The background history of the Indiana State Board of Medical Registration and Examination was also discussed.

March 10 will be next meeting.

Owen-Monroe

Dr. Glen Irwin presented a paper entitled "Diseases of the Thyroid" before 32 members of the Owen-Monroe County Medical Society. The meeting was held January 29 at the Bloomington Country Club.

Next scheduled meeting was February 12, 7:00 p.m., Van Orman Hotel.

Perry

February 3 a meeting of the Perry County Medical Society was held at the Nursing Center, Cannelton. The guest speaker was J. M. James, M.D., whose topic was "Plantar Warts."

Date set for next meeting was March 3 at the same place.

Randolph

The Randolph County Hospital was the scene of the Randolph County Medical Society meeting February 9, 7:00 p.m. Dr. C. R. Slick read a paper that had been presented to the society 38 years ago by Dr. Martin entitled "Straight Salary Versus Piece Work."

Starke

Eight members of the Starke County Medical Society were present at their February 3 meeting held at the Starke Memorial Hospital, Knox.

Next meeting was set for March 3, same place.

Vanderburgh

Dr. Rex O. McMorris, medical director of the new Rehabilitation Center, presented the scientific program at the December meeting of the Vanderburgh County Medical Society.

Warrick

Warrick County Medical Society held their February 5 meeting at the Elks Club, Boonville, with 8 members present.

Wayne-Union

"The Role of the County Medical Society in the Science Fairs" was the paper Dr. Ralph C. Eades, Valparaiso, presented before 32 members of the Wayne-Union County Medical Society, February 10, Reid Memorial Hospital. The following subjects were discussed: possibility of county health officers, emergency call system and the chiropractor bill.

Reid Hospital will be the meeting place for the March 10 meeting.



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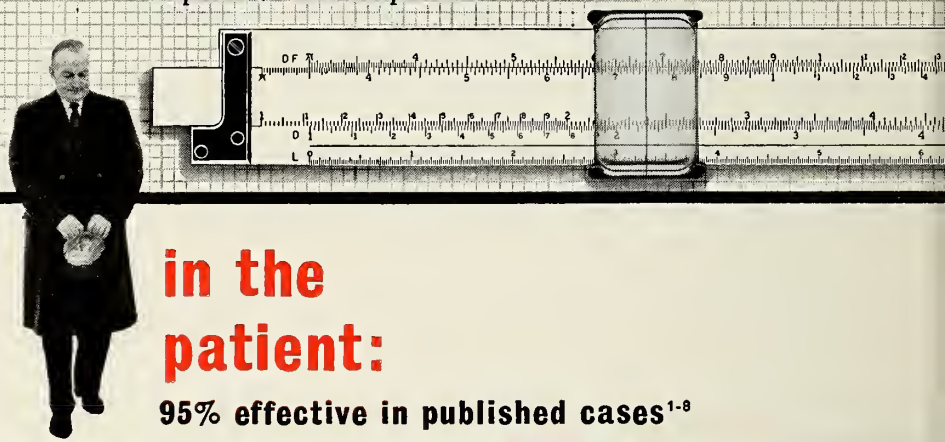
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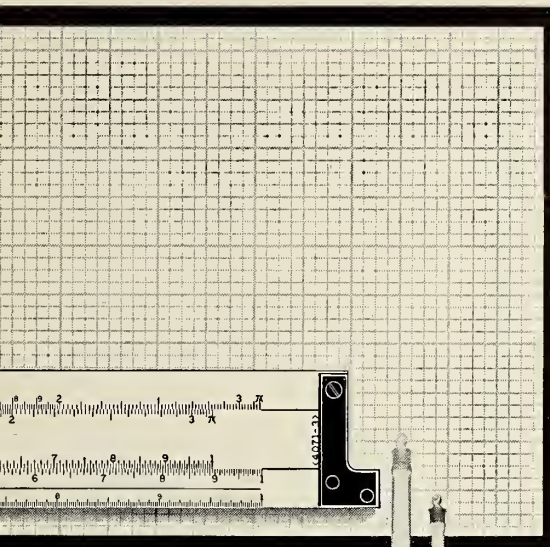
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in the patient:

95% effective in published cases[1-8]

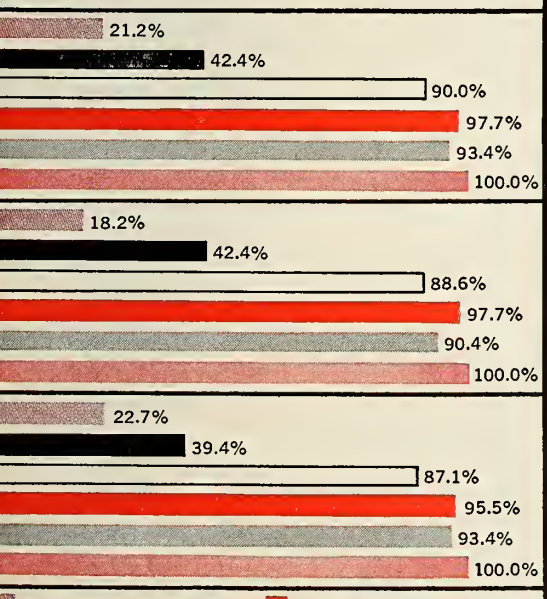
Conditions treated	No. of Patients	Cured	Improved	Failure
ALL INFECTIONS	**558**	**448**	**80**	**30**
Respiratory infections	**258**	**208**	**31**	**19**
Pharyngitis and/or tonsillitis	65	58	5	2
Pneumonia	90	66	17	7
Infectious asthma	44	38	—	6
Otitis media	31	29	2	—
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	**230**	**191**	**38**	**1**
Infected wounds, incisions and lacerations	41	33	8	—
Abscesses	51	43	8	—
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	—
Pyoderma	19	19	—	—
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	—
Genitourinary infections	**28**	**19**	**3**	**6**
Acute pyelitis and cystitis	10	8	2	—
Urethritis with gonorrhea or cystitis	8	8	—	—
Pyelonephritis	4	1	—	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	—	—
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	42	30	8	4



in the laboratory:

over 90% effective against resistant staph

COMPARATIVE TESTS BY THREE METHODS (DISC, TUBE DILUTION, CYLINDER PLATE) ON 130 STAPHYLOCOCCI[9]



Percentage of organisms inhibited by the range of concentrations listed for each antibiotic.

Other Tao advantages:

Rapidly absorbed – stable in gastric acid,[7] TAO needs no retarding protective coating

Low in toxicity – freedom from side effects in 96% of patients treated; cessation of therapy is rarely required

Highly palatable – "practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. **For adults,** the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. **For children** 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules – 250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension – 1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

Tao dosage forms – for specific clinical situations

Tao Pediatric Drops

For children – flavorful, easy to administer.

Supplied: When reconstituted, 100 mg. per cc. Special calibrated droppers – 5 drops (approx. 25 mg.) and 10 drops (approx. 50 mg.). 10 cc. bottle.

Tao-AC (Tao analgesic, antihistaminic compound)

To eradicate pain and physical discomfort in respiratory disorders.

Supplied: In bottles of 36 capsules.

Taomid* (Tao with triple sulfas)

For dual control of Gram-positive and Gram-negative infections.

Supplied: Tablets, bottles of 60. Oral Suspension, bottles of 60 cc.

Intramuscular or Intravenous

For direct action – in clinical emergencies.

Supplied: In 10 cc. vials.

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Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

Association Reports

Executive Committee

January 17, 1959

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Kenneth L. Olson, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; O. W. Sicks, M.D.

Robert Hollowell, attorney, and James A. Waggener, executive secretary.

Guests: Mrs. Earl Bailey, president, and Mrs. J. M. Black, president-elect, Woman's Auxiliary to the Indiana State Medical Association; Mr. Roscoe C. Edlund of Rogers, Slade and Hill; Mr. James of Booz, Allen and Hamilton; Mr. John J. Cahill of Robert Heller & Associates; Mr. Richard P. Miller of Wolf Management Engineering Company.

The committee listened to presentations by representatives of the management survey firms, and upon motion of Drs. Mericle and Sicks, Mr. Edlund of Rogers, Slade and Hill, and Mr. Miller of Wolf Management Company, were asked to appear before the Council on Sunday, January 18, at 10:00 a.m.

Membership report was approved by consent.

Treasurer's Office

Statements of Receipts and Expenditures for the first quarter of 1958 were approved by consent.

The treasurer gave a preliminary report from the auditing firm, and presented a request from the Board of Trustees of the Employees' Retirement Fund for the 1959 premium in the amount of $4,682.66. Payment of this sum was approved on motion of Drs. Covalt and Mericle.

1958 Annual Convention

Financial report for the 1958 annual convention was reviewed and accepted by consent.

1959 Annual Convention

Report on the survey authorized by the Council for suggestions for the 1959 annual convention was reviewed in detail and by consent this report was ordered referred to the Council.

Organization Matters

Request of the Northern Tri-State Postgraduate Association for use of the mailing list was approved on motion of Drs. Mericle and Covalt.

Letter from the National Foundation requesting the naming of three physicians to represent the Indiana State Medical Association on the new Health Scholarship program of the National Foundation was reviewed and upon motion of Drs. Olson and Mericle this letter was to be referred to the Council.

Letter from the Tippecanoe County Medical Society concerning the letters sent by the headquarters office to two Philippine physicians who are taking residencies in the hospitals of Tippecanoe county was read, and the secretary was instructed to write the county society and the physicians involved that the Executive Committee regretted they were not eligible for membership in the state medical association.

A letter and a report from Dr. Lall G. Montgomery concerning the meeting of the group concerned with the codification of the Indiana Common School Laws was reviewed and the secretary was instructed to write Doctor Montgomery thanking him for his report.

Legislation Matters

Dr. Wood, chairman of the Commission on Legislation, reviewed legislative matters in Congress and in the State legislature.

New Business

Mr. Robert Hollowell reported on the directive of the Council, requesting him to procure from the Judicial Council of the AMA a clarification on the question of osteopathy.

On motion of Drs. Mericle and Covalt, this matter was referred to the Council.

The president read a letter from the Lincoln National Life Insurance Company concerning the establishment of a liaison committee between the insurance industry and the medical association.

On motion of Drs. Covalt and Mericle the previous definition prepared by the Association of "permanent disability" was reaffirmed.

The president read a letter of resignation from Dr. W. L. Portteus as a member of the Grievance Committee, and it was suggested that Dr. M. C. Topping be asked to fill Dr. Portteus' unexpired term.

Dr. Wood reported on the meeting between the officials of Indiana University and the state medical association. This report was referred to the Council.

The Journal

The report on advertising was accepted by consent.

The request for advertising space by Crai-Ger Investment Research Corporation was reviewed, and upon motion of Drs. Owsley and Mericle the Journal is not to accept this advertising.

Future Meetings

A letter from the Blue Shield Commission inviting the secretary to be a discussion leader during the National Professional Relations Conference in Chicago, February 8 and 9, was read. On motion of Drs. Mericle and Owsley the secretary was instructed to accept the invitation.

A letter was read concerning the forthcoming Medico-Legal Conferences conducted by the AMA. On motion of Drs. Mericle and Owsley Mr. Hollowell was authorized to attend.

There being no further business the committee adjourned, to meet again at 4:00 p.m. Central Daylight Savings Time, February 18, 1959, at the I. U. Medical Center.

Continued

MEETING OF THE EXECUTIVE COMMITTEE WITH THE WOMAN'S AUXILIARY TO THE INDIANA STATE MEDICAL ACCOCIATION

January 17, 1959

Present: Mrs. Earl W. Bailey, president; Mrs. J. M. Black, president-elect.

Executive Committee members: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Kenneth L. Olson, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; O. W. Sicks, M.D.

Mrs. Earl W. Bailey, president, and Mrs. Joe M. Black, president-elect of the Woman's Auxiliary, appeared before the Executive Committee and reviewed their program and their financial needs with the Executive Committee.

The Executive Committee complimented the Auxiliary on the fine they have accomplished in the past, and expressed its desire that the auxiliary continue their fine program, as outlined by Mrs. Bailey.

The Executive Committee informed Mrs. Bailey that it would like to call upon the legislative chairmen of the auxiliary to participate in the meeting of the Commission on Legislation.

The Executive Committee further suggested the following as auxiliary projects:

a. To submit suggestions and help on the state meetings each year, and to encourage husbands to attend the annual convention.
b. To take an active interest in medical organization.
c. To stimulate their husbands to be aware of what is going on in organized medicine and the importance of their active participation at all levels.

On motion of Drs. Owsley and Mericle the Committee voted to send the auxiliary a check for $1,000.00 to help on the expenses of their program.

There being no further business the meeting was adjourned.

INDIANA STATE MEDICAL ASSOCIATION
THE COUNCIL

January 18, 1959

The Council of the Indiana State Medical Association convened for its mid-winter meeting at 10:15 a.m., Sunday, January 18, 1959, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Guy A. Owsley, chairman, presiding.

Roll call showed the following present:

COUNCILORS

First District—William B. Challman, Mount Vernon
Second District—J. H. Crowder, Sullivan; Sam I. Rotman, Jasonville, alternate
Third District—John M. Paris, New Albany (also AMA alternate delegate)
Fourth District—J. E. Dudding, Hope
Fifth District—Robert K. Webster, Brazil; V. Earle Wiseman, Greencastle, alternate
Sixth District—Harry P. Ross, Richmond
Seventh District—Ralph V. Everly, Indianapolis
Eighth District—Guy A. Owsley, Hartford City
Ninth District—Kenneth O. Neumann, Lafayette
Tenth District—James P. Vye, Gary; Ralph C. Eades, Valparaiso, alternate
Eleventh District—Max R. Adams, Flora
Twelfth District—Maurice E. Glock, Fort Wayne
Thirteenth District—G. O. Larson, LaPorte

OFFICERS

Kenneth L. Olson, South Bend, president
Earl W. Mericle, Indianapolis, president-elect
Okla W. Sicks, Indianapolis, treasurer
Journal—Frank B. Ramsey, Indianapolis, editor

EXECUTIVE COMMITTEE

Don E. Wood, Indianapolis, chairman (also co-chairman, Commission on Legislation)
Wendell E. Covalt, Muncie, member

GUESTS

Harold C. Ochsner, Indianapolis, AMA delegate
Robert H. Brown, Marion, AMA alternate delegate
Wm. Harry Howard, Hammond, president, Mutual Medical Insurance, Inc.
Edward T. Edwards, Vincennes, chairman, Commission on Medical Economics and Insurance
Emmett B. Lamb, Indianapolis, chairman, Commission on Public Health
James M. Leffel, Indianapolis, chairman, Commission on Convention Arrangements
Harry Pandolfo, Indianapolis, chairman, Commission on Public Information
Howard S. Williams, Jr., Indianapolis
Cleon A. Nafe, Indianapolis, member of AMA Board of Trustees
A. C. Offutt, Indianapolis, director, Indiana State Board of Health

STAFF

Robert Hollowell, Indianapolis, attorney
Robert J. Amick, field secretary
Howard Grindstaff, field secretary
J. A. Waggener, executive secretary

On motion of Drs. Larson and Glock, the minutes of the meetings of the Council held at Indianapolis on October 12 and 15, 1958, were approved as printed in the December, 1958, issue of *The Journal.*

Minutes of the special Council meeting, held in Indianapolis on December 10, 1958, were approved on motion of Dr. Neumann, duly seconded.

Reports of Councilors

The councilors invited the officers and councilors to attend district meetings scheduled as follows during 1959:

First District—Evansville, April 30, 1959
Second District—Sullivan, May 7, 1959
Third District—New Albany Country Club, New Albany, May 6, 1959
Fourth District—Madison, May 6, 1959
Fifth District—Terre Haute Country Club, Terre Haute, May 20, 1959
Sixth District—New Castle, May 7, 1959 (probably Westwood Country Club)
Seventh District—State Teachers' Association Building, Indianapolis, April 28, 1959
Eighth District—Portland, June 3, 1959
Ninth District—Monticello, May 21, 1959
Tenth District—Whiting, May 13, 1959
Eleventh District—Logansport, May 20, 1959
Twelfth District—Fort Wayne, May 20, 1959
Thirteenth District—South Bend, November 18, 1959

The suggestion of Dr. Paris that Dr. Webster's letter to members of the Fifth District, copy of which was sent to each councilor, be printed in The Journal, was approved by consent.

The chairman called attention to Chapter XXVI,

Section 8, of the Bylaws which states that programs for district meetings shall be in the headquarters office early enough in advance of district meetings that the headquarters office may notify all members within the districts of the meetings at least thirty (30) days prior to the date thereof.

Reports of Officers

DR. KENNETH L. OLSON, president:

Thank you, gentlemen. I have been getting quite a bit of education about politics going around the State with Dr. Wood and Mr. Waggener. We have been to East Chicago and we have been having meetings down here with legislative leaders. We have met with leaders of the Democratic party in both the House and in the Senate and I had a meeting with the Governor about the legislative program. I won't go into detail because the Legislative chairman will do that later. It has been a really frustrating experience to attempt to convince these people that our objective is for the public good.

I have been to a couple of Liaison Committee meetings; one, the Liaison Committee with Blue Shield with their Executive Board. We met with them one Sunday morning and discussed some of the problems that I thought the medical profession had with Blue Shield. I believe the Liaison Committee is to report later.

Also, on Wednesday of this last week, I, along with our Liaison Committee, met with the members of the Liaison Committee of the medical school, which included the Dean and faculty members, and we were very much honored by the presence of the President of the University, President Wells. They presented their projected programs of enlargement of the medical school in the future and particularly the problems that will come up in the Legislature.

I had Dr. Van Nuys write me a letter explaining what the problems were and, to make it clear and so there won't be any misunderstanding in regard to their opinion, I will read his letter.

Letter from Dean Van Nuys, I.U. School of Medicine

"The first item has to do with the development of the experimental teaching program in medicine on the Bloomington campus. You may recall that approximately five years ago a Dr. Vernon Lippard, then President of the Association of the American Medical Colleges, asked for the establishment of 15 basic schools of medicine in the next 10-year period. He pointed out in his presidential address at the time that there were approximately 600 less junior students enrolled in the medical colleges than freshmen. The drop-out rate in Indiana has been substantially reduced the past 10 years but we still, for one reason or another, lose approximately 10 freshmen students each year. The need to expand the school here to meet the growing needs of the State is clearly evident. The present applicants are of high quality and increased number."

Incidentally, I questioned him about that particular point, wondering about the fact that I had been led to believe, that they had a problem in getting suitable applicants, and he said that they did the last few years, but, in this year, they have now again a larger and sufficient number of applicants of good quality men.

"We can gradually expand the admission program to 200 freshmen as we plan to do when the faculty has been obtained and some additional teaching facilities made available."

One of their problems in regard to expansion is the fact of getting adequate faculty.

"We feel that we have a good opportunity to accept small classes at Bloomington and feel that we can accommodate the students at Indianapolis for their junior and senior years. The Bloomington program would be attractive particularly to bright students who are interested in following a teaching or research career. They would be admitted to the program at the end of their second year of college and would be admitted to the School of Medicine at the end of the third year. They would receive their Bachelor of Arts degree at the end of the fourth year and Master's degree at the end of the sixth year.

"This program has been very carefully studied by medical educators throughout the country and has been the subject of considerable study by the faculty of Indiana University. The program was accepted by the Commonwealth Fund of New York City which has offered financial support. I may say that approximately 60 applicants for the Medical School this year indicated an interest in the Bloomington program."

Now, that is substantially his point in regard to the 2-year program which they feel is an experimental thing that they would like to go into and, as he has pointed out, they have given it considerable study and would like to have our support for this. He said that it would not subtract from the Medical School here in Indianapolis; if it did, they would be against it, themselves.

"Among the requests of capital expenditures presented at the General Assembly is one for the first unit of a teaching hospital for adults. This would be constructed on land recently acquired and adjacent to the new Medical Science Building. It would be a modern teaching hospital, with teaching amphitheatre, areas for resident physicians, student clerks, student nurses and the various students in the technical fields. It would contain a rehabilitation unit which we do not have at the Medical Center at this time.

"The buildings that we now have are old and we are advised by our architects they cannot be economically remodeled into a modern teaching hospital. It would be our purpose to gradually replace the beds for adults now in these buildings and in the Clinical Building and to use Long Hospital and the Clinical Building for out-patient services entirely.

"University hospitals are obligated to serve

the entire State and, at the present time, we must deny admissions to a substantial number of patients because of lack of facilities. Because of the specialized nature of our University hospitals, the teaching cases are often complex and truly supplement the educational experience that students receive at the Indianapolis General and Veterans Hospital.

"Several years ago when expansion of the School of Medicine was planned, the Governor of the State appointed a commission to make a thorough study of the future needs. After several months of review, the Commisison reported that:

"1. A new Medical Science Building should be built on the Indianapolis campus to permit the teaching of all 4 years at Indianapolis.

"2. Expansion of the faculty to guarantee good quality of the instruction.

"3. Construction of a modern teaching hospital for adult patients to replace the inadequate existing facilities."

That, I think, is a good explanation of their viewpoint in regard to the 2-year school and also to the request that they be supported on establishing a new hospital with modern facilities.

Now, Dr. Wells went into a lot of other details in regard to the University and it seems that their funds have been reduced in some categories in regard to maintaining expenses and also for reclamation of land in the slum clearance area. Of course they are interested in getting them all but particularly interested in the 2-year school and also the building.

I think that's all I have to say about that. I might mention a couple of other comments that I have.

Building Committee

I was instructed to appoint a committee to study the building program, as you know, from the House of Delegates, and I have appointed that committee and it has been completely appointed at the present time. I have particularly seen to it that I have not appointed any Councilors and have appointed only members of the House of Delegates who are elected as Delegates so that there would be no question about any bias from the Council on this matter. The names of the members of this committee are:

Dr. James N. Leffel, Dr. Irvin Wilkens and Dr. Howard Williams of Indianapolis
Dr. R. B. Dubois of Lafayette
Dr. Glen Ward Lee of Richmond
Dr. Henry Rusche of Evansville
Dr. Guy Ingwell of Knox
Dr. Basil Merrell of Rockville
Dr. Harry Stimson of Gary
Dr. Paul Tindall of Shelbyville
Dr. Jack Shields of Brownstown
Dr. Frederic Brown of Fort Wayne
Dr. Truman Caylor of Bluffton
Dr. Burton Kintner of Elkhart, who has been designated the Chairman.

Dr. Kintner has spent one day down here going over reports and will call a meeting of this committee shortly.

Blue Shield Committee on Radiology and Pathology

The other committee that I was asked to appoint was a committee to study the feasibility and possibility of transferring the radiological and pathological fees from Blue Cross to Blue Shield. The members on that committee are:

Pathologists:

Dr. A. W. Ratcliffe of Evansville
Dr. Robert Burger of Gary
Dr. Joseph Haymond of Indianapolis
Dr. William Bailey of Lafayette
Dr. David Adler of Columbus

Radiologists:

Dr. Joe Weber of Terre Haute
Dr. Harold Ochsner of Indianapolis
Dr. John Beeler of Indianapolis
Dr. John Lionberger of South Bend
Dr. Wallace Buchanan of South Bend

Dr. Buchanan has been designated as Chairman.

Action on Indiana University School of Medicine Matters

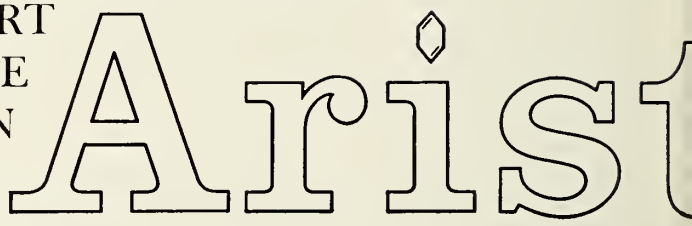
DR. DON E. WOOD: Regarding the meeting of our Liaison Committee with the University, I would like to make one point of explanation. Actually, what he is asking us to do is to support him in the Legislature for his proposed budget and the proposed budget is divided into a capital expenditure which amounts to some three million dollars for a new hospital on the University campus. It proposes a fifty to sixty thousand dollar expenditure for the reclamation of condemned properties surrounding the University, and the third item is for salaries for the teaching staff not only of the Medical School but also of the University in its entirety.

I think that the point that is of most importance is, when you study a budget and appear before the Legislature, you have to be able to substantiate that expenditure from a taxwise investment. Really all this tax is going to come out of your pocket as well as the rest of the taxpayers of the State.

I think that medicine as a whole wants to see a forward-looking program at the University and they want to see that medical education continues at its high rate of accomplishment because, as he said, knowledge today is in an explosive form and we have to keep pace. To do that, we have to spend money.

There could be possibly some thought given as to whether the expenditure for the hospital at this time is a wise move taxwise and whether we should ask the citizens of the State to pay out of their

NOW—YOU CAN GET THE
UNSURPASSED ADVANTAGES
OF ARISTOCORT
IN SALICYLATE
COMBINATION



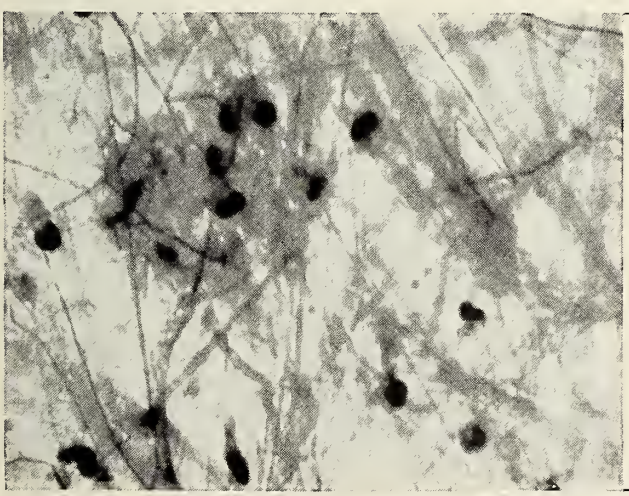
Aristogesic combines the *anti-inflammatory* effects of Aristocort® Triamcinolone with the *analgesic* action of a most potent salicylate. This means that the dosage of each is *substantially lower* than that ordinarily required for each agent alone. With Aristogesic the physician has exceptionally wide latitude in adjusting the dosage to the lowest effective level.

The possibility of gastric distress from either salicylamide or corticosteroid is minimized because of lower dosage required. This is further reduced by the buffer action of aluminum hydroxide. And the ascorbic acid helps meet the increased need for this vitamin in stress conditions. Because of the low dosage, side effects with Aristogesic have been relatively infrequent and minor in nature. However, more serious side effects have traditionally been observed on all corticosteroid therapy. Patients on long-term Aristogesic therapy should, therefore, be observed carefully.

ogesic*

Steroid—Analgesic Compound LEDERLE

for relief of *chronic*—but *less severe* pain of rheumatic origin



Indications: Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis and certain muscular strains.

Dosage: Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

Each Aristogesic Capsule contains:

ARISTOCORT® Triamcinolone 0.5 mg.
Salicylamide 325 mg.
Aluminum Hydroxide . . 75 mg.
Ascorbic Acid 20 mg.

Supply: Bottles of 100.

Collagen tissue (x250)

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pockets more money for a hospital. I think that point should be made clear.

(On motion of Drs. Crowder and Glock, the Council approved the items presented by the Liaison Committee of the Indiana University School of Medicine to the Liaison Committee of the Indiana State Medical Association.)

DR. EARL W. MERICLE, president-elect, reported on the A.M.A. clinical session, held at Minneapolis December 2 to 5, 1958. (Full report in January, 1959, Journal.)

Treasurer's Report. In the absence of Dr. O. W. Sicks, treasurer, the Chairman of the Council read the following report:

Assets of the Association as of this date, as shown by the unfinished report of Wolf and Company, auditors, are:

General Fund	$256,642.83
The Journal	4,152.96
Medical Defense Fund	26,639.90
Student Loan Fund	15,293.29
Total assets, all funds	$302,728.98

DR. FRANK RAMSEY, editor of *The Journal:* Mr. Chairman, our Yearbook Issue this year is going to be published in the month of May instead of July and, if there are any reference articles that any of you would like to have written for that issue, if you will let me know, we will try to get them for that.

Also, this is a good opportunity, if you are visiting any of your county medical societies, to impress upon them the importance of having their dues in earlier than they usually do so that their rosters will be as complete as possible for publication in the May issue instead of July.

Since we have been putting pictures on the front cover of *The Journal*, we have found that the supply of pictures is much more limited than you can imagine. What we would like to have in the future is mostly pictures of outdoor Indiana and we are going to invite the members of the Association to submit either black and white or colored photos for that purpose. It might be something the councilors can mention when they meet with their societies. Thank you.

Unfinished Business

(1) **Student Loan Fund.** Dr. Ross, chairman of the Committee on Student Loan, reported that the committee had interviewed ten applicants since the Council last met and loans totaling $4,450.00 had been approved. After checks have been written for these students, the balance in the Student Loan Fund will be $598.00.

(2) **Liaison Committee between Council and Blue Shield.** Dr. Challman, chairman, reported on the meeting of the Liaison Committee with the Blue Shield Board, held Sunday, January 11, 1959. Discussion covered the following matters:

a. Charges in questionable cases.

b. Suggestion that the President and President-elect of the Indiana State Medical Association be members of the Blue Shield Board by virtue of their offices. **(The Council approved of this suggestion.)**

c. AMA resolution on prepaid medical coverage for the aged, which was referred to the Reference Committee on Insurance and Medical Service at the AMA meeting last December, and which follows:

> "For persons over sixty-five years of age, with reduced incomes and very modest resources, it is necessary immediately to develop further voluntary health insurance or prepayment plans in the way that would be acceptable both to the recipients and the medical profession. The medical profession must continue to assert its leadership and responsibility for assured adequate medical care for this group of citizens. Therefore, the Council on Medical Service recommends to the House of Delegates the adoption of the following proposal:
>
> > "That the American Medical Association, the constituent and component Medical Societies, as well as physicians everywhere, expedite the development of an effective voluntary health insurance or prepayment program for the group over sixty-five with modest resources or low family income; that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate.
>
> "This recommendation has been studied and restudied by the Board of Trustees and it has received its wholehearted endorsement. Your Reference Committee recommends that, in order to effect the immedate implementation of such a program, copies of this report be distributed to Medical Society approved plans, including Blue Shield and private insurance programs, requesting their cooperation."

Dr. Challman summarized objections to the above as follows:

1. No definition is offered as to what is modest resources or income.
2. It offers in essence a service-type service, which has been opposed by Indiana.
3. In many counties the payments of the welfare agencies are based on the Blue Shield rates given in the book.
4. Blue Shield also brought out that it already carries in the plan that is effective twenty-five per cent of all the people in Indiana over the age of 65.

(It was taken by consent that this matter is one for House of Delegates action.)

d. Letters from delegates and alternates of the Indianapolis Medical Society regarding payment by Blue Shield for preparation for, or after care, of surgical or obstetrical cases by internists and general practitioners.

(Suggestions made by the Blue Shield Board to

add additional medical benefits to the Blue Shield policies were discussed by Dr. Challman. **Following discussion also by Drs. Leffel and Howard, it was taken by consent that the Liaison Committee with Blue Shield should confer with the Indianapolis Medical Society delegates, or their representative, the chairman of the Commission on Medical Economics and Insurance, and the chairman of the Commission on Public Health, and take the results of their deliberations to the Blue Shield Board.)**

1959 Annual Convention at Indianapolis

1. Dates. Tuesday, Wednesday, Thursday and Friday, October 6, 7, 8 and 9, 1959. Headquarters, Murat Temple.

2. **Scientific program.** Dr. Leffel, chairman of the scientific program, reported that general scientific programs will be held on Wednesday and Thursday only and that these meetings will not conflict with any of the business meetings of the Association, or with reference committee meetings.

The sessions will be from 9:30 to 10:30 in the morning and from 2:30 to 3:00 in the afternoon. The speakers will give ten-minute talks on the subjects listed.

From 10:30 to 11:00 a.m. and from 3:00 to 3:30 p.m. the sessions will adjourn to view the technical and scientific exhibits.

At 11:00 in the morning and at 3:30 in the afternoon, the speakers for those sessions will form a panel to answer questions from the audience. The program will be of the audience-participation type whereby written questions are sent to the presiding officer and he, in turn, will assign the question to the appropriate speaker.

The program is as follows:

Wednesday, October 7th, 1959, at 9:30 a.m.

Cancer of the Breast ——George Crile, Jr., M.D.
Post Operative X-Ray Radiation for Cancer of the Breast ——John W. Beeler, M.D.
The Role of Cobalt Bomb in Cancer of the Breast ——James C. Katterjohn, M.D.
Hypophysectomy for Metastatic Carcinoma of the Breast——Bronson S. Ray, M.D.

Wednesday, October 7th, 1959 at 2:00 p.m.

Functioning Ovarian Tumors ——J. Donald Woodruff, M.D.
Functional Uterine Bleeding ——Wiliam C. Keettel, M.D.
Adrenal Cortical Tumors ——James T. Priestley, M.D.
Pituitary Tumors ——Bronson S. Ray, M.D.

Thursday, October 8th, 1959, at 9:30 A.M.

Ulcerative Colitis ——Charles W. Mayo, M.D.
The Tired Mother Syndrome ——Leonard L. Lovskin, M.D.
Convalescence Following Illness and Surgery ——N. Henry Moss, M.D.
Modern Treatment of Diabetes ——Glenn W. Irwin, M.D.
The Steroids ——Robert M. Salasse, M.D.

Thursday, October 8th, 1959, at 2:00 P.M.

Malignancy of the Rectum and Lower Abdominal Portion of Colon ——Charles W. Mayo, M.D.
Congenital Lesions ——Arthur De Boer, M.D.
Headache ——Leonard L. Lovskin, M.D.
Behavior Problems of Children ——John G. Young, M.D.
The Problems of Emphysema——John Hickam, M.D.

3. **Questionnaire.** To the questionnaire regarding convention arrangements, which was sent to all members of the Association, 290 replies were received, with answers as follows:

Should instructional courses be held? Yes, 246; no, 50.
On Tuesday, 81; Wednesday, 125; Thursday, 79.

Should round-table luncheons be held? Yes, 141; no, 144.
On Tuesday, 41; Wednesday, 70; Thursday, 76.

What type of scientific program preferred, general or specialty?
General, 196; specialty type, 104.

Do you want section meetings? Yes, 147; no, 126.

Do you prefer panel type program? Yes, 196; no, 76.

Subjects desired:
General, 63; Ob-Gyn, 32; Surgery, 24; Orthopedic, 11; Pediatrics, 21; Heart, 25; ENT, 10; the latest things, 39.

Would you visit exhibits on two floors? Yes, 221; no, 52.

How much entertainment? None, 48; one night, 100; two nights, 44; three nights, 40.

Do you have a paper to present at next annual meeting? Yes, 11; no, 199.

Are you willing to prepare an exhibit? Yes, 15; no, 185.

Dr. Glock's suggestion that the results of this survey be summaried and printed prominently in *The Journal* was approved by consent.

Legislative Matters

DR. DON E. WOOD, co-chairman of the Commission on Legislation, reported that the majority of the bills that were in the last Congress have been re-admitted into the Congressional files, namely, the Keough bill, Hill-Burton bill, and the Forand bill, which is a modification of our present social security law to cover all persons over the age of 60, for health care, including medical, hospitalization and home care. "We are vitally interested in that."

On the state level, the following matters are before the Commission on Legislation:

1. **Blue Cross-Blue Shield matters.** Dr. Wood discussed a joint resolution, prepared by the attor-

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ney for the Indiana Hospital Association, which would "authorize and direct the Indiana Legislative Advisory Commission to conduct a study and investigation of the total public health and hospital, and the hospital and medical insurance, prepaid hospital expense plans, policy provisions, hospital costs, hospital collection problems, problems of the aged, utilization of hospital facilities, financing of hospitals, and operation and construction, and care of the aged, giving the committee full discretion with regard to the method of investigation and requiring reports to be made on or before September 15, 1960, to the Indiana Legislative Advisory Commission for transmission to the Ninety-second Session of the General Assembly."

Dr. Wood said, "This resolution, which we are being asked to sign, would establish a study commission consisting of two members of the House, two members of the Senate, and other parties who would be ex officio members, one from the Indiana State Board of Health, one from the Insurance Department, one for the Indiana State Medical Association, one from the Indiana Hospital Association, and one from Labor and Management."

On motion of Drs. Glock and Mericle, the Council voted to take no positive stand on this joint resolution.

2. **Radiation bill.**
3. **Household poisons bill.**

Economic and Organization Matters

1. **1958 membership report by districts,** as follows, was presented (See opposite page):

2. **Remission of state dues.** On motion of Drs. Everly and Glock, remission of the state dues of a member of the Marion County Medical Society, who has retired because of illness, was approved.

On motion of Dr. Neumann, duly seconded, the remission of the state dues of a member of the Tippecanoe County Medical Society, who has retired from active practice because of ill health, was approved.

On motion of Drs. Glock and Dudding, the dues of a member of the LaGrange County Medical Society, who has retired because of ill health, was approved.

3. **Report of Commission on Medical Economics and Insurance.** Dr. Edward T. Edwards, chairman, gave a progress report on the activities of his Commission to date, pertinent points of which were:

(1) Preparation of Indiana relative value scale.

(2) Preparation for distribution to members statement entitled, "Medical Benefits and Health Insurance."

(3) Preparation of brief digest of the National Conference on Labor Health Services held in Washington, D. C., on June 16 and 17, 1958. "The main thing that is of interest to Indiana physicians is the avowed intention of all the physicians and of the lay administrator, speaking for the union-sponsored plans, to do away with fee-for-service type practice and to put all of us on salary practice, to extend it not only within the limits of a union but also into communities which are outside of union activities for providing health care for the nation."

(4) Endorsement of standardized reporting form for health and accident insurance (a set of simplified claims forms, depending on the nature of the problem) prepared by the Health Insurance Council.

(On motion of Dr. Glock, seconded by several councilors, the Council went on record as recommending the form, as presented by the Commission on Medical Economics and Insurance, to the House of Delegates at its next meeting.)

(5) Review of various resolutions which were presented at the last House of Delegates meeting.

(6) Requested, through *The Journal*, that individuals, as well as medical societies, feel free to submit their ideas and suggestions to this Commission prior to October, 1959, in order that the Commission may have time to study any proposed resolutions before the 1959 convention.

(7) Study of problems of the aged, in conjunction with the Commission on Public Health.

Passed the following resolution in principle:

"In support and furtherance of the efforts of the American Medical Association to effect a proper and fair reduction in the cost of health care for the financially insecure elderly citizen, the Commissions of the Indiana State Medical Association on Medical Economics and Insurance and on Public Health, in joint session, recommended by a majority vote to support a strictly basic hospitalization insurance policy written by any acceptable insurance carrier, designed to cover basic hospital care at the lowest feasible premium. To those recipients of social security payments as either retirement or total permanent disability benefits, and others with comparable income but who are otherwise indigent, no medical or surgical care coverage is implied, as such care will be supplied by physicians on an individualized basis in accordance with traditional professional policy."

(Here Dr. Edwards explained in detail the reasons for the above action by his Commission.)

(On motion of Drs. Paris and Challman, the Council approved the recommendation of the Commission on Medical Economics and Insurance and the Commission on Public Health relative to persons over sixty-five.)

(8) Acting in liaison with other commissions involved with some of the same problems as the Commission on Medical Economics and Insurance, especially the Commission on Legislation.

(9) Consideration and study of all the policies offered by Blue Shield with the purpose of recommending improvements in medical benefits which are feasible.

4. **Report of Commission on Public Health.** Dr. Emmett B. Lamb, chairman, spoke of the many aspects of the care of the aged, which his Commission is studying in conjunction with the Commission on Medical Economics and Insurance. Some of

MEMBERSHIP REPORT

INDIANA STATE MEDICAL ASSOCIATION

December 31, 1958

County Society	#M. D.s in County	Mems. Dec. 31 1958	Mems. Dec. 31 1957	Loss Gain	Elig. Non-Mems.	New Members	Removed & Retired	Deceased	Ineligible
1st District									
Posey	12	11	11	—	—	—	1	—	—
*Vanderburgh	228	209	202	7	11	13	13	4	2
*Warrick	18	13	10	3	2	3	3	—	—
Spencer	9	8	8	—	—	—	2	—	—
Perry	12	12	12	—	—	—	—	—	—
Gibson	17	17	17	—	—	—	2	—	—
Pike	5	3	5	—2	2	1	1	—	—
Total	301	273	265	8	15	17	22	4	2
2nd District									
Knox	43	42	40	2	1	2	2	1	—
*Daviess-Martin	26	24	25	—1	1	—	1	2	—
Sullivan	16	16	16	—	—	—	2	2	—
Greene	18	18	19	—1	—	—	—	—	—
*Owen-Monroe	57	54	55	—1	2	1	1	1	—
Total	160	154	155	—1	4	3	6	6	—
3rd District									
Lawrence	30	26	26	—	1	1	4	—	—
Orange	13	11	9	2	—	2	2	—	—
Harrison-Crawford	15	13	14	—1	2	—	—	—	—
Washington	7	7	7	—	—	—	—	1	—
Scott	5	3	3	—	—	—	2	—	—
*Clark	36	30	32	—2	5	—	2	—	—
*Floyd	40	39	38	1	1	1	2	1	—
*Dubois	24	24	22	2	—	1	—	—	—
Total	170	153	151	2	9	5	12	2	—
4th District									
*Bartholomew-Brown	43	40	40	—	1	—	2	—	1
Jackson	20	20	21	—1	—	—	—	1	—
Decatur	15	13	13	—	1	—	—	1	—
*Jennings	10	8	13	—5	1	—	1	1	—
Ripley	14	13	13	—	1	—	—	—	—
Jefferson-Switzerland	33	30	30	—	2	1	4	2	—
*Dearborn-Ohio	15	13	13	—	1	—	—	—	1
Total	150	137	143	—6	7	1	7	5	2
5th District									
Parke-Vermillion	27	22	24	—2	4	—	5	—	—
*Putnam	16	16	16	—	—	1	—	—	—
Vigo	118	115	119	—4	—	3	4	4	—
Clay	14	14	13	1	—	1	2	—	—
Total	175	167	172	—5	4	5	11	4	—
6th District									
Hancock	20	20	19	—1	—	1	—	1	—
*Henry	45	42	40	2	1	3	3	1	—
Wayne-Union	92	82	82	—	5	1	3	4	2
Rush	16	15	16	—1	—	—	1	—	1
Fayette-Franklin	23	22	23	—1	—	—	—	1	—
Shelby	21	18	19	—1	1	—	2	1	—
Total	217	199	199	—	7	5	9	8	3

County Society	#M. D.s in County	Mems. Dec. 31 1958	Mems. Dec. 31 1957	Loss Gain	Elig. Non-Mems.	New Members	Removed & Retired	Deceased	Ineligible
7th District									
*Hendricks	20	19	17	2	—	1	1	—	1
Marion	1122	1036	1027	9	56	64	80	21	9
Morgan	21	18	15	3	3	2	—	—	—
Johnson	32	26	24	2	6	2	1	—	—
Total	1195	1099	1083	16	65	69	82	21	10
8th District									
*Madison	114	108	106	2	2	4	6	—	2
*Delaware-Blackford	127	115	113	2	8	6	4	4	2
Jay	21	17	17	—	3	—	2	1	—
Randolph	23	21	22	—1	2	1	2	—	—
Total	285	261	258	3	15	11	14	5	4
9th District									
Benton	9	8	7	1	1	—	—	—	—
Fountain-Warren	16	16	16	—	—	1	1	—	—
*Tippecanoe	109	101	97	4	8	3	8	1	—
*Montgomery	31	28	31	—3	—	—	2	1	—
Clinton	25	23	26	—3	—	—	3	1	—
Tipton	12	11	12	—1	—	—	1	—	—
Boone	23	20	20	—	1	—	2	—	—
Hamilton	23	20	20	—	3	—	1	—	—
White	12	11	11	—	—	—	—	—	1
Total	260	238	240	—2	13	4	18	3	1
10th District									
*Lake	408	394	374	20	9	29	23	2	2
Porter	25	21	24	—3	4	—	—	—	—
Jasper-Newton	17	15	15	—	1	2	2	—	—
Total	450	430	413	17	14	31	25	2	2
11th District									
Carroll	11	10	10	—	1	—	—	1	—
*Cass	52	42	38	4	6	3	2	2	3
Miami	26	21	20	1	3	—	2	3	1
Wabash	28	22	21	1	4	2	5	—	—
Huntington	24	23	23	—	—	—	—	1	1
Howard	53	47	46	1	2	1	4	—	2
*Grant	72	60	61	—1	8	1	4	1	—
Total	266	225	219	6	24	7	17	8	7
12th District									
LaGrange	8	8	8	—	—	—	—	—	—
Steuben	14	13	13	—	—	—	1	—	—
Noble	23	23	25	—2	—	—	1	1	—
DeKalb	22	21	22	—1	1	—	2	—	—
*Whitley	18	18	16	2	—	1	2	—	—
*Allen	264	256	250	6	4	8	15	2	2
*Wells	39	35	33	2	2	2	3	1	—
Adams	17	15	14	1	2	1	—	—	—
Total	405	389	381	8	9	12	24	4	2
13th District									
*LaPorte	98	89	86	3	5	4	3	2	—
*Elkhart	107	101	102	—1	3	—	6	2	—
St. Joseph	248	224	222	2	16	7	12	6	1
Starke	6	6	7	—1	—	—	—	—	—
Pulaski	6	6	6	—	—	—	—	—	—
Fulton	12	12	12	—	—	—	—	—	—
Marshall	25	23	22	1	1	—	1	1	—
Koscuisko	21	15	15	—	6	1	1	—	—
Total	523	476	472	4	31	12	23	11	1

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the actions of the Commission on Public Health to date are:

(1) Disapproval of publicity concerning the care of the aged at AMA level. **(On motion of Drs. Ross and Dudding, the Council concurred in this action of the Commission on Public Health.)**

(2) Commission to hold public meeting, with approval of Council, on February 15, bringing in the state police, the Governor's Committee, the auxiliary, and anyone else interested in traffic safety. **(Taken by consent by the Council.)**

(3) Invitation extended to Dr. N. Henry Moss, Philadelphia, to appear on annual session program. Dr. Moss is a member of the faculty of Pennsylvania University and has made an intensive study of the convalescence and rehabilitation of the industrial worker.

(4) Annual Junior-Senior Day, tentatively set for March 21. **(Approved by Council by consent.)**

(5) **Report of Commission on Public Information.** Dr. Harry Pandolfo, chairman, announced that the I. U. Extension Center, Indianapolis, is planning on inaugurating a course for training of medical assistants and presented the following recommendations regarding this course, from the Commission on Public Information, for approval of the Council:

a. That the Indiana State Medical Association, through this Commission, encourage participation by medical assistants in this course.

b. That adequate publicity be given this course, both to the medical profession and their assistants.

c. That physicians be encouraged to assist in defraying the cost of this course to their employees who wish to attend the same.

d. That an advisory committee be set up on a state level to work with the Medical Assistants' Association and the Indiana University Extension Center in establishing the course for medical assistants.

e. That these medical assistants who complete a satisfactory portion of this course be given some recognition in the form of a certificate from the State Association.

By consent the Council approved of this program.

New Business

1. **Matters referred to Council by Executive Committee**

a. **Employment of management analyist firm.** Dr. Wood, chairman of the Executive Committee, in elaborating on the need for a survey of the operation of the Association, read from the minutes of the October 15, 1958, meeting of the House of Delegates, as follows: "Report from Dr. Rusche, chairman of the Reference Committee on Miscellaneous Business: 'Third and finally, if they do desire a building, then we believe a survey by a qualified business consultant should be made to determine if we can afford it.' "

Representatives of two firms, Mr. Roscoe C. Edlund of Rogers, Slade and Hill, and Mr. Richard P. Miller of Wolf Management Engineering Company, were then introduced, each of whom outlined the procedure his firm would follow if permitted to make a management survey of the Association.

On motion of Drs. Paris and Glock, the offer of the Indianapolis firm, Wolf Management Engineering Company, was accepted, the fee to be $3,000.00, plus 15% for out-of-pocket expenses. The survey is to consist of the following nine points:

1. The organization structure of the Association in the light of changes made recently.
2. The organization structure of the office and the general internal operations of the Indiana State Medical Association. This part of the analysis would include office operations, outside men, the medical *Journal*, and the Medicare program.
3. Internal operating procedures in order to determine in what areas they can be made more efficient.
4. Staffing patterns needed to fill properly the objectives of the Association.
5. Physical requirements of the organization. The purpose of this analysis and recommendation is to make possible to reach conclusions regarding the new type of quarters necessary.
6. Current accounting methods and office procedures in order to ascertain how to determine proper work loads and how to obtain full collection of funds due the organization and necessary reports for management. We will determine how to accomplish these ends at minimum cost.
7. A review of the services rendered the membership and how to improve or expand these services.
8. Budgeting and report procedures and how to control more effectively fund expenditures and current position.
9. Other areas of analysis which we may be directed to undertake and which lie within the scope of the fee budgeted for this assignment.

b. *Report of Maternal Mortality Study Committee.* **On motion of Drs. Paris and Challman the Council voted not to publish this report.**

c. *Employment of additional legal counsel* is under way, but the Executive Committee had no definite report to be made at this time.

d. *Veterans Fee Schedule.* **On motion of Drs. Paris and Ross, the Council voted that Item 0070, Office Visit, remain at $4.00, as in the old schedule.**

e. *Woman's Auxiliary.* Dr. Wood reported that the president and president-elect of the Woman's Auxiliary had met with the Executive Committee on January 17, 1959, and had given a detailed report of their activities. The Auxiliary has contributed some ten thousand dollars to A. M. E. F. through memorials, et cetera, for which the Executive Committee commended them highly.

The Executive Committee asked the Auxiliary for help with the next state convention in maintaining a better attendance.

f. *National Foundation for Infantile Paralysis*

SUMMARY BY DISTRICTS

1st District	301	273	265	8	15	17	22	4	2
2nd District	160	154	155	—1	4	3	6	6	—
3rd District	170	153	151	2	9	5	12	2	—
4th District	150	137	143	—6	7	1	7	5	2
5th District	175	167	172	—5	4	5	11	4	—
6th District	217	199	199	—	7	5	9	8	3
7th District	1195	1099	1083	16	65	67	82	21	10
8th District	285	261	258	3	15	11	14	5	4
9th District	260	238	240	—2	13	4	18	3	1
10th District	450	430	413	17	14	31	25	2	2
11th District	266	225	219	6	24	7	17	8	7
12th District	405	389	381	8	9	12	24	4	2
13th District	523	476	472	4	31	12	23	11	1
Total	4557	4196	4151	45	217	182	270	83	34

* Physicians are listed in the counties in which they hold membership; not in the counties in which they reside.

68 physicians received membership gratis in 1958 because of military service.
393 physicians were senior members in 1958.
1 honorary member in 1958.
184 physicians paid dues of $10.00 in 1958 as interns and residents.
52 physicians had their dues remitted by the Council in 1958.

request for establishment of a Scholarship Committee in which three Indiana physicians would participate, one of whom would be on the National Advisory Scholarship Board, was **turned down on motion of Dr. Glock, seconded by several.**

2. *Nominations for membership on Blue Shield Board of Directors.* **On motion of Drs. Glock and Webster, the Council confirmed the following district nominations for membership on the Board of Directors of Blue Shield for the three-year term expiring March, 1962:**

Representing

District 9 ____ R. R. Calvert, Lafayette
" 8 ____ E. H. Clauser, Muncie
" 1 ____ George W. Willison, Evansville
" 12 ____ Mahlon F. Miller, Fort Wayne
" 5 ____ Hubert T. Goodman, Terre Haute

Member-at-large. On motion of Drs. Eades and Larson, Dr. William Harry Howard, Hammond, was nominated for member-at-large for the three-year term ending March, 1962.

3. **DR. A. C. OFFUTT,** director of the State Board of Health, presented the following matters for consideration of the Council:

a. *Tuberculosis bed survey.* Dr. Offutt solicited support on a study of the tuberculosis bed situation in Indiana, to find out, if possible, something about the status of non-hospitalized tuberculosis patients. "This would mean that we would take certain counties and come to your Society for support locally to allow us to interview people in the area . . . This will mean that we will have to have outside help come in . . . it would be the Public Health Service . . . they will be sent with some of our people."

(On motion of Drs. Larson and Webster, the Council approved of this survey being made by the State Board of Health.)

b. *Polio immunization.* Dr. Offutt reported that a fourth inoculation of polio vaccine is now recommended.

c. *Health survey in Allen county.* This is a United States Public Health Service survey which is being done on one person from each of 200 households by a team of internists. Complete physical examinations are being done, from which information will be incorporated in an over-all report. Dr. Glock stated that the survey was being made in accordance with the Federal law passed in 1956 providing for a continuing health survey. "It is

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Type of infection	Number of Patients	RESULTS Excellent to Good	Fair	Poor
Respiratory[3,4]*	32	32		
Shigella dysentery[5]	14	14		
Enteritis[5]	10	6	2	2
Bacteremia[3,5]	5	5		
Meningitis[3,5]	4	3		1**
Rocky Mountain spotted fever[3,5]	2	2		
Ear abscess with cellulitis[4]	1	1		
Lung abscess[4]	1			1
Typhoid fever[5]	1	1		
TOTALS	70	64	2	4

*Includes 15 patients who were administered CHLOROMYCETIN SUCCINATE by nebulization under intermittent positive pressure breathing.

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In all cases, severity of infection and clinical response to therapy should be the guiding factors determining the proper dosage schedule. Premature and full-term newborn infants require special dosage supervision. For details see literature.

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REFERENCES—(1) Glazko, A. J., *et al.*, in Welch, H., & Martí-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 792. (2) Unpublished data: Research Laboratories, Parke, Davis & Company, 1958. (3) Ross, S.; Puig, J. R., & Zaremba, E. A., in Welch, H., & Martí-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 803. (4) Payne, H. M., & Hackney, R. L., Jr.: *ibid.*, p. 821. (5) McCrumb, F. R., Jr.; Snyder, M. J., & Hicken, W. J.: *ibid.*, p. 837.

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4	Joseph E. Dudding, Hope	Oct. 1959
5	Robert K. Webster, Brazil	Oct. 1960
6	Harry P. Ross, Richmond	Oct. 1961
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12	Maurice E. Glock, Fort Wayne	Oct. 1961
13	G. O. Larson, LaPorte	Oct. 1959

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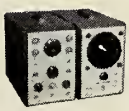
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2.	Fred M. Dukes, M.D., Dugger	J. S. Brown, M.D., Carlisle	May 7, 1959
3.	Robert LaFollette, M.D., New Albany	Daniel H. Cannon, M.D., New Albany	New Albany, May 6, 1959
4.	Robert O. Zink, M.D., Madison	Frank W. Hare, M.D., Madison	Madison, May 20, 1959
5.	James Richart, M.D., Terre Haute	Roy Pearce, M.D., Terre Haute	Terre Haute, May 20, 1959
6.	Frank Lewis, M.D., Liberty	John H. Smith, M.D., Greenfield	New Castle, May 7, 1959
7.	Leon Gray, M.D., Martinsville	Herbert L. Egbert, M.D.	Indianapolis, May 12, 1959
8.	Forrest Keeling, Portland	Ara Badders, Portland	Portland, June 3, 1959
9.	S. E. McClure, M.D., Monon	David C. Beck, M.D., Monticello	Monticello, May 21, 1959
10.	Ralph T. Hartsough, M.D., Remington	Kenneth Ockerman, M.D., Rensselaer	Crown Point, May 13, 1959
11.	Eugene Cook, M.D., North Manchester	C. L. Wise, M.D., Camden	Logansport, May 20, 1959
12.	F. B. Kantzer, M.D., Garrett	Max M. Gitlin, M.D., Bluffton	Fort Wayne, May 20, 1959
13.	R. L. Bender, M.D., Elkhart	James M. Wilson, M.D., South Bend	South Bend, Nov. 18, 1959



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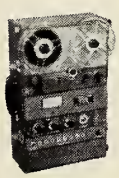
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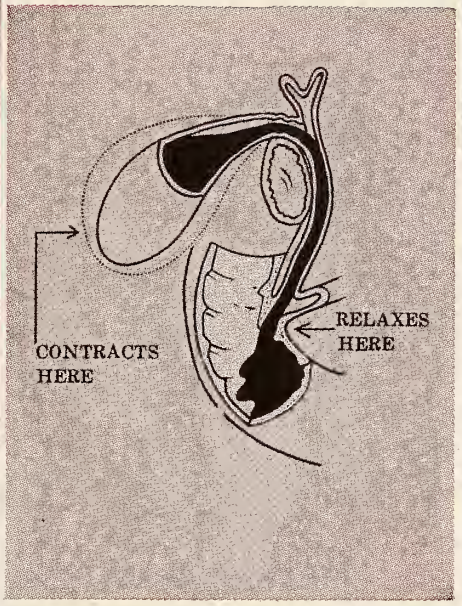
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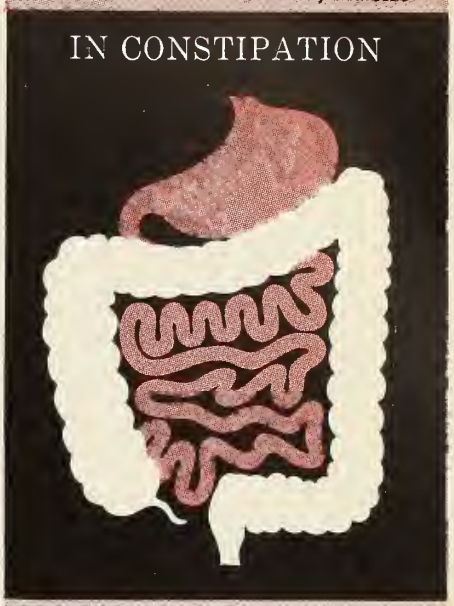
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1. Herland, A. L., Lowenstein, A.: Quart. Rev. Surg. Obst. & Gynec. 14:196 (Dec.) 1957

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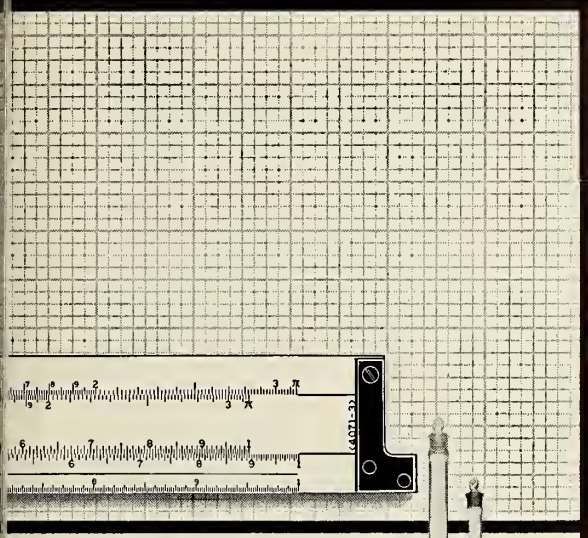
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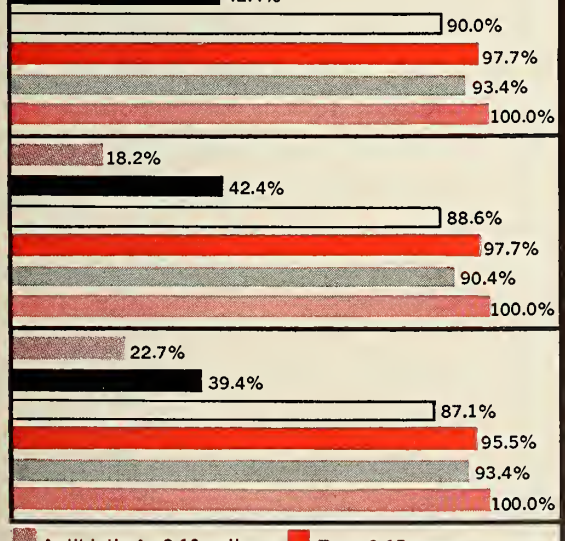
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References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Meilman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

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THE MONTH IN WASHINGTON

Washington, D.C. — If every member of Congress had his way, there would be anywhere from 10 to 15 institutes at the National Institutes of Health in Bethesda. The total now stands at 7, and there is a good possibility that an eighth will be in inoperation this year or next.

Fifty-eight Senators of both parties joined in sponsoring a resolution that would do 3 things: (1) establish a National Institute for International Medical Research, (2) create a National Advisory Council for International Medical Research, and (3) authorize $50 million annually for international research programs. Senator Lister Hill (D.,Ala.) a leader in health legislation and health welfare appropriations, has taken the lead in pushing this bill.

Four days of hearings brought almost unanimous support of the resolution, only 2 witnesses complaining it did not go far enough. The administration asked for 3 postponements to testify. This gave rise to speculation that it either may object on budgetary grounds or dissatisfaction over location of the institute.

Dr. Gunnar Gundersen, American Medical Association president, pledged full support and assistance of the AMA for the project. ". . . we believe that the promotion of international health through research is one of the best means of promoting international cooperation and understanding." He noted "a growing recognition that medicine, with its resources and influence fully mobilized, can perhaps do more for world peace than the billions of dollars being poured into armaments."

The AMA President made several suggestions for the committee's consideration; including (1) that the World Medical Association be included among the international groups to be cooperated with, (2) that due care be taken not to "rob" other countries of experts in medical care and scientific research through support grants not geared to salary differentials. (3) That the program should be primarily one of research itself rather than construction of research facilities. (4) That the greatest care be exercised in setting up the research grants and research programs to avoid overlapping or duplicating.

NOTES:

The Forand bill for hospitalization and surgical services of retired social security recipients has been introduced in only slightly revised form. Its number is H.R. 4700. One change of interest is permitting surgical services to be performed by other than board-certified surgeons. The author says the program will be financed by increasing social security taxes (above increases already scheduled) by one-fourth of 1% for both employer and employe and three-eighths of 1% for the self-employed, both starting in 1960.

Continued on p. 468

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Because ERYTHROCIN Stearate is rapidly absorbed, patients get therapeutic blood and tissue levels within 30 minutes. High, peak levels occur between one and two hours—and effective concentrations are maintained for at least six hours. Always at hand, then, against more critical infections is ERYTHROCIN-I.M.—the only intramuscular form of erythromycin available.

backed by years of clinical effectiveness

Actually, every prescription you write for ERYTHROCIN is backed by more than six years of clinical effectiveness against coccal infections. And, with the problem of antibiotic resistance becoming more important daily, the value of ERYTHROCIN as a day-to-day anticoccal agent is dramatically underlined.

supported by an unparalleled safety record

During all the years ERYTHROCIN has been prescribed, serious reactions have been practically nonexistent. Unlike penicillin, allergy is no problem. And, in contrast to "broad-spectrum" action, the normal flora of the intestinal tract is virtually unaltered with ERYTHROCIN therapy.

offers bactericidal activity

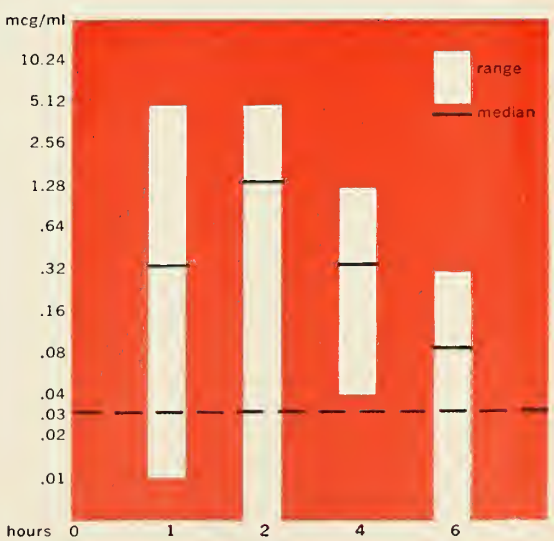
Unlike broad-spectrum antibiotics, ERYTHROCIN is classed as a bactericidal antibiotic. It offers lethal action against common coccic invaders—resulting in prompt clinical response.

provides convenient dosage forms

Usual adult dose is 250 mg. four times daily. Children's dosage is reduced in proportion to body weight. ERYTHROCIN comes in Filmtabs® (100 and 250 mg.), bottles of 25 and 100. Also in oral suspension and for intramuscular use. Won't you prescribe ERYTHROCIN doctor? Abbott

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Dotted line shows actual inhibitory concentrations against most organisms. Note the high ranges and medians of ERYTHROCIN Stearate at one, two, four and six hours. Data represents three studies with adults. Each was given one 250-mg. Filmtab.



And where you need a consistent uniform response that only an injectable form can provide, remember—**ERYTHROCIN-I.M.**(Erythromycin Ethyl Succinate, Abbott) and **ERYTHROCIN LACTOBIONATE.**

®*Filmtab—Film-sealed tablets, Abbott; pat. applied for.*

Month in Washington

Continued from p. 464

More significant than even the introduction of the bill was the statement Mr. Forand filed in the Congressional Record the same day. It was moderate in tone and seemed to be asking the support of all groups. He noted, for instance, that some of his strongest backers have questioned the inclusion at this time of surgical services.

This, he commented, should be weighed by the committee when it takes up the bill.

On hearings, little is known. Neither the House Leadership nor Chairman Wilbur Mills of Ways and Means Committee have given any indication when hearings would be held.

While some committees of Congress have been moving rapidly ahead on health legislation, others like the House Interstate Committee only recently got around to organizing its health subcommittee. It was given a new name: health and safety subcommittee when Rep. Kenneth Roberts (D.,Ala.) who headed a special highway safety committee was tapped for the new post. Its area of interest includes public and quarantine, food and drugs, hospital construction, highway and air traffic safety, and air pollution. Mr. Roberts is a lawyer by profession and is now serving his fifth term.

*** ***

The first woman physician to be honored in Statuary Hall is the late Dr. Florence Sabin of Colorado. She is the first person selected from Colorado. Each state is permitted two statues of distinguished persons. Dr. Sabin was a noted medical researcher and in her later years a public health leader in Colorado. At the unveiling ceremonies in the Capitol, Dr. George Fister of the AMA Board of Trustees represented the association.

*** ***

Three Republican members of the Senate Labor subcommittee on health would have a two-year study of health needs of all citizens, young and old. The 15-man commission would recommend to the President and Congress necessary legislation to supplement or stimulate broader health protection coverage by existing private and non-profit plans. Senators Javits of New York, Case of New Jersey and Cooper of Kentucky are the co-sponsors.

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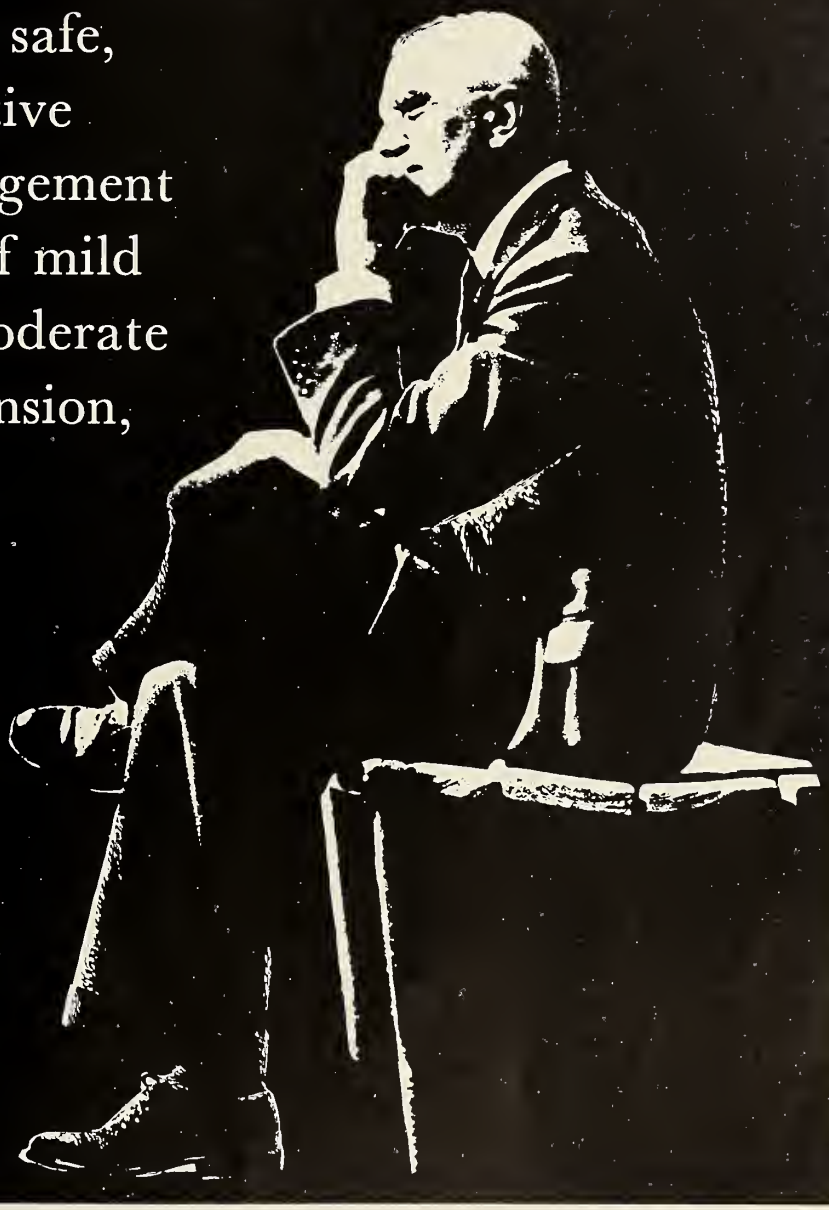
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The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Same Old Story

The magazine *Der Spiegel* reports on Germany's socialized health program. Eighty % of West Germans are under the plan and 2½% are covered by poor people's aid. Of the remainder of the populace, 12½% are covered by private insurance and 5% have no coverage.

Under the German system, anyone enrolled in the state system before he attained earnings of $1,000 a year can remain in the plan, no matter how high his earnings may go. Moreover, his contributions to the plan amount to no more than those whose earnings per year are as low as $165. The result is that chauffeurs call at the pharmacy for free medicine for their affluent employers.

The availability of state medical services seems to promote demand for them. Companies employing 5,000 persons apply for 5,000 sickness certificates a quarter, for they figure that every employe will find it convenient to report sick at least once.

The same tendency is reflected in the rise in demand for pharmaceuticals. The cost of drugs to the state has increased by more than 50% in 6 years, whereas in the United States the increase has been 37% in 23 years.

Similarly, the average period of hospitalization has steadily risen. In general hospitals in Munich, the average patient in 1955 remained 21 days. In the same hospitals he now remains 38 days. Part of the incentive to malinger is that the socialized system must pay a worker 90% of net salary for a maximum of 6 weeks while he is reported sick, but he cannot collect for the first 2 days unless he is sick for at least 14 days.

The minimum fee paid by the state to a physician serving under the socialized plan is 2.28 deutschmarks, or about 50 cents, for each visit by a patient. The minimum fee Germans must pay for a visit to the veterinary is 4 DM for a large animal, 3 for a dog or cat, and 1 for a chicken or a rabbit. The physician's attention to the human patient therefore nets him somewhere between the minimum fee for a dog and that for a rabbit.

Needless to say, the German physician is not getting rich. He rarely is admitted into socialized practice until he is about 40, meanwhile having spent about 15 years in school, assistantships and internships. Even if he supplements his state stipend with about 25% private practice, his average income will not exceed $6,000. After taxes, he has $4,500 net, and, after deduction for old age insurance, he retains less than $3,000.

These conditions have not only occasioned widespread protest from the German medical profession, but they have led to a serious deterioration in the quality of medical care. The most serious example cited by *Der Spiegel* is that West Germany has the highest mortality rate for women from pregnancy thru childbirth of any civilized country in the world with the exception of Japan.

In 1956, 312 of each 100,000 German mothers died of complications during pregnancy, 150 of miscarriages and 675 during difficult deliveries—1,137 deaths per 100,000. Last year, in comparison, the United States public health service reported that maternal mortality was at an all-time low of 3.9 per 100,000 births, a drop from 58.2 per 100,000 just 20 years ago.

The principal reason for the sad record in Germany is that the overworked physician on state service has inadequate time for attending during pregnancies, so that more than one-half of all pregnant women go unattended and frequently present complications at delivery time.

The defects of socialized medicine have already been abundantly manifest from the experience elsewhere. The record in West Germany deserves attention if only for the reason that Walter Reuther and the social democrats of the American labor movement have renewed their agitation for socialized medicine as part of the social security system.

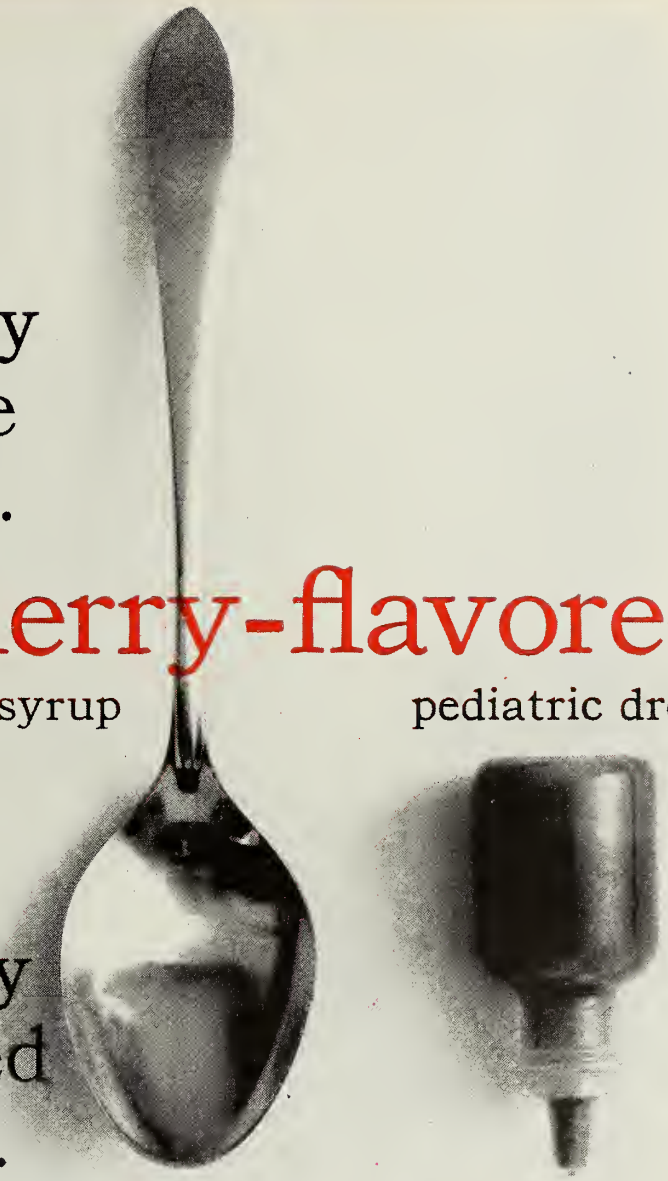
—*Chicago Tribune*
Jan. 29, 1959

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1. *Based on six-month National Physicians Survey.*

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Fourth Estate

Continued

News Media and Hospitals Seeking Code

By Ed Klinger

Press Associate Editor

You have been injured in an automobile accident.

The police summon an ambulance, rush you off to the hospital, and you are deposited in the emergency surgery room.

Before the nurses are finished wiping the blood from you, the emergency room phone begins to ring. The newspapers, radio and television stations, who have heard of the accident through police, want to know how badly you're hurt.

This sounds like a routine matter (which it is) calling for routine answers (which it isn't).

Bear in mind it's your bloody, battered body lying there on the surgery table. So far, your wife doesn't even know you've been hurt.

She may be at the beauty shop, or the supermarket, or at a bridge game, and it may be hours before she can be found. Should she get the bad news from the newspapers, or from the radio?

That's an almost daily dilemma faced by physicians and hospital personnel.

Or suppose your wife is with you when the accident occurs and she knows all about it.

The dilemma for doctors and hospitals doesn't go away. The examination hasn't yet been completed. Obviously, your leg is broken, but so far as the physician knows at this moment your back may be broken, too. What kind of answer should the hospital or physician give? Or should they give any answer at all?

The solution to such problems as these now is being sought by the Evansville Area Hospital Council, and the Vanderburgh County Medical Society. They're undertaking to compile codes fixing the outlines of their relationship with the news media.

They would like to answer news inquiries immediately, and as fully as possible, but you, the patient, are the barrier.

The hospital and the physician are there to serve you and your interests first, and the news media afterward.

In effect, you are the client, and your well-being and privacy is their first concern.

On the other hand, from the standpoint of the newspaper, radio or television station, getting the news is the first concern.

Here lies a conflict of interest not easily resolved.

The tentative codes so far prepared recognize the fact that some hospital cases are matters of public record — accidents, violence, poisonings, suicides. They also recognize the fact that some people are "public figures," persons so prominent in the community they have sacrificed much of their privacy, if not all of it.

In the illness or injury of such people, hospitals and physicians expect to provide answers as soon as they are available. On the other hand, they expect to protect the privacy of the average individual who is a hospital patient, and may decline to answer unless authorized by a member of the family.

The point between privacy and non-privacy isn't clear, and it's likely it never will be.

Another troublesome point between hospitals and the news media is describing the condition of a newsworthy patient.

Most hospitals have pat terms, each covering a broad spectrum. For example: Good, satisfactory and critical. These terms tell something, but not much. Experience has taught hospitals even to be cautious in use of the word "improving." A critical patient may be improving one hour, and declining the next.

Nurses, who do most of the talking for hospitals in reality have practically no authority to diagnose a case for the benefit of news media, and even less in explaining how the patient is getting along. That's the prerogative of the physician, and here's why: If nurses were permitted to express even a small opinion, at what point would the line be drawn? As hospitals see it, the only way to curb possible excesses is not let it start.

—*Evansville Press*
Jan. 1, 1959

Doctors

A man who signs himself "Lami Nate" writes, his pen apparently dipped in umbrage: "I have seen, on my television set, an advertisement which says that 'five out of six doctors recommend' this fine thing they are advertising. Well, this is all very well, but what about that sixth sawbone? Is he trying

Continued on p. 476

more potent and comprehensive treatment than salicylate alone

. . assured anti-inflammatory effect of low-dosage corticosteroid[1] . . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

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acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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SG-J-618

Continued from 472

to build a unique reputation by dissenting? Is he such a stuffed shirt that he is no longer interested in the common man?

"Has he no interest in research for the common good? Has he made so much money that he just sits around figuring his income tax? He sounds to me like a doctor who would not make night calls."

O, come now, Lami Nate! Let us examine the facts—not forgetting that doctors are the same self-sacrificing fellows who give their all for an inconsequential fee.

Suppose, when this researcher came panting into the doctor's office, that he was not there. "How do you stand on this subject?" the researcher may have said, and, not getting any answer, and having seven more doctors to see before supper, he may have just made a little mark on his paper and gone away.

And why was this physician not in his office—old Number Six? He might just have been at some hospital carving a Croat who needed major amendment. Perhaps he was skewering a faulted appendix, slicing a surly ligament, or hemstitching a half dozen hemoglobin from a pattern his mother used to use.

Just suppose a friend said to Number Six, "Physician, heal thyself," and he had gone somewhere to put a patch on a slow leak in his personality. Suppose he, Number Six, that is, was a Horse and Buggy doctor. Well, you do not treat a Horse and Buggy and go way and leave it. You stay there until the Horse and Buggy both are cured.

No, let us not jest about serious things like doctors. Let us have the facts before we sell a doctor short. And, if you did, what would you get? There are so many doctors.

—*Chicago Tribune*
January 21, 1959

Is Man Smart Enough to Survive?

A panel of top scientists, speaking at a health conference in Ann Arbor, has raised a question concerning the future of man's health that should stagger the nation.

Modern medicine, they agreed, would soon reach a point where it can control virtually all of mankind's ills. But now comes the question that stumped them:

How can you get people to use this knowledge for their own benefit even when they seem unwilling to do so?

What made these speeches so pointed was the fact that they were heard by some 50 teen-age leaders from all parts of the country gathered at the University of Michigan in behalf of the 1959 March of Dimes campaign against polio, arthritis and birth defects.

Concerning polio, for instance, they heard Dr. Alexander Langmuir of the U.S. Public Health Service indicate that the disease might be practically wiped out in this country if millions of unvaccinated Americans would get their Salk vaccine shots. Because this has been neglected out of ignorance, apathy or indigence, we still have unnecessary tragedies like Detroit's 1959 epidemic that claimed 867 victims and 23 lives.

Concerning basic medical research, they heard Dr. Thomas M. Rivers of The National Foundation (originally "for Infantile Paralysis") tell how juggling the atoms of a complexed chemical that directs the course of all life can lead man



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to his own destruction or to the solution of a host of uncontrolled disease problems.

Concerning atomic energy, Dr. Edward L. Tatum, newest of Nobel Prize winners in medicine, said that unless man learned to adjust himself to this new hazard and live together in "world brotherhood," he did not "in a biological sense deserve to survive." If, on the other hand, man used his common sense, according to Dr. William S. Clark of The National Foundation, many teen-agers of today would live to be 100.

So there's the problem. Will men be smart enough to use what he knows to improve his physical lot? Or will he remain the victim of his own stupidity, ignorance and inertia?

One answer to these questions may lie in the suggestion of Dr. Thomas Francis Jr. of the University of Michigan. He urged a health code listing what every citizen should do to maintain the physical well-being of himself, his family and his community. An individual should be expected to comply with this code just as he now observes housing, electric, plumbing and sanitation codes.

There would be a risk in making such a step compulsory, for it is dangerous for government to extend controls over the lives of its citizens. But a voluntary health code, repeatedly emphasized by health officials, might do much good.

—*Kokomo Tribune*
Feb. 5, 1959

Should Concern Every Family

If it will help to find solutions to the plight of those like the little boy next door who was born with a physical defect—

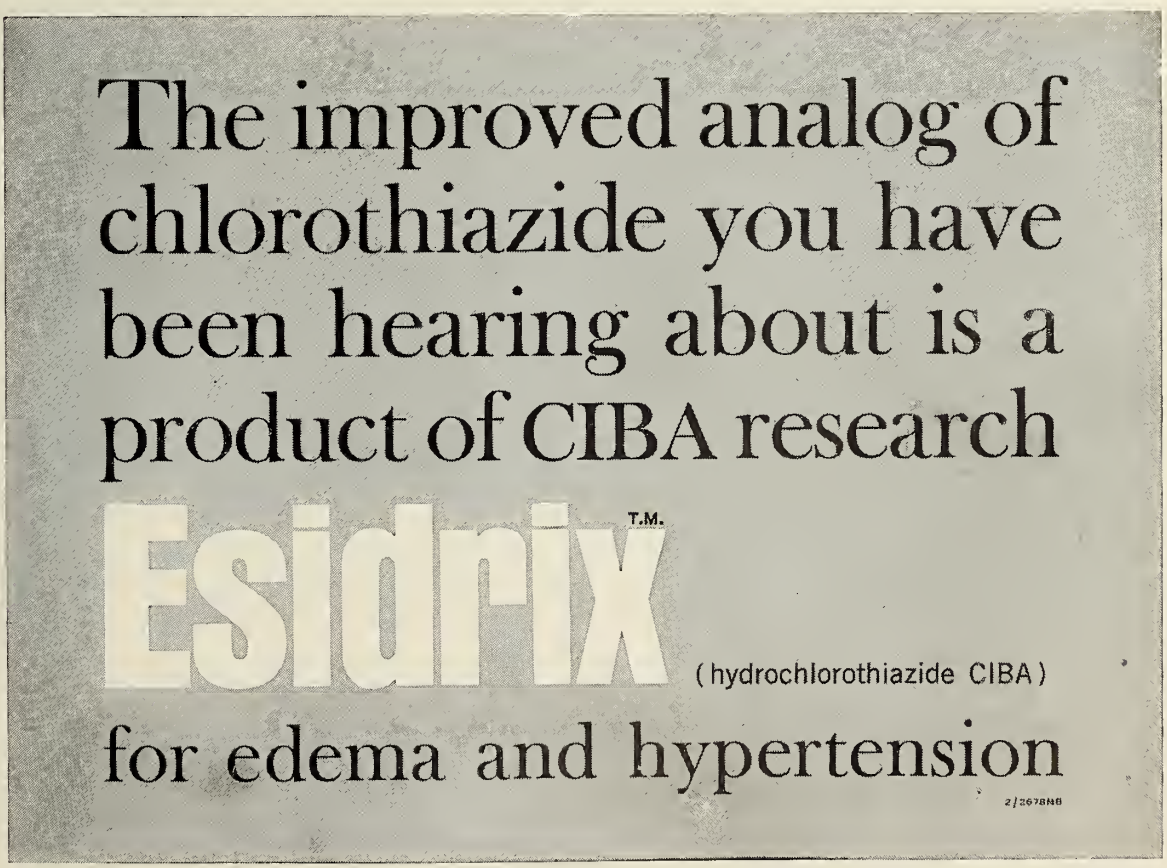
If it will help to bring improved treatments of arthritis which so many people suffer from today—

If it will help continue the unfinished fight against polio—

I'll be glad to give something.

That is the basis on which many citizens will respond during January to the various March of Dimes fund raising projects. Conducting the month-long campaign is the National Foundation (formerly known as the National Foundation for Infantile Paralysis) and in this area the organization's Howard County chapter is making the drive.

The Salk vaccine, wonderful as it was, didn't deal polio a knockout blow. Last year the num-



Fourth Estate

Continued

ber of paralytic cases ran nearly 50% higher than in 1957, the Associated Press has reported. This reversed the sharp downward trend that had been in effect since the introduction of the Salk vaccine in 1954.

Experts of the Public Health Service have expressed the opinion that 1958 would have been a very bad year for polio had it not been for the vaccine.

The Foundation is now devoting itself to the care of those who have polio and is moving into two new fields—the conquest of arthritis and birth defects. Since these are afflictions that can visit any family, every family ought to be concerned.

How to give your bit? School children have dime cards they will be bringing home to be filled out. A tag day and pretzel day sale is set for Jan. 17. A collection will be taken at the KHS-Richmond basketball game on Jan. 23 and at other games in the county. A bowling tourney will be held next week with entry fees going to the March of Dimes. Letters urging donations will be placed in the mail and sent to homes throughout the county. And the traditional mothers' march will be held Jan. 29.

Actually, America is fortunate that it has organizations of citizens who are interested enough and will give their time in concentrated efforts to find out how to cure diseases like polio, arthritis, etc. The least we can do is help by giving something.

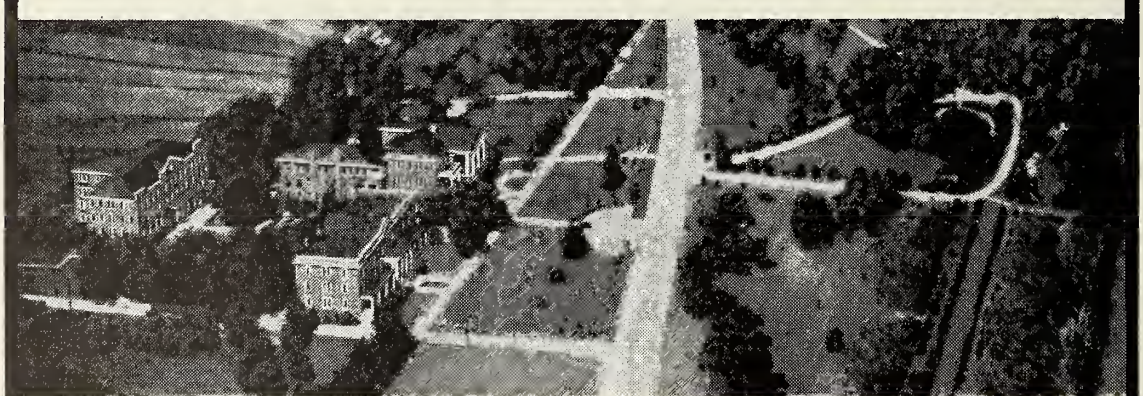
—Kokomo Tribune
Jan. 14, 1959

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The following article is quoted from *Wall Street Journal*, Jan. 12, 1959, for the benefit of members of the Commission on Medical Economics and Insurance, and for all ISMA members.

Social Security and Forand Bill Can We Afford Both?

CONSIDERING Social Security alone, we find an increasingly costly program trying to keep its benefits up to the pace of inflationary effects on living costs for the retired and widows with dependent children. A special Federal advisory council reported in January '59 that the present financial program for the Social Security System was "sound," but neglected to say what the future held if inflation results in another congressional increase in benefits. In other words, the present "income" is "sound" IF THE PRESENT "expense" remains constant! Past experience makes one skeptical of this idealized future.

When adding hospital-surgical benefits to this doubtful future, it is obvious that the "income" or taxes will have to be increased. Here again "inflation" rears its ugly head for those concerned with medical practice . . . physicians, hospital administrators, the insurance and drug industries plus labor leaders . . . realize that the cost of medical care is going to continue to rise regardless of maintaining status quo or "reducing" physicians fees. Paramedical personnel, eg., lab and x-ray technicians, nurses, aides, orderlies, hospital maintenance and office personnel, have all trailed behind industry in salary and fringe benefit schedules. Physical equipment and expendable materials used in medical care have not been excluded from the general economic upward spiral. The total national population is increasing due to greater birth rate and length of life span. Don't forget Social Security covers children, too! No legislator will refuse funds for child care!

Another source of increased medical expenses is the trend of research . . . more complicated therapy and diagnostic procedures requiring more expensive equipment and better trained paramedical personnel who must be paid comparable incomes to industry's for similar talent. The present experience of the Armed Forces losing expensively trained persons to private industry should be sufficient warning.

Probably the saddest part of this whole proposal is the absence of truth regarding the sick elderly patient. What happens to him? Does he need expensive surgical technics for which the Forand Bill attempts to compensate or does he have non-surgical problems more often and for a longer duration? Which physicians provide the majority of medical care for the recipients of Social Security benefits . . . surgeons or internists? When this fact is recognized, the projected program expense will increase above 1 or 2 billion per year now estimated.

Physicians are criticized for publicly stating their lack of confidence in a federal government operated medical program, yet the evidence supports our fears. Medicare operated only one year before its benefits and budget were restricted by Congress. The actual cash benefits presently given by Social Security to many of its recipients are too small to provide a suitable diet and housing; the same holds true for State Welfare programs, but in the latter's medical program, physicians are condemned for "luxury treatment" and "wasting" public funds when simple vitamins are prescribed to supplement the inadequate diet, thereby preventing more serious and expensive illnesses. The implication is frequently made that

Continued on page 486

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Social Security

Continued from 484

there are two ways of treating an illness: First class, expensive but reserved for paying patients, and Second class for the indigent and tax supported programs. This concept is not only erroneous, but insulting to the integrity of the American public. John Q. Citizen knows his doctor better than that!

The goose that lays the golden eggs can be killed for social planners and legislators with restricted vision. The present "sound" Social Security tax schedule at 2½% for the employe and his boss means $120.00 per year on $4800.00. It is scheduled to hit $216.00 for each and $324.00 for the self-employed per year. The percentage will rise to 4½ in 10 years, 1969. Do you think that will be enough? Won't there be any increases in benefits in the next 10 years or won't we have any elections? Remember 1958, the American citizen votes "against" more often than "for."

It is admitted that the medical care picture for the aged must be improved as must his total situation in meeting his life needs. No one is more aware of this fact than the practicing physician. We wonder, however, why there has not been a "special movement" to provide better housing, recreation, job opportunities, and protection against inflation gnawing at his life savings. Has a man at 65 years of age lost his pride, his interest in productive work? Has he become feebleminded to be treated like a child? Does he benefit from being put on a shelf, deprived of his independence? Can we buy his soul for a pittance? Is the Forand Bill the first order of business in meeting the requirements of the man of 65? Can we as a nation afford to scrap completely the productive efforts of every person at 65?

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Local Leadership Necessary For Improved Traffic Safety

AL HUBER

Indiana Traffic Safety Director

IT HAS BEEN a privilege to work with Dr. Hammel* and his fellow committee members. The series of articles on traffic safety carried in the Indiana Medical *Journal* have been well designed to stimulate increased interest among members of the medical profession in traffic accident prevention.

When we were approached several months ago by Dr. Lamb** and Dr. Hammel on the matter of a more active role for the Indiana medical profession in the state traffic safety movement, we, of course, were tremendously encouraged by the possibility of working more closely with the more than 4,000 members of the State Medical Association.

Your profession has attained a high position in our social structure. Particularly at the local level, where so much needs to be done in so many areas, including law enforcement and traffic safety, the doctor is a man of considerable influence. This influence can and often does extend beyond his main function as a medical practitioner.

We recognize that if a doctor accepts a position of leadership, he can help accomplish much in the way of improving the general welfare of his community.

One area of community life in desperate need of outside support is that of law enforcement. Crime and traffic problems which affect not only doctors, but every other level of civilian life, have been growing much faster than the governmental forces designed to handle them. This is particularly true in the field of traffic, where we have seen an actual doubling of the number of vehicles, licensed drivers and highway travel in the past decade.

Traffic Growth Not Met

This surging growth of vehicular traffic has not been met at the local or state level with adequate facilities and manpower to control it and, as a consequence, heavy loss of human life and property has resulted.

It has been repeatedly stated that there is no such thing as a state or national traffic problem. The problem is one of a local nature and only as a strong, organized effort at the local level is effectively directed toward accident causes will an acceptable reduction in traffic losses be accomplished.

And so it has been the objective of both official and citizen state safety organizations to encourage the formation of public support groups for traffic safety and law enforcement at the local level throughout Indiana. It is in this area that efforts seem to be most productive in the field of traffic accident prevention. It is in this area, too, that we feel members of the medical profession interested in reducing traffic losses can best serve.

It is said we can have just as good a traffic safety program or police department as we are willing to pay for. Wherever a responsible, alert, energetic and well-grounded group of citizens undertakes to encourage and support a local traffic program, positive improvement has resulted—not only in reducing traffiic losses but, also, in developing a more orderly and peaceful community.

It has been well established that we drive as we live. How we live is influenced greatly by our environment.

Traffic safety is the product of many things

Remarks presented at the Traffic Safety Meeting, Feb. 15, 1959, and reprinted for the information of ISMA members.

* Howard T. Hammel, M.D., chairman, Traffic Safety Committee.

** Emmett B. Lamb, M.D., chairman, Public Health Commission.

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Local Leadership

Continued

that go to make up our community safety environment. The primary causes of traffic accidents are rather well known. There is no single cause but rather a wide variety of them.

The remedies also are well known. We can predict with confidence and accuracy a reduction of accidents commensurate with the application of these remedies. Our greatest trouble is that we seldom get all of them applied in force at the same time and place.

For many years, 50 to 60 Hoosier cities and towns have been participating in a self-analysis type program called the Annual Inventory of Traffic Safety Activities administered by the National Safety Council. In the past 1½ years, we have had a State Traffic Safety Survey Team in the field; available to cities upon request by the mayor. Some 25 Hoosier communities have been surveyed to date.

From these two activities we have learned first hand some of the safety deficiencies of Indiana communities.

Let's look at some of them—you may keep score of your own community, if you wish.

1. Many city councils and town boards starve the traffic safety effort by failing or refusing to appropriate funds for adequate safety measures. (Signs, signals, markings and traffic control devices.)
2. Most cities fail to make someone definitely responsible for traffic engineering.
3. Most cities change chiefs with every change of mayor or *more frequently.*
4. Many police departments fail to maintain an adequate system of accident records.
5. Most departments fail to use accident records fully in planning enforcement or engineering action.
6. Most cities fail to pay police officers a living wage.
7. Most fail to provide for police training.
8. Most cities fail to mark center lines, use standard signs and to maintain these lines and signs in proper condition.
9. Only a few cities have adopted the Model Traffic Ordinance.
10. Most police departments have a low level of traffic enforcement—fail to arrest at accidents.
11. Another common failing is in our traffic courts. Quarters are inadequate, not kept clean, sessions are not conducted with decorum, and few courts have written rules to govern procedures.
12. Perhaps half of Indiana's city school systems have not yet made one person responsible for school traffic safety activities.
13. One further stumbling block is the refusal of citizens to file affidavits for traffic violations, refusal to give evidence as a witness, reluctance to serve on juries, and a reluctance to convict when they do serve.
14. Only a few cities have a planned program of public safety education.

There are many other deficiencies, but I'm sure this is more than enough to raise in your minds the question "How are we doing as well as we are?"

On the brighter side, there are several outstanding traffic safety programs currently active. One of the most important parts of all successful programs, whether it be engineering, education, enforcement or legislation, is public support. Nearly every public official who has made even a small attempt to prevent accidents has recognized the need for public support.

Public officials, no matter how dedicated, can go only as far as the public goes with them.

Only through citizen understanding of the needs and objectives of a local program can strong support be generated.

So the challenge we would like to present to your profession is one of providing leadership at the local level to organize for stronger efforts to reduce needless traffic losses.

Public support groups can do much to provide the means to get the facts and make plans for an effective local traffic safety effort.

Local support organizations can assist in providing the necessary time and money required to adequately cope with the growing traffic problem. We subscribe to the high priority placed on the formation and maintenance of active citizen support groups by the President's Committee for Traffic Safety when such a program was labeled, "America's Number One Traffic Need."

I sincerely hope each of you will seek and find ways to take a full and active part in local programs designed to provide an adequate law enforcement and traffic safety program for your community.



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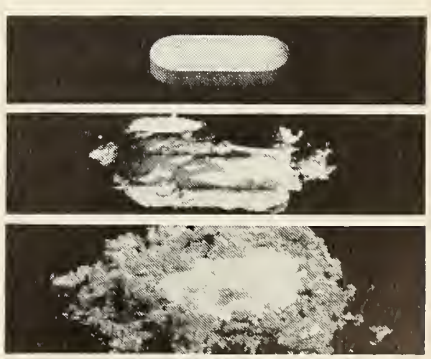
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The Negative Road to Socialized Medicine

This article is the second in a series prepared by Blue Cross—Blue Shield dealing with the cost of health care and trends in the financing of health care.

Those in favor of socialized medicine are using legislation in the attempt to destroy our voluntary health care system. We are aware of that *positive* road, and can take opposing action accordingly.

But there is a second, the *negative* road. It is dangerous because it is not marked so accurately as to destination.

This road to socialized medicine includes: (1) failure to meet the health care financing needs of the American people, and (2) opposition to necessary changes in our voluntary health care system.

What can we do to avoid a government controlled program by this route? First, we must make available health care coverage for all, including the aged, the unemployed, and the sick—at a price they can afford to pay. Failure to do so will encourage pressures, public and official, that could make socialized medicine an accomplished fact.

The bad risk should not be eliminated from coverage. And health care benefits should not be cancelled, waivered, or changed for physical or employment reasons. Such practices, common among many companies in this field, are an open invitation to government intervention.

Another negative approach to socialized medicine is to price health care beyond the reach of those who need it. If rates for health care coverage are established on the experience of the individual, those who have known need for the services will not be able to pay for the protection. Many sick persons are unable to pay the full cost of necessary medical care. Blue Cross and Blue Shield believe that a successful program requires the community-service approach—with younger persons to balance the cost of the older, and well people to balance the sick—for such a program to be of optimum benefit for all.

Occasionally Blue Cross and Blue Shield have been labeled socialistic because they are not-for-profit organizations. At times they are grouped with charitable or philanthropic organizations, despite the fact that Blue Cross and Blue Shield do not disburse charity or philanthropy.

Not-for-profit community service is not socialism. Blue Cross and Blue Shield believe that all funds paid for health care coverage above those necessary for administration should be used for health care benefits, and that profits are unnecessary because benefits are paid only from funds paid in by members.

There are no cut-rate bargains available in the field of health care coverage. Either going rates are paid, or something less than full benefits is received. Unfortunately, the cost of necessary care is just as much for a low-income person as it is for a high-income person. It is people of low income who are attracted by the seeming advantages of low-cost coverage, and these same people are the most receptive towards socialized medicine. Individuals who have been victims of cancellation, waivering, and other such practices, tend to favor government control.

Such people cannot pay most of their health care bills if the insuring companies deny or restrict payment. The unpaid balance must be paid from taxes, or absorbed by the hospitals and doctors as bad debt losses. Either way, this loss is passed on to the community at large through higher taxes or higher charges to paying patients.

Blue Cross and Blue Shield are accepting a major responsibility in eliminating this bad debt loss. Companies that cancel and waiver, and follow other practices necessary to insure a profit, simply aggravate the problem.

Blue Cross and Blue Shield were organized by hospitals and doctors to help solve the problem of financing health care, and to prove there was no real need for socialized medicine. At the same time Blue Cross and Blue Shield were a major factor in helping to eliminate bad debts in the health care field. Both in terms of philosophy and practice, Blue Cross and Blue Shield have made and will continue to make positive contributions toward strengthening our voluntary health care system.

They oppose socialized medicine on both roads.

Warren Huddlestone
Public Relations Division

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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Management of Malignant Disease of The Accessory Nasal Sinuses

RALEIGH E. LINGEMAN, M.D.*

Indianapolis

FOR hundreds of years tumors of the upper jaw have been removed by crude methods of surgery; however, it wasn't until 1846 when Sir William Ferguson[10] published his text on a treatise of surgery and in it devoted a chapter to management of tumors of the upper jaw, that the first thorough discussion of the management of neoplasms in this area appeared. Ferguson reviewed the previous surgical procedures and also outlined his operation of choice which was an external approach to tumors of this area. He used an incision along the lateral margin of the nose, curving beneath the ala region to the columella and splitting the upper lip. The incision was carried laterally in the buccoalveolar fold and a second incision made from the corner of the mouth laterally over the zygomatic region. This cheek flap was retracted and the upper jaw quickly removed, using mallets and chisels. The surgery was accomplished without anesthesia in a few minutes.

Until 1900 this was the type of management that was advocated for control of tumors of the upper jaw and paranasal sinuses. In 1900 Sir Henry Butlin[3] reviewed the cases already done and the results. He concluded that the results were rather poor as far as salvage of these patients was concerned and that the mortality was extremely high. He noted that the majority of these patients died from shock, excessive blood loss at the time of surgery or perhaps from complications from infection if they were fortunate enough to survive the procedure. He, therefore, condemned the type of procedure that had been described by Sir William Ferguson. In 1920 Douglas Quick[29] wrote that surgery was ineffective in the control of malignant disease of the paranasal sinuses and that the use of radium or x-ray alone was not the treatment of choice. He concluded that if surgery could (1) facilitate

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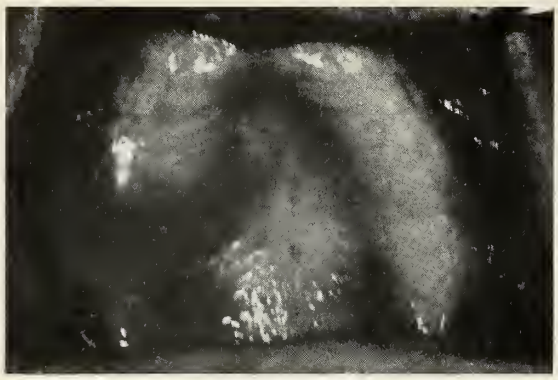


Fig. 1. Illustration of an oral lesion of antral carcinoma.
Patient had no symptoms of pain, but had had two episodes of epistaxis in recent months. His only complaint was that his dentures no longer fit properly.

implantation of radium into the center of the tumor mass and (2) provide adequate drainage and removal of the products of tumor and x-ray necrosis, then there may be some hope for these patients.

For the next 15 years the trend was against the use of external operations. The sublabial approach was used with minimal surgery, emphasis being placed on the electrosurgical technic. In 1933 Ohngren[26] of Sweden reported 45 cases which had been treated with electrosurgical technic with a 33% 5-year cure. In 1935 Gordon New[24] of the Mayo Clinic reported 141 cases treated with electrosurgical technic with a 37% 5-year cure. His series of cases was sharply criticized because he had operated upon only 56% of the total number which he had seen.

Until 1945 there was emphasis toward the control of malignancies in this area by means of external irradiation and intra-cavitary radium with minimal surgery. Obviously, the rationale for the use of this method of treatment was by default rather than by virtue of good results. It was believed that this type of therapy was less hazardous to the patient, was less difficult for the surgeon, and would greatly surmount many of the disadvantages of surgical procedures. In 1945 with the development of better technics of anesthesia, better methods of blood replacement and with the advantage of antibiotics, a return to the external approach, as advocated nearly a hundred years previously by Sir William Ferguson, was the trend. This procedure has become increasingly more popular in this country. This technique complemented with the use of intra-cavitary radium with or without external irradiation, is now the procedure of choice.

With an appreciation of the background of the management of this disease, it is the author's objective to review the present concept of treatment of malignancies of the paranasal sinuses based upon a survey of the literature and the personal experience from a group of 32 cases treated during a 3-year period.

Incidence

The incidence of malignant tumors of the paranasal sinuses is relatively rare. Watson[40] has reported 127 in 26,000 admissions or .44% of all admissions. Hayes Martin[19] has later reported .2% of all cancer and 3% cancer of the upper respiratory and G.I. tracts to be lesions of the accessory nasal sinuses. Ewing reports 2.5% of all cancer is to be found in the



Fig. 2. A patient with extensive carcinoma of the ethmoid labyrinth, orbit, and maxillary antrum with marked facial asymmetry and soft tissue involvement.
Initial symptoms were pain over cheek with later nasal blockage and serosanguineous nasal discharge.

nasal sinuses and at the Manhattan Eye, Ear and Throat Tumor Clinic[39] there have been reported 30 cases in 467 admissions or 6.4%. As with other malignancies of the head and neck region, the ratio of male to female is about 2 to 1. The average age of patients having malignancies in this area is 54 years with the majority in the 5th, 6th, and 7th decades of life.

Pathology

Malignant tumors of the paranasal sinuses may result from tumors arising primarily within the sinuses themselves or perhaps from invasion of tumors from the nasal cavity, nasopharnyx, orbit and oral cavities. Most of the tumors in this area are of the epidermoid or squamous cell variety, with the grading varying from well differentiated to highly undifferentiated neoplasms. Adenocarcinomas, mucoepidermoid carcinomas, cylindromas and mixed cell tumors are also found. Tumors of the malignant lymphoma group, reticulum cell sarcomas and lympho sarcomas arising from lymphoid elements within the nasal cavity or perhaps from connective tissue stroma within the nasal sinuses are also reported. Adamantinomas from the oral cavity and juvenile nasopharyngeal angiofibromas may invade the paranasal sinuses and, although these tumors do not metastasize, they do have malignant characteristics because of their local invasive tendencies. Because of the complex anatomy of the paranasal sinuses, it is difficult to classify the site of origin of these tumors, but it is generally believed that primary tumors of the maxillary antrum are 5 times more frequent than of the other sinuses. Tumors of the ethmoid region are next in frequency with primary malignancies of the frontal and ethmoid regions being extremely rare.

Symptoms

The numerous symptoms of malignancy of the nasal sinuses are, of course, not peculiar to this disease alone. Although the majority of these patients present themselves for treatemnt quite early in the course of the illness, accurate diagnosis is usually not made until the condition has become quite far advanced. Fifty % of the patients in our group had as their initial symptoms, pain over the cheek, purulent nasal secretion and nasal obstruction. Other subjective symptoms include swelling of the cheek, serosanguinous nasal drainage, and ocular symptoms such as proptosis, diplopia, or unilateral lacrimation. On admission most of these patients were found to have either facial asymmetry, tumor visible on anterior rhinoscopy, or tumor palpable from the oral cavity (Figs. 1, 2, 3). Ringertz[31] and others have reported that from 14% to 20% of these patients have a history of predisposing factors such as long standing sinusitis or nasal polyposis. It is the belief of Ringertz that under the stimulus of chronic irritation from infection metaplasia of the respiratory epithelium occurs and a papillary type of sinusitis may result. Papillary sinusitis has long been known to be a premalignant disease similar to leukoplakia. It is the belief that in many cases a conversion to a papillary type of epithelium need not occur, but that polypoid degeneration may undergo further metaplasia and develop into malignant disease. For this reason, all polypoid tissue removed from the nasal region

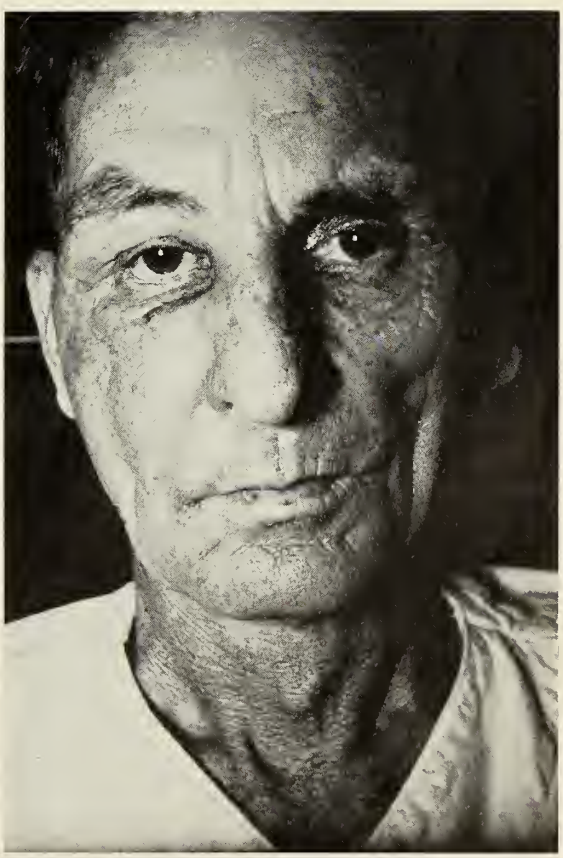


Fig. 3. Patient with facial asymmetry due to right antral carcinoma.
Patient had been treated for 6 months for facial neuralgia and sinusitis. Otolaryngology consultation was requested when facial asymmetry appeared.

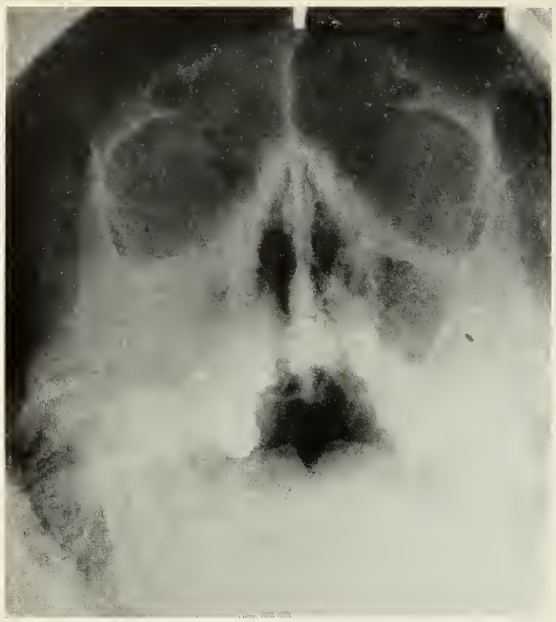


Fig. 4A. The x-ray studies of a patient with carcinoma of the right maxillary sinus, showing a cloudy maxillary antrum without evidence of destruction.
Antral lavage was clear on two occasions. Patient refused an exploratory operation. He elected to receive consulation at a large mid-western clinic where it was felt that the problem was inflammatory and he was assured that he did not have a malignancy.

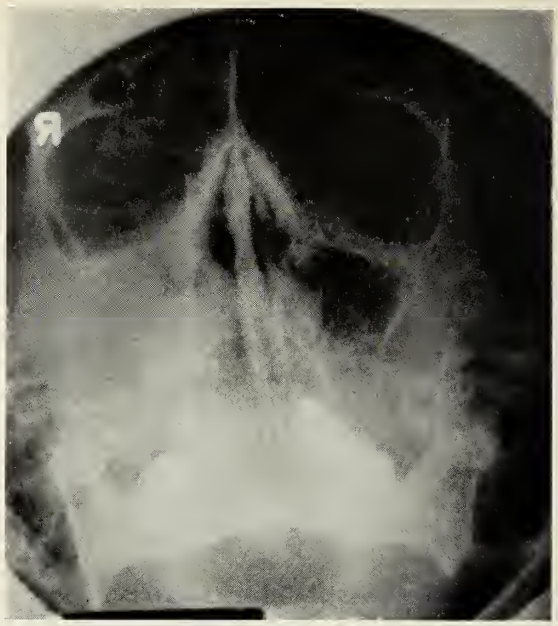


Fig. 4B. X-ray studies taken approximately 8 months later with unmistakable evidence of malignant disease.
Adequate removal of the maxilla and contents of the orbit was done and later a neck dissection because of cervical metastasis.

should be submitted for thorough microscopic study.

Early diagnosis of malignancy of the paranasal sinuses is extremely difficult. To rely entirely on x-ray study for diagnosis is a treacherous philosophy, since by the time there is x-ray evidence of destruction of the sinus area, the disease is in an advanced stage. Almost always in the course of this disease, x-ray studies reveal cloudiness which may be due to the usual inflammatory conditions, but also could be the result of an early malignancy (Fig. 4A). Cytologic examination of secretion washed from the maxillary antrum or smears from the nasal fossae are recommended, but so far have shown nothing remarkable in the early diagnosis of these problems. It is recommended, however, that more operations for exploration of patients with suggestive symptoms of infectious conditions or perhaps early malignancy should be performed. Certainly those patients whose symptoms have failed to respond to treatment in a reasonable period of time should be explored (Fig. 4B). Of great importance in the diagnosis of these tumors is the cancer awareness of the attending physician or dentist. It is only by the doctor in charge being cancer-conscious that one will make an early diagnosis of these conditions. The differential diagnosis in addition to chronic sinusitis and nasal polyposis must include osteomylitis, atypical facial pain, tic-douloureux, and benign cysts and tumors of the sinus areas.

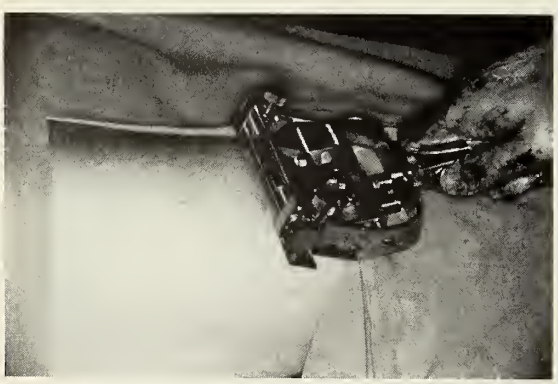


Fig. 5. Illustration of Brown electro-dermatome. The graft is removed from the thigh at the beginning of the operation.

Treatment

In this country the accepted method of treatment, for the control of malignancies of the paranasal sinuses, is to utilize the external oper-

ation as described by Ferguson in combination with intracavitary radium with or without external irradiation. It is our belief that once a diagnosis of malignant disease has been made, adequate surgery should be carried out. Contraindications to surgery are x-ray evidence of erosion of the base of the skull, involvement of the nasopharynx, distant metastasis, and general debility of the patient. Also, tumors of the malignant lymphoma group, reticulum cell sarcoma and lymphosarcoma are not considered surgical problems.

The technic of surgery employed by the author is similar to that described by other surgeons during the past 10 years. Prior to surgery the patient is given medical clearance and is typed and cross-matched for 4 units of whole blood. In our early experience with surgery of this type, it was our routine to ligate the external carotid artery on the involved side a day prior to surgery or just before the surgical procedure. In recent years, however, this has been discontinued, since it has been noted that the volume of blood loss is nearly the same whether or not ligation is done. Anesthesia is accomplished through intravenous pentothal and nitrous oxide with intubation. A split-thickness graft is removed from the thigh at the beginning of the procedure using the Brown electro-dermatome at one sixteen-thousandths of an inch (Fig. 5). The modified Ferguson incision is made. It is our custom to split the lip in the midline with the first incision, extending the incision in the bucco-alveolar sulcus laterally to the tuberosity of the maxilla. Bleeding from the labial vessels is controlled by digital pressure until they may be clamped and ligated. The horizontal arm of the Ferguson incision is made from the inner canthus of the eye and extended beneath the palpebral fissure laterally over the malar bone (Fig. 6A). If it has been determined prior to surgery that the contents of the orbit should be included in the operation, then a second horizontal incision is made just over the palpebral fissure and extended from the inner canthus of the eye laterally to the zygo-

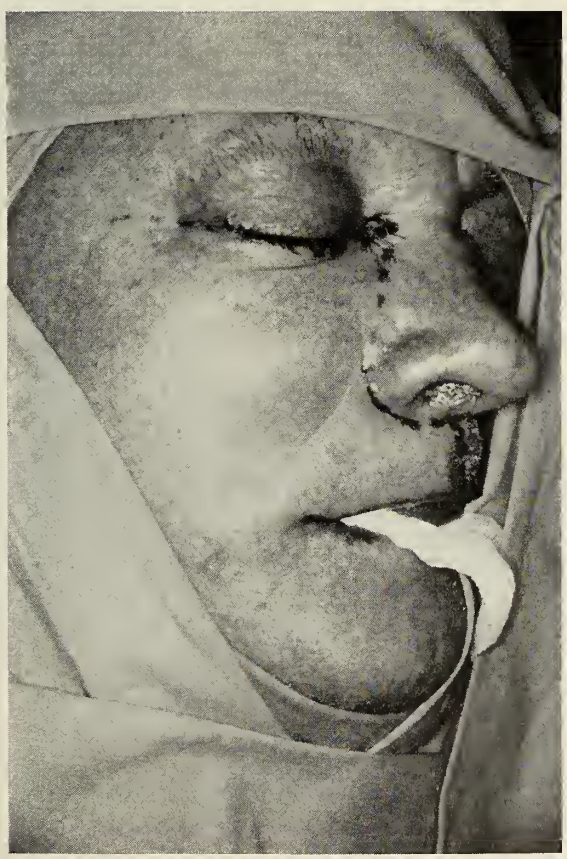


Fig. 6A. Incision outlined for partial maxillectomy when orbital contents may be preserved.



Fig. 6B. Incision outlined when complete maxillectomy with removal of orbital contents is to be done.
The upper and lower lids are preserved and used as grafts for closure.



Fig. 7. Skin flap has been elevated in this illustration.



Fig. 8. Illustration showing split-thickness graft sutured in place lining the cheek flap and the entire operative cavity.

matic area (Fig. 6B). The vertical incision is made lateral to the nose and curved beneath the lower portion of the alar region connecting to the vertical incision through the upper lip. The incision is not carried through the periosteum, but it does include as much of the subcutaneous tissue as possible. The cheek flap is then rapidly elevated using sharp dissection with no effort being made to control bleeding until the flap has been completely elevated (Fig. 7). Hemostasis is completed using electro-coagulation. If it is felt that the contents of the orbit must be included in the surgical specimen, the incision is made along the supra-orbital rim through the periosteum. Using blunt dissection, the medial, superior and lateral portions of the orbit are dissected free down to the roof of the antrum. The dissection is then carried laterally and posteriorly; the masseter muscle is dissected from its zygomatic attachment and the posterior portion of the maxilla is exposed. A Stryker bone saw is used to cut the zygomatic attachments of the maxilla as well as the attachment of the frontal process of the maxillary bone to the nasal bones. Sharp osteotomes are used to complete the fractures in these areas. An incision is made using electro-surgery through the midline of the palate down to the aponeurosis between the hard and soft palates. The incision is then extended laterally to the tuberosity of the maxilla. A wide osteotome is used to complete the separation of the maxilla from the pterygoid plate. The maxilla is rocked free and, using a heavy pair of scissors, the soft tissue attachments are severed and the maxilla delivered. If it is felt that the malignancy is confined to the inferior portion of the maxilla, and that the contents of the orbit may be preserved, then the periosteum is reflected just beneath the infra orbral rim and using a Stryker bone engine, the maxilla is cut through along this line. The zygomatic and nasal attachments are separated and the palate is split in the midline. Delivery of the lower portion of the maxilla or partial maxillectomy is now accomplished. The ethmoid cells and lining membrane of the sphenoid sinus are extenerated using cur-

retage. Hemastasis is completed using electrocoagulation, although occasionally the larger branches of the internal maxillary artery must be ligated if the dissection has been carried very deeply into the pterygoid-palatine area. The split-thickness epithelial graft is sutured into position in order to line the cheek flap and prevent the disturbing contracture which would otherwise result (Fig. 8). If the tumor has involved only the lower portion of the maxilla, or if it is felt that the malignancy has been completely encompassed during the procedure, then radium is not used. Usually these cases are seen in the advanced state where the process is not confined to one set of sinus air cells; consequently, the block removal of the maxilla has not been adequate and the remainder of the tumor must be removed in a piecemeal fashion. In order to be certain that the patient is given every possible chance of survival, then intracavitary radium should be used. The position of the intracavitary radium depends upon the judgment of the surgeon as to where residual tumor tissue may remain; the amount of radium depends upon the decision of the radio-therapist working in conjunction with the surgeon. Usually, the amount of radium is calculated to produce a tumor dose of 6 to 8 thousand r within 4 days to a week. The operative cavity is then packed with Cornish wool impregnated with 3% Aureomycin ointment. If the patient has dentures, the denture is wired into place to the frontal process of each orbit in order to hold the packing in normal position and enable the patient to maintain a regular diet in the immediate post-operative period. If the patient is without dentures, a temporary denture is prepared prior to surgery. The skin edges at the original incisions are approximated using interrupted 5″0″ silk suture and a pressure dressing applied (Fig. 10). If radium has not been used at the time of surgery, the packing is allowed to remain in place for 3 to 4 weeks. It is then removed and the patient is fitted with a temporary dental prosthesis. We have found that the use of 3% Aureomycin ointment on our packing enables us to leave our pack in position for this period of time without any evidence of infection or disturbing odor which otherwise would occur within a few days. Usually, at the end of the 3- to 4-week period when the packing is removed, the skin graft has completely taken and the healing has progressed to the point where the patient may be fitted with a dental prothesis without too much discomfort. If radium has been used, at the end of the calculated time that it must remain in position, the denture is loosened,

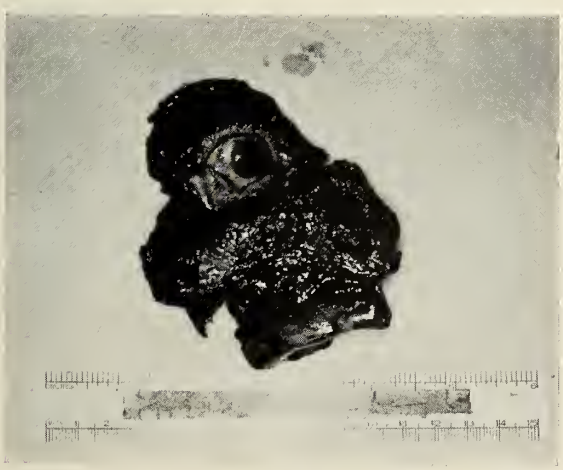


Fig. 9. Surgical specimen of orbital contents and entire maxilla.

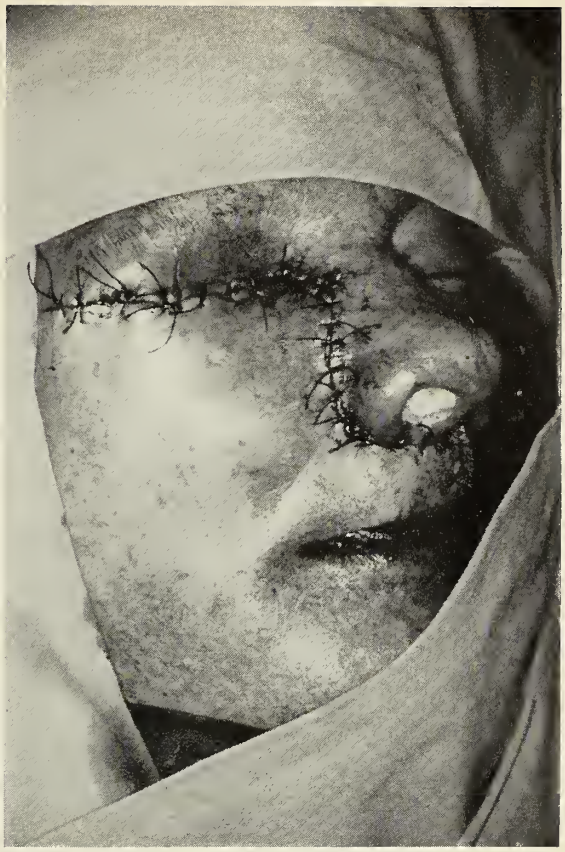


Fig. 10. Illustration at conclusion of surgical procedure.

Operative cavity has been packed with Cornish wool and Aureomycin and the denture has been wired into place to the lateral wall of each orbit.

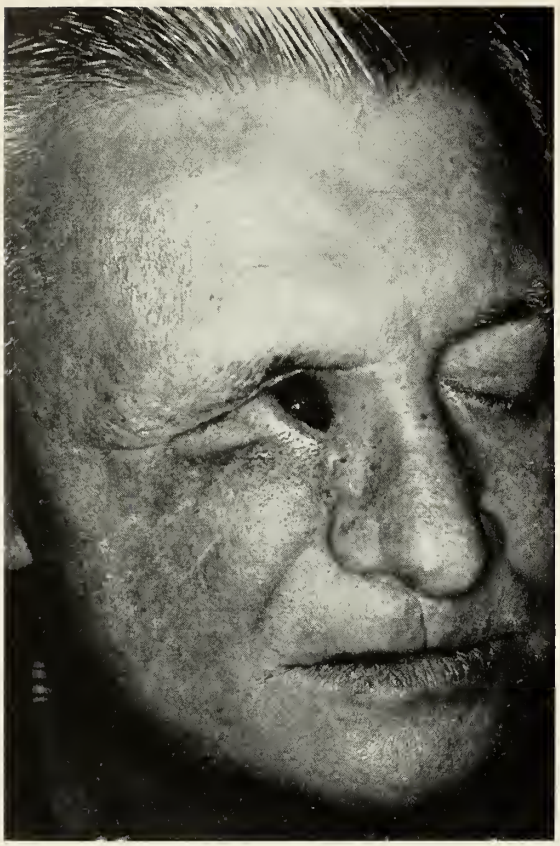


Fig. 11. Picture of patient taken approximately one year after surgery.
Patient prefers to wear black eye patch to cover the right orbit and the cosmetic result is favorable.

some of the packing is removed, and the radium is taken out of the operative cavity. The packing and the denture are then replaced and allowed to remain in position for the 3- to 4-week period. We feel rather strongly that this plan of management is much to be preferred over a nasal gastric feeding tube for a month's period or until the patient is able to tolerate preparation of a dental prosthesis. Tracheotomy is not necessary as a routine in these patients, but it should be done at the judgment of the surgeon, depending on the individual situation. In surgery on patients in the older age groups we consider tracheotomy a wise practice in order to avoid complications of the lower respiratory tract.

The initial lymphatic drainage from the paranasal sinuses is by way of the retro-pharyngeal lymphatics into the retro-pharyngeal lymph nodes and from there into the deeper cervical chain. It is well to consider the prophylactic administration of external irradiation over the retro-pharyngeal areas as a routine measure. If evidence of cervical metastasis does occur, then radical neck dissection is indicated. From our own experience and a review of other series it is noted that about 15% to 20% of these lesions will metastatize to the cervical area.

The use of the split thickness skin graft to line the operative cavity is certainly one of the major advances in the successful surgical management of these lesions.[6] This enables the physician (1) to provide his patient with the early fitting of a dental prothesis, (2) to produce a cavity free of excessive granulation and polypoid tissue, and (3) to prevent the unsightly contracture of the cheek flap which would otherwise occur (Figs. 11, 13A, 13B).

After the use of intra-cavitary radium or external irradiation, contracture of the cheek flap and retraction of the upper lip may ocur (Fig. 14). At a later date, certainly no sooner than a year to 18 months, scar tissue may be removed from the operative cavity,[11] the entire flap mobilized, and this area lined with a split thickness graft. In some cases it will be necessary to do a wide resection of the skin over the cheek area and later close this defect with an epithelial lined pedicle flap.[11]

Discussion

The management of malignant disease of the paranasal sinuses has progressed over a period of 100 years from primary surgery to control

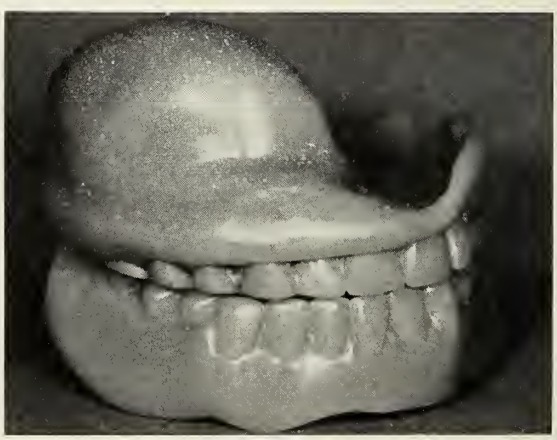


Fig. 12. Dental prosthesis constructed for the patient in Fig. 11.
This appliance is necessary for good function and it is easy to construct if the patient does not have marked trismus. If trismus is present, then the upper plate will have to be constructed in two parts. These are inserted separately and held together with small magnets.



Fig. 13A. Illustration showing the oral-antral cavity lined with split-thickness graft.

utilizing irradiation alone. At the present time, the combination of primary adequate surgery with the use of intra-cavitary radium, with or without external irradiation, is the treatment of choice. The author's experience is based upon 32 cases of malignant tumors of the paranasal sinuses treated during a 3-year period. This group of cases is small and the time element too short to be of any great significance as to the validity of this type of management; however, when the patients treated in this manner are compared with patients controlled with irradiation, the importance of adequate surgery is appreciated. The group of patients managed with primary irradiation consistently develop severe pansinusitis, suppuration, and sepsis with a period of disability and severe morbidity often prolonged for months.

The few patients who have survived such a program eventually developed such an extensive osteo-radio-necrosis that wide surgical drainage is necessary and might as well have been employed initially.

The pathology of my cases is as follows:

25 cases were epidermoid carcinoma
2 cases were lymphosarcomas of the maxillary antrum
2 cases were nasopharyngeal angio-fibroma involving the nose and paranasal sinuses
1 case was a mixed tumor of the palate involving the paranasal sinuses
1 case was a rhabdomyosarcoma of the maxilary antrum
1 case was a fibrosarcoma of the ethmoid labyrinth

The further breakdown of my series consists of 4 groups arranged according to the treatment employed.

Group I. 2 patients treated only with irradiation.

2 cases were of lymphosarcoma of the maxillary antrum. One of these patients is dead from the disease and the other is still living with his disease 2 years after treatment.

Group II. 5 patients treated with primary surgical extirpation.

3 patients had primary epidermoid carcinoma of the upper aveolus with secondary involvement of the maxillary antrum; it was possible to completely remove the neoplasm with partial maxillectomy. One of these patients has survived 3 years without recurrence and 2 are alive and without recurrence 2 years after surgery.

1 patient had an extensive mixed tumor of the palate and antrum. She is free of disease 1 year after surgery.

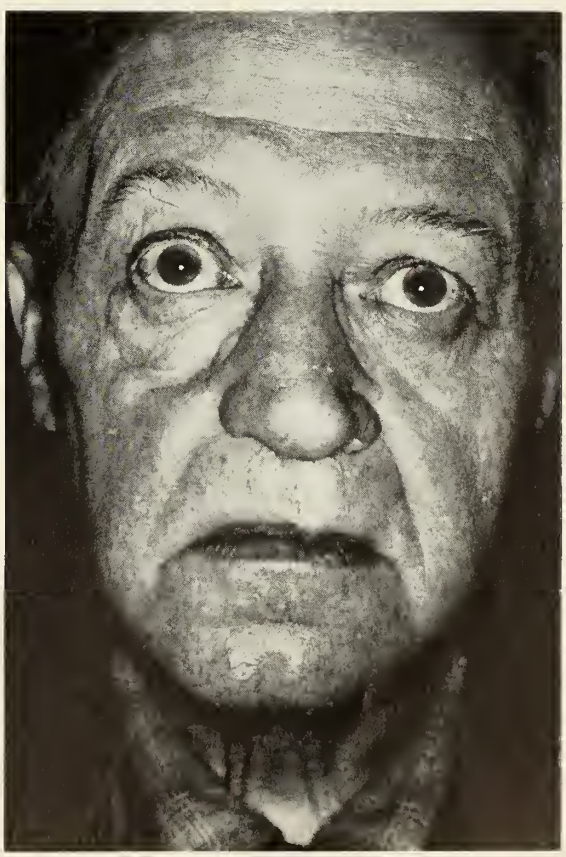


Fig. 13B. The same patient showing lack of any contracture of right cheek.

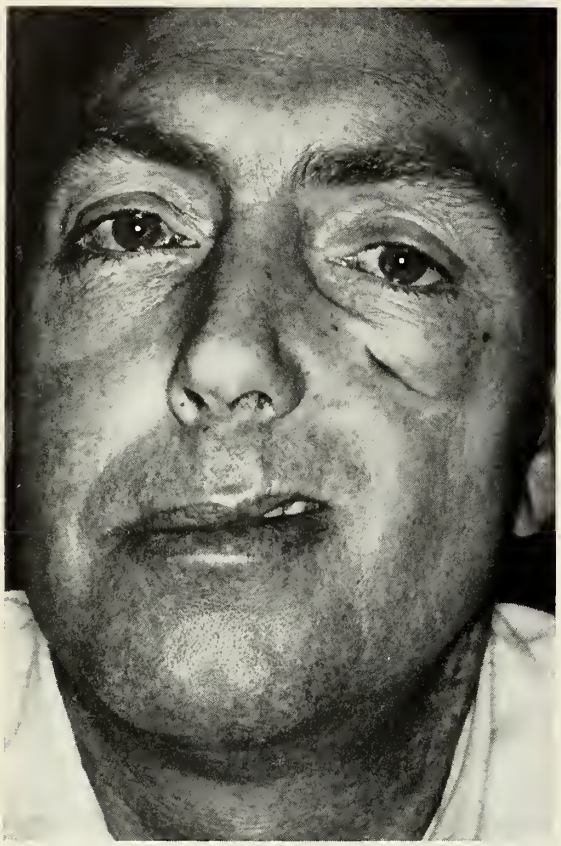


Fig. 14. Post operative result twenty-four months after partial maxillectomy, the use of radium bomb, and external super voltage irradiation. Patient had extension of tumor into pterygoid-palatine fossa. Illustration shows contraction of cheek flap with small fistula beneath orbit. A better cosmetic result can be obtained if a cheek flap is mobilized and the operative cavity lined with split-thickness graft.

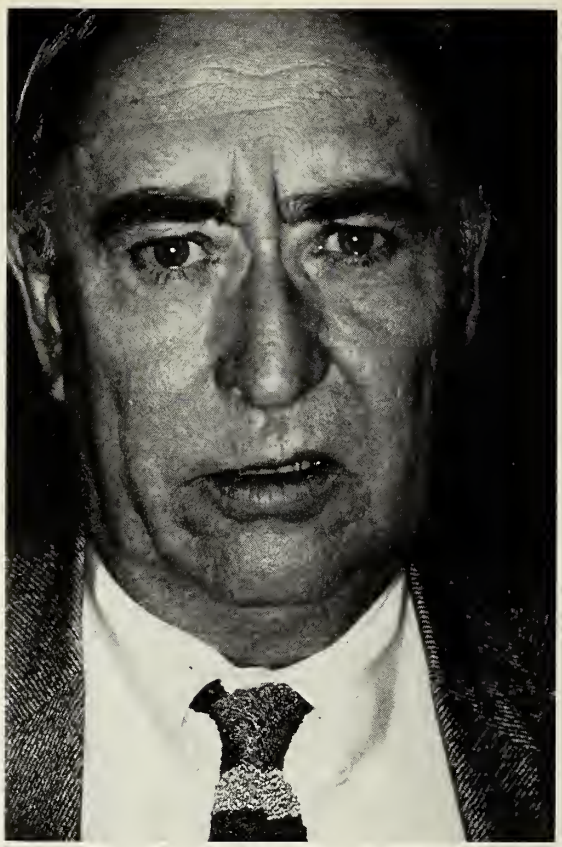


Fig. 15. Illustration of patient who has had partial maxillectomy for carcinoma of alveolus extending into antrum.

1 patient had an extensive naso-pharyngeal angio-fibroma involving the paranasal sinuses. He was operated upon 1 year ago and at the present time there is no evidence of recurrence.

Group III. 22 patients treated with combined surgery and irradiation.

20 patients had epidermoid carcinoma of the antrum and ethmoid labyrinth. One of these patients was operated on by the author near the conclusion of his residency and she is alive and free of the disease 7 years after treatment. Two patients are alive and free of tumor 3 years after treatment. Four patients are without disease 1 year after treatment. Four cases have been operated on within the past 6 months and are without evidence of recurrence at the present time. Four patients have been operated on during the past 2 years and are alive, but with the disease. Five patients are dead from their disease.

1 patient had a nasopharyngeal angio-fibroma which was operated on during the past 6 months. He is free of disease at the present time.

1 patient had a rhabdomyosarcoma of the antrum. He was operated on approximately 1 year ago and is alive, but the disease is still present.

Group IV. 3 patients died shortly after surgery from cardio-vascular complications.

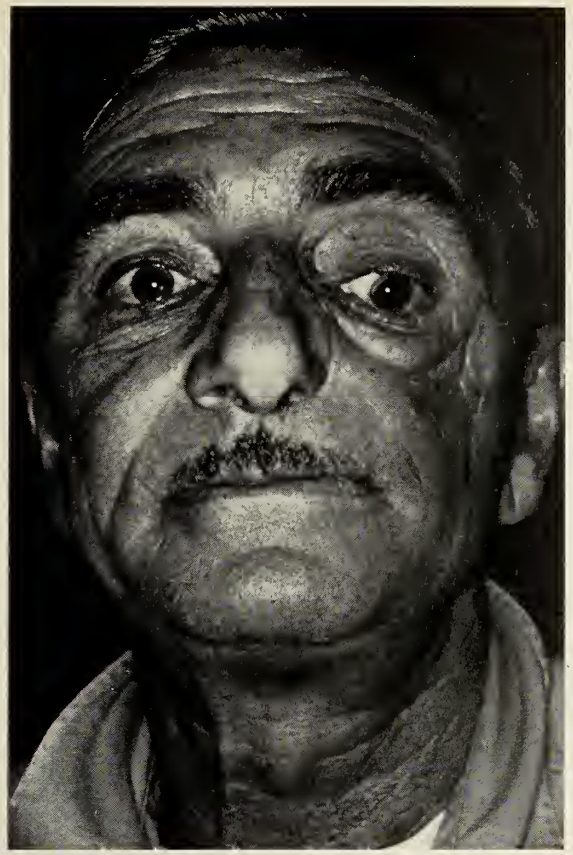


Fig. 16. Illustration of patient who had had initial extensive irradiation therapy with minimal surgery for carcinoma of the antrum.

In six months osteo-radionecrosis resulted and partial maxillectomy was done. No evidence of tumor was found and the patient has been followed for two years without recurrence. As the illustration indicates, there is depression of the left orbit. The orbital contents could be raised with a cancellous bone graft.

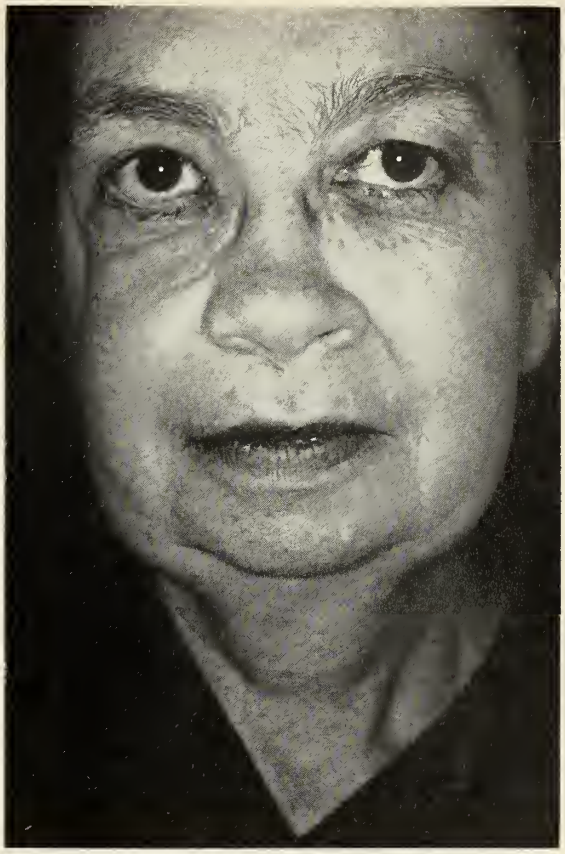


Fig. 17. Illustration of patient who has had partial maxillectomy with removal of most of palate and nasal septum because of a large mixed tumor of the right antrum and nasal fossa.

1 patient had a fibrosarcoma of the ethmoid labyrinth.

2 patients had epidermoid carcinomas of the antrum and ethmoid labyrinth.

In the most recent large series which has been reported, that of Larson and Martensson from Sweden, conclusion has been that a combination of adequate surgery and the use of intra-cavitary radium with or without external irradiation has provided the best results. In a group of 256 cases observed over a 5-year period, they found that 142 of those patients treated with emphasis on irradiation resulted only in a 12% 5-year cure. In 114 of these cases treated with a combination of surgery and irradiation, there was a 45% 5-year cure.

Summary

At the present time early diagnosis of malignant disease of the nasal sinuses is extremely difficult. It remains that the cancer awareness of the physician first treating these patients will probably be the deciding factor in an early diagnosis.

It is recommended that exploratory procedures be carried out if one is not certain that he is dealing with a benign inflammatory condition.

The external surgical procedures can be carried out with a low operative mortality and minimal morbidity. When used in combination with intra-cavitary radium or external irradiation, it will provide the greatest chance for cure.

The results of 32 cases treated during a 3-year period with a combination of adequate surgery and irradiation have been presented.

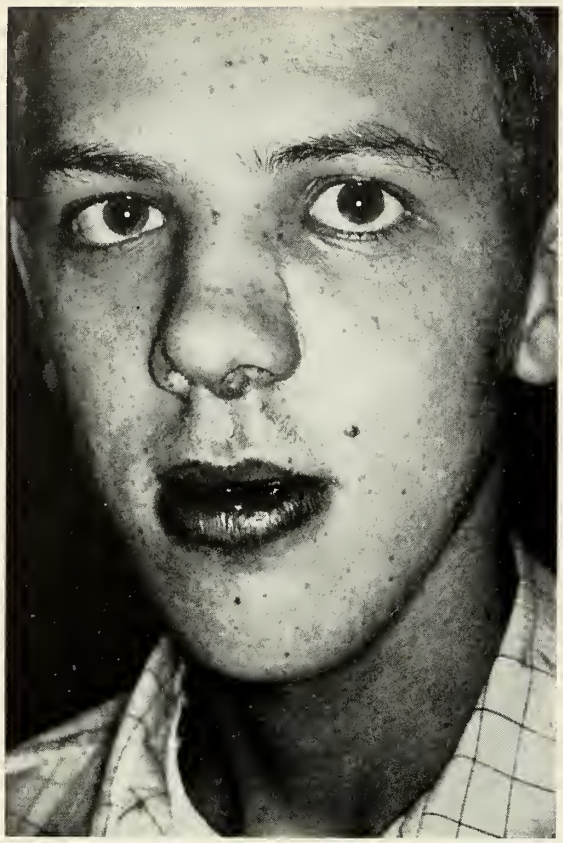


Fig. 18. Patient with extensive juvenile nasopharyngeal angiofibroma with involvement of the left orbit and antrum.
Patient was operated via modified Ferguson approach with removal of tumor and preservation of alveolus. Picture was taken two months following surgery.

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A Sheep is a Sheep is a Sheep!



It has been the habit of the JOURNAL, since the institution of our cover pictures, to give a description of the photo used and other pertinent information. Unfortunately, without serious research, the writer knows little beyond the facts that (1) a sheep is a sheep is a sheep (or so it is called in the English speaking world), (2) a sheep has wool which is cut once a year (or is it twice?) and eventually winds up as a coat or sweater that scratches, (3) from sheep come lamb chops, which are good when combined with curry, and also mutton (remarks censored), (4) lambs have, at times, been referred to as "cute" and grazing sheep bring to some minds a peacefulness and serenity (and to cattlemen, a rather opposite reaction—especially on TV westerns!), and (5) a popular song of a few years back contended that "little lambs eat ivy."

Well, never-the-less, there does seem to be something serene about grazing sheep in early summer with a late afternoon sun throwing slanting rays through Indiana trees. Henry S. Wood, New Palestine photographer who shot this peaceful scene, writes of it, "A pastoral scene near Metamora. At this quaint little southeastern Indiana town, a portion of the Whitewater Canal has been restored."

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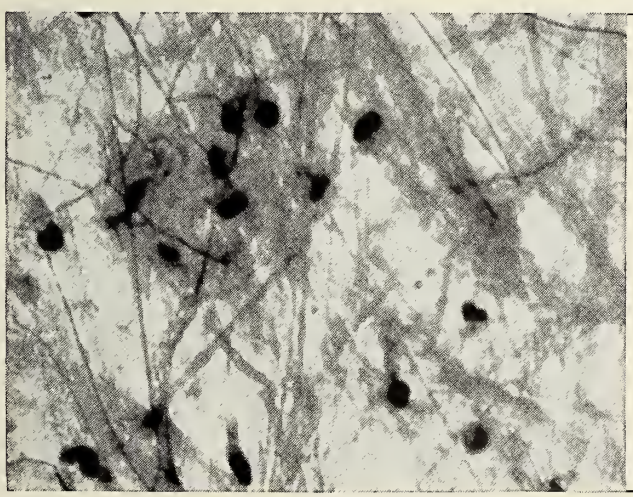
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A Quarter Century of Anemia Caused by A Single Leiomyoma of the Small Bowel

ABRAHAM M. OWEN, M.D.*
PHILIP T. HOLLAND, M.D.
Bloomington

THIS CASE is presented in the hope that no "secondary" anemia may be pigeonholed before solution. That the case is rare is attested by the superb article published in 1956 by River, Silverstein and Tope, who had reviewed the world's literature, finding 77 cases of benign tumors of the small intestine over half of which were discovered at autopsy. Of the 77, 22 were leiomyomas.

Six months ago a nice-looking woman of the upper economic stratum came to our office requesting a thorough examination. She was 56 years old and could not recall the time when she had ever felt strong. She had been under constant but casual medical care over half of her life and had taken so many combinations of iron and liver that she thought black was the normal color for a bowel movement. She had not had a blood count since hospitalization 15 years previously at which time she had bled following a tonsillectomy.

A careful physical examination was entirely negative except for extreme pallor of the mucous membranes. Serology, chest x-ray, urinalysis, and stress electrocardiogram and cervical Papanicolaou tests were negative. A blood count revealed a severe hypochromic, mycrocytic anemia of undetermined origin.

Her family history caused her to fear cancer since 3 siblings had died in middle age from carcinoma. A complete gastrointestinal x-ray performed at our office was non-informing. She had been taking hydrochloric acid for years in the belief that this would alleviate or suppress her frequent attacks of nausea. This treatment was based upon one gastric analysis which had been reported as achlorhydric. Analysis at our office showed free and combined hydrochloric acid in normal amounts.

She had borne 3 children, now adult. Her menses had been characterized by excessive blood loss to such an extent that 20 years ago she had submitted to a radiologically induced menopause. Recent news discussions of the carcinogenic effects of x-ray had frightened her.

Oral iron was discontinued and replaced by intramuscular injections of sacharated irons. Stools thereafter were of a normal brown color and negative for blood and parasites. Her hemoglobin increased from 7 to 15 gm. in one month and with it her strength. Then she experienced a day of nausea with frequent "tarry" stools. The blood count dropped to its previous low figure. An emergency admission was obtained for her at Indiana University Medical Center. All of our findings were confirmed.

Roentgenologists were unable to determine the site of the gastro-intestinal bleeding in their 2 gastro-intestinal studies. Her consultant advised an exploratory laparotomy, which she refused because he was admittedly skeptical of the ability of any surgeon to find the bleeding area. She was returned to her home severely depleted of blood and extremely weak. We had feared, despite our study, that the anemia was of some rare primary type and was, therefore, the cause rather than the result of the gastro-intestinal bleeding.

Intramuscular iron again achieved a quick reconstruction of her strength and erythrocyte count, only to be cancelled by another attack of

* Deceased.

nausea and "tarry" stools. A hemotologist, having confirmed the fact that this was a secondary anemia, advised that massive doses of estrogenic hormones be given because of the possibility of congenital familial intestinal telangiectasis. Before this therapy could be instituted she had another attack of nausea followed by a "tarry" stool, coffee ground emesis, following which she went into shock. An emergency hospitalization and 2500 ml. of blood transfusion brought her erythrocyte count and strength back to normal. Massive estrogenic therapy was given for a period of one month during which she happily noted that "she never had felt better in her life."

This state of bliss was interrupted by another attack of nausea and "tarry" stool. This time it was accompanied by pain in the lower right quadrant. Auscultation revealed an abnormally quiet abdomen. There was tenderness, but no rigidity low in the right quadrant. Rebound tenderness was marked. The erythrocyte count had returned to its former level with a leukocyte count of 7,000 and with a marked shift to the left. Immediate surgery was advised on the basis that the abdomen was an acute one and that the pain might point the way to the site of the bleeding. Due to fear of surgery the patient's consent for hospitalization was not obtained for 6 hours. One of us (P.T.H.) was called in consultation and concurred with the findings. The patient agreed and a laparotomy was performed.

Findings and Procedure at Surgery

FINDINGS: A right paramedian incision was used and exploration carried out. The gall bladder was thin walled and filled with fluid bile. The liver was normal. The large bowel, upon exploration, showed no abnormalities. The small intestine was explored, working proximally from the ileocecal junction. It contained dark fluid to the level of the proximal ileum. A tumor was found at approximately the junction of the jejunum and ileum. The stomach was normal. Pancreas and kidneys were apparently normal. The right ovary was atrophic and the uterus was post-menopausal in size and contained two hard, presumably calcified leiomyomas in its posterior wall. The left ovary was atrophic and uterine tubes were normal. There were 2 small simple cysts of the serosa of the small intestine which were removed.

OPERATIVE PROCEDURE: A longitudinal incision was made in the small bowel in the wall opposite the tumor. The tumor was removed by a longitudinal incision over it, and the muscularis and serosa were closed with 5.0 chromic sutures following which the mucosa was closed in one layer. The incision opposite the tumor was closed similarly. The appendix was removed. Chromic O suture was used for peritoneum and fascia and approximation of the rectus muscle to the midline, and 3.0 chromic was used for hemostasis and as a continuous suture for skin.

Report of Pathologist

GROSS DESCRIPTION: The specimen consists of a firm, rubbery, light tan tumor measuring 1.5 cm. in diameter. It is partially covered by glistening mucosa. The cut surface is glistening, white and uniform. Also received are 2 small fragments of light yellow tissue which measure 0.2 cm. in diameter.

MICROSCOPIC DESCRIPTION: The mucosa is intact. The wall contains scattered acute inflammatory cells, also. The tumor is well circumscribed and composed of interlacing bundles of dense, moderately collagenized fibromuscular tissue containing scattered subacute and chronic inflammatory cells. It is partially covered by small intestinal mucosa.

Pathologic Diagnosis

1. Leiomyoma of the small intestine.

It is our belief that the leiomyoma had been present for many years and had induced innumerable intussusceptions which had spontaneously reduced themselves. In the article previously quoted, Rivers, Silverstein and Tope refuted the general conception that intussusception is an event of great pain, shock and marked symptomatology. They believe that benign tumors of the small bowel are its chief cause in adults. They also point out the difficulties of x-ray visualization of these tumors. Physicians unfamiliar with the limitations of x-ray examination of the small bowel may wonder why anyone could miss a tumor with a diameter approximating the caliber of the bowel. River, Silverstein and Tope remind us that food in this area is largely in the liquid state and of the known ability of the bowel to dilate. They believe that a high index of suspicion and an abdominal scout film to show an area of ileus, or even the intussusception itself, is the most rewarding preoperative method of diagnosis.

Summary

The myomata tend to decrease in size after the menopause, therefore the radiation of the gonads doubtless decreased the size of the tumor 20 years ago. The blood loss from the uterus could have been caused by an anemia produced by blood loss from the bowel. Oral iron played the dual role of keeping the patient alive and obscuring the source of the anemia. Any anemia should be a challenge to the medical profession. It requires time, both to study the case and to explain the situation to the patient, in an effort to obtain complete cooperation.

It is our belief that every case of microcytic anemia deserves an adequate investigation and that all repeated, unexplained bleeding from the gastrointestinal tract is indication for an exploratory laparotomy when all reasonable preoperative diagnostic measures have failed to demonstrate the exact bleeding point.

Addendum

Four months after surgery, this patient had recovered her strength and had maintained a normal blood count without medication. It was then that I received an early emergency call. She had endured several loose "tarry" stools during the night but had not bothered her family until she started to vomit. The emesis was first of coffee-ground appearance followed by red blood. A hypodermic of morphine had stopped both the vomiting and melena by the time we had taken her to the hospital. The pulse and blood pressure had returned to her normal figure. The abdomen was neither tender nor rigid to palpation. For the first time during my study of her case the patient recalled some hunger pangs several hours after meals. On the preceding afternoon she had medicated this epigastric distress with a Coca-Cola, which failed of its objective and caused her to go to bed without her supper. Doctors P. T. Holland and John Owen believed that an x-ray study of the upper gastrointestinal tract might show the site of bleeding. A full Sippy regimen was carried out until midnight. At eight on the next morning, Doctors William Stangle and C. R. McIntire demonstrated a small crater in the distal duodenal bulb. Routine ulcer treatment was maintained and in addition a daily intramuscular dose of sacharated iron was given during her two weeks of hospitalization. There has been no further bleeding. The blood count has remained normal for three months without antianemic therapy. X-ray had been advised but refused, so there is no objective evidence of a cure.

It is impossible to determine the duration of this ulcer. Repeated histories failed to reveal ulcer symptoms prior to a few days before the last hemorrhage. One gastrointestinal x-ray study at my office in November 1957 and two more at the Indiana University Medical Center in January of 1958 were completely negative as to findings. The insidious development of this ulcer simulates an iatrogenic lesion from corticosteroid therapy. I gave six doses of one milligram each, last February, for an inflamed hip, resultant from an intramuscular dose of sacharated iron. There was no x-ray at the time of surgery last May. It would be logical to assume the ulcer etiology was from worry during the six months of diagnostic uncertainty.

A person can have more than one lesion. I can only hope that this lady will not have any more. A physician becomes humble in the presence of the vagaries of the human body during its life on earth. We can bewail our luck when honest, but perhaps overzealous scientists frighten the public with publicity regarding the danger from exposure to a useful tool such as x-ray.

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Diet Salt in Pregnancy

Told to take more salt than usual with their food, 1039 pregnant women had a *lower* incidence of toxemia and edema, as well as reduction in prenatal mortality and bleeding, compared with 1038 pregnant women told to reduce salt intake. Similarly, 20 women with early toxemia, given extra salt, showed improvement. (From DIURETIC REVIEW, specialty publication dealing with cardiorenal subjects, from Lakeside Laboratories, Inc., for the profession.)

Use of a Steroid Ointment for Debridement

S. WILLIAM BECKER, JR., M.D.*

B. BRENNAN, M.D.**

THE REMOVAL of dead tissue from superficial wounds is at times a difficult problem. A variety of therapeutic agents have been used without obtaining perfect results.[1, 2] While some ulcerating diseases (pyoderma gangrenosum) have been successfully treated with systemic steroids,[3] we are not aware of any report on the use of local steroids. We wish to describe the effect of locally applied steroid ointment on a variety of gangrenous ulcers.

Case Reports

The following patient first suggested this therapeutic use of a steroid ointment. A 45-year-old white male presented a necrotizing infection which had destroyed the dorsal foreskin and produced a 2.5 x 1 cm. ulceration just proximal to the glans penis. The surface of the ulcer was moist, foul smelling and consisted of dense, adherent, necrotic tissue. The glans was swollen and circulation in the area was impaired. A steroid ointment containing an antibiotic was appled 3 times a day to reduce the swelling. Two days later the necrotic tissue was loose and 6 days later all necrotic tissue was gone. The lesion then consisted of a clean defect which extended through the skin to the fascia covering the corpora cavernosa. The disappearance of necrotic tissue from this wound was so rapid and complete that we decided to use a steroid ointment on other patients with similar problems.

A 52-year-old white female presented a 5 x 4 cm. ulcer on the medial left calf. The surface of the ulcer (Fig. 1) was moist, foul smelling and covered by necrotic tissue. Bacteriological examination revealed Esch. Coli, Eshc. freundi and micrococci; a search for mycobacterium tuberculosis was negative. A steroid ointment containing an antibiotic was applied to the ulcer 3 times a day. All necrotic tissue had separated after one week. After 2 weeks of therapy (Fig. 2) the epithelium had begun to cover the ulcer; there was no formation of granulation tissue. The epithelium continued to grow in slowly from the sides of the ulcer. Fig. 3 shows the results after 5 weeks of treatment.

A 60-year-old white female had a stasic ulcer of several years duration. This lesion had become infected and the surface of the ulcer was similar to that in the previous patients. All necrotic tissue was removed by a week's therapy with a steroid and antibiotic ointment. There was no healing of the ulcer during this time.

Dr. D. H. Rudser and Dr. Lowell H. Steen of the Whiting Clinic, Whiting, Indiana, helped us evaluate this type of debridement.

This therapy was useful in treating diabetic gangrene. Only the moist gangrene responded. The ointment had no effect (probably due to lack of penetration) in areas of dry gangrene. In one diabetic patient amputation of a finger was considered because of gangrene. The steroid ointment removed the gangrenous area and the finger was preserved.

Debridement of dead tissue was successful

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** Department of Dermatology, University of Illinois School of Medicine.

The steroid ointment (Metiderm ointment with neomycin) and the control ointments were supplied by Schering Corporation, Bloomfield, N. J.

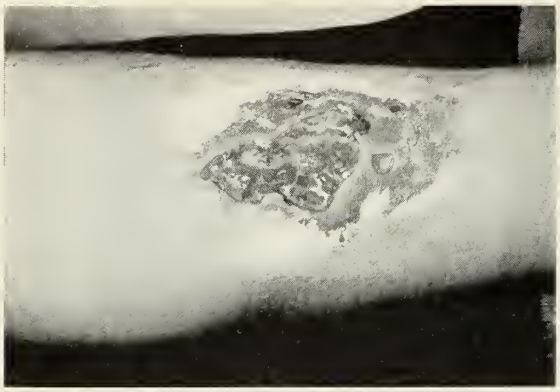


Fig. 1 Untreated ulcer showing necrotic surface.

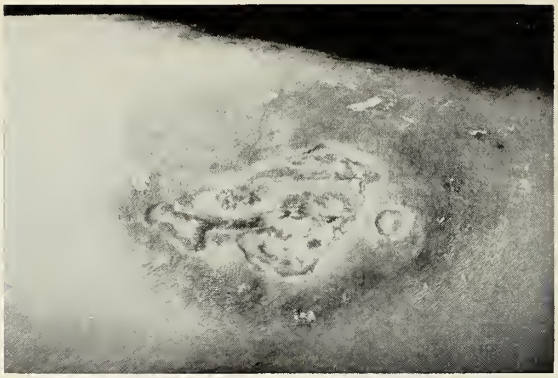


Fig. 2 After two weeks of therapy. Surface of ulcer is clean and epithelium is growing.

following traumatic injury and burns. One patient with extensive burns developed symptoms of systemic hypercortisonism when the steroid ointment was applied to large denuded areas.

Controlled Studies

It was impossible to find a patient who had several identical necrotic lesions. We were fortunate, however, to have a patient who had 4 gangrenous areas resulting from equal amounts of x-ray irradiation. Three areas were treated with the following:

1. Metiderm with neomycin.
2. Steroid ointment O (unknown)*
3. Neomycin ointment.

Each ointment was applied to a gangrenous area twice a day for 5 days. Biopsy specimens were then removed from the base of the ulcers. Clinically there had been some loss of necrotic tissue from all 3 areas. The exact amount was impossible to judge accurately.

Microscopic Examination

Periodic acid—Schiff (PAS) stain:

All specimens contained an abnormal amount of red staining material. Bacteria at the surface were easily visualized. No significant differences between the specimens were visible in the PAS stains.

Hematoxylin and eosin stain:

The specimen from the area treated with neomycin ointment was extremely necrotic and stained very lightly. The other 2 specimens stained more nearly normal although examination revealed that the tissue was degenerated.

Aldehyde—fuchsin stain:

No elastic fibers were seen in the specimen from the areas treated with neomycin. Specimens from the other two areas revealed swollen and fragmented elastic fibers.

INTERPRETATION — Tissue from the base of the ulcer treated with neomycin ointment was very degenerated, did not stain well and contained no elastic fibers. This would indicate that very little of the surface had sloughed off. It appears that the most superficial necrotic tissue had sloughed off the ulcers treated with steroid ointment since the tissue at the base was, at least, viable enough to contain elastic fibers. This indicates a definite effect from the steroid although the mechanism was not revealed.

Summary

It has been shown that a steroid ointment will cause the separation of necrotic tissue in areas of moist gangrene. The mechanism of this effect is not known but apparently the cohesion between dead and living tissue is destroyed and the dead tissue falls off.

When any steroid ointment is applied to large raw areas there will be some absorption into the systemic circulation. Signs of hypercortisonism—

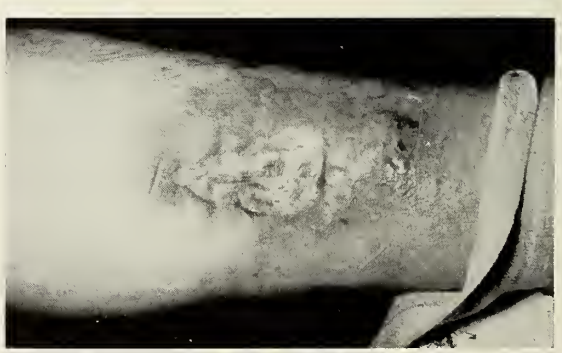


Fig. 3 After 5 weeks of therapy. Epithelium has almost covered the ulcer.

* After the study was concluded this was found to be Metiderm with neomycin.

increase in appetite and weight and change in psyche should be watched for in these patients.

Any cortisone will stop the proliferation of fibroblasts but does not interfere with the growth of epithelium. If the necrotic ulcer is superficial, epithelium will cover the defect during treatment with the steroid ointment (Figs. 1, 2, 3). If the defect extends deeply into or through the dermis the steroid will interfere with formation of granulation tissue and stop healing. Under these conditions the steroid ointment should be used only as long as necrotic tissue is present and then be replaced with stimulating therapy.

Although every treated area was superficially infected there was no spread of bacteria into living tissue. An ointment containing neomycin was used as a safeguard against this dissemination. The steroid had no effect upon the barrier which was preventing the spread of bacteria.

Only a single steroid ointment was used because it was difficult to obtain enough patients for adequate study.

136 Medical Arts Bldg.

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Medical Meeting—Celestial Style

As a reward for their occasional sufferings, there must be a Heaven for well-behaved audiences. There the speakers will have thought about their audience—what their level of knowledge is, what their interests are, what their threshold for fatigue is—and prepared their addresses accordingly. If they are asked to speak for fifteen minutes, they will have prepared a discourse running at ordinary conversation speed for fourteen minutes; they will address this in clear and bright tones to their audience and not gabble it to the lectern or whisper it just out of microphone range. Their talk will have two or three points of importance, and everything else will be subordinated to getting these few points fixed in the heads of the audience. Their slides will contain the bare minimum of detail needed to make their points, and will be left on the screen long enogh for the slowest and most presbyopic readers in the audience to study them. And the only extraneous sound will be the sighs of contentment from former organizers of medical meetings.

EDITORIAL
in *The Canadian Medical Association Journal*
p. 276, August 15, 1958

Leg Bandages and Cardiac Failure

Is there any special "trick" to leg bandaging as an aid to treatment of refractory cardiac failure?

Yes. Perhaps the most important factor is proper timing, it has been found. The most propitious time to bandage and elevate the legs is on the day when a mercurial injection is administered. This has reportedly helped to increase the extent and duration of diuresis. However, for optimum effect, the physician is advised to observe the precaution of waiting for definite diureses to be well started before proceeding with the bandage. (From DIURETIC REVIEW, specialty publication dealing with cardiorenal subjects, from Lakeside Laboratories, Inc., for the profession.)

The Use of Tranquilizing Medications In General Medical Practice

FRANK J. AYD, JR., M.D.*

Baltimore, Md.

UNPRECEDENTED PROGRESS in the treatment of psychiatric disorders has been made possible by the tranquilizing drugs. Properly used, these compounds enable the general practitioner to treat effectively more patients in his office than ever before, to admit a larger number of psychiatric patients to general hospitals and to reduce the admissions to psychiatric hospitals. Most important, he can alleviate psychic suffering more quickly, shorten the period of disability and reduce the cost of mental illness. These desirable goals can be achieved only by physicians who master the art of treatment with tranquilizing drugs.

There are 3 prerequisites to successful tranquilizer therapy. These are a knowledge of (1) the patient, (2) the nature and severity of his illness and (3) the drug to be prescribed. Disregard of any of these factors is responsible for most therapeutic failures and adverse reactions to tranquilizers.

When interviewing a patient with an emotional disorder the physician must not only watch for diagnostic signs and symptoms but for those things which tell him something about the person with the illness. By doing this he can detect those for whom tranquilizers would be inadvisable. For example, some anxious individuals become more anxious when they cannot maintain their self-imposed standards. A housewife who has compensated for chronic anxiety by a neurotic compulsion to be meticulous and perfectionistic, and who is content only when she is doing something, may have symptoms for which a tranquilizer would seem indicated. To prescribe such a drug for her may enhance her anxiety because the tranquilizer-induced psychomotor retardation interferes with her meeting her self-requirements. Instead of helping, therefore, a tranquilizer may make such a patient worse.

Some people are alarmed by any deviation from the normal for them. When they fall ill, anxiety is always a component of their disorder. Tranquilizers, especially those with frequent physiologic or allergic reactions, should be prescribed judiciously for these people. Unless forewarned they may be catapulted into an acute emotional disturbance when side effects occur.

Accurate Diagnosis Important

An accurate diagnosis is equally important to avoid prescribing tranquilizers for conditions which are not benefited by them. These drugs are of little or no value for depressive reactions. frequently they make depressions worse and increase the risk of suicide. Since depressions are among the most common psychiatric ailments encountered by the general practitioner, he should consider this diagnostic possibility in every patient, particularly those over age 35. Many depressions masquerade as an anxiety state or a psychosomatic condition and their detection challenges the diagnostic acumen of all physicians. A clue that a depression exists is offered by the patient who reports that a tranquilizer makes him feel worse in the morning. It is likely that the patient is suffering a typical morning exacerbation of his depression and erroneously blames the drug for his symptoms.

Besides depressed patients, hysterics, obses-

* Chief of Psychiatry, Franklin Square Hospital, Baltimore, Md. Read at the Psychiatric Seminar for General Practitioners, Indiana University School of Medicine, Indianapolis, Nov. 19, 1958.

sive-compulsives, pseudo-neurotic schizophrenics and patients with a life-long history of deviant behavior without anxiety are not good candidates for tranquilizer therapy. It is not always easy to recognize these people initially. Many of them have been inadvertently given tranquilizers which have not benefited them or to which they have reacted adversely.

Before prescribing for a patient it is prudent to inquire if he has been treated previously with an ataractic and his response to it. If he confesses he did not take the medicine as directed, or he reacted unfavorably to it, then it is likely that he falls into one of the above diagnostic categories. Such patients should be referred to a psychiatrist for treatment of another sort.

Other factors to be considered before giving a tranquilizer are the duration and severity of the disorder and the therapeutic goal. Drug therapy is more apt to relieve an illness of recent origin in a previously stable person than a chronic disorder. The more acute the emotional disturbance the more probable are the chances of a favorable outcome. Chronic illnesses do not respond as completely or as dramatically. Nevertheless, tranquilizers can produce sufficient symptomatic relief to prevent hospitalization, to permit the patient to work, and to be reasonably comfortable in spite of the persistence of the basic ailment. This is a reasonable and realistic therapeutic objective for most patients seen by the general practitioner. He should not refrain from administering tranquilizers solely because they do not always cure or eradicate the total illness.

Patient Indoctrination

Essential to successful pharmacotherapy in ambulatory patients is an indoctrination of the patient and his relatives regarding potential side effects, the therapeutic aim and the duration of treatment. When instructed about normal side reactions of a drug patients are seldom perturbed by their occurrence. In addition, they will promptly notify their physician of an unusual reaction—the surest way of detecting serious side effects early. Informed patients are cooperative patients. They do not become discouraged and discontinue treatment prematurely if they know that they require treatment for months to obtain the relief they desire. They should be told it is unrealistic optimism to expect a cure with a short course of drug therapy, since most individuals need prolonged treatment with a tranquilizer to achieve the best results.

Tranquilizers may be divided into those effective in psychoses and neuroses and those useful in neurotic conditions only. The former are the phenothiazine and rauwolfia derivatives; the latter are Atarax, Miltown, Suavitil and Ultran.

Phenothiazine Derivatives

Stelazine, Trilafon, Dartal, Compazine, Vesprin, Thorazine, Sparine and Pacatal are phenothiazine derivatives. On the basis of chemical structure these compounds can be divided into (1) the piperazine group, characterized by a piperazine ring in the side chain and represented by Stelazine, Trilafon, Dartal and Compazine; (2) the chlorpromazine model group, characterized by a 3 carbon straight side chain and represented by Vesprin, Thorazine and Sparine; and (3) the piperdine group, characterized by a piperdine ring in the side chain and represented by Pacatal.

These groups differ from each other in milligram potency and their propensity to cause side effects. There is also intragroup variability in potency and side reactions, depending on the type of halogen attached to the phenothiazine nucleus and the composition of the side chain Pacatal and Sparine are half as potent as Thorazine which is less potent than Vesprin. Compazine is 3 to 5 times, Dartal 4 to 7 times, Trilafon 5 to 10 times, and Stelazine 8 to 12 times as potent as Thorazine.

The more potent the phenothiazine drug the smaller is its effective initial daily dosage range. This initial dosage must be adjusted to the needs of the patient according to the severity of symptoms such as anxiety, tension and psychomotor excitement. Neurotic and mildly disturbed psychotic patients should be started on small doses. For example, the initial dose of Thorazine should be 25 or 50 mg. tablets 3 or 4 times daily and the starting dose of Stelazine should be 1 or 2 mg. tablets 2 or 3 times a day. The dosage should be increased gradually until a therapeutic level for the patient is achieved. The patient should be maintained at this dose schedule until he appears to have obtained maximum therapeutic benefit. The drug should be discontinued by reducing the dose gradually over several months. In the event of a relapse the patient should be placed immediately on his previous therapeutic

dose. There are some patients who will require medication indefinitely.

Many physicians order too small a dose of an ataractic and are hesitant to give large amounts for fear of complicating side effects. If the patient can be carefully supervised there should be no reluctance to administer as much of the drug as needed. Most side effects occur in the first month of treatment. Thereafter, agranulocytosis is the most important reaction to guard against. This is best done by reliance on clinical judgment rather than repeated blood counts. The latter give a spurious security. More than one patient with a phenothiazine derivative-induced agranulocytosis had a normal white count only a few days before clinical signs of the dyscrasia appeared. Repeated white counts also may cause the unnecessary withdrawal of the drug when a leukopenia is detected.

Many patients treated with phenothiazine derivatives develop a transient leukopenia with a return to a normal blood picture as treatment is continued. Unusual fatigue, weakness, sore throat or any evidence of illness or infection in a patient taking a phenothiazine drug are frequent clinical warnings of agranulocytosis. Whenever any of these symptoms occur leukocyte and differential counts are mandatory. The more potent the phenothiazine derivative the fewer the side effects it produces because less of the chemical is needed to effect behavioral and therapeutic changes. Consequently, reactions such as agranulocytosis and jaundice have not occurred with Stelazine, Trilafon, Dartal or Compazine but appear with increasing frequency as one goes down the potency scale. Under no circumstances should a patient who has had a phenothiazine derivative agranulocytosis be retreated with any phenothiazine drug.

Counteracting Drugs Aid

Most phenothiazine derivative side effects remit with continued treatment. Their severity can be diminished and their disappearance hastened by the addition of counteracting drugs. The most common side reaction is lethargy and fatigue. Usually 30 mg. Ritalin daily suffices to abolish this. There is not a reaction to the phenothiazine drugs which does not remit with withdrawal of the drug or specific treatment if detected early and vigorously treated. However, since some phenothiazine derivatives cause quite serious toxic reactions, the physician should be acquainted with these potentials and be prepared to treat them should the need arise.

The more potent the phenothiazine derivative the less are its sedative and hypnotic properties but the greater its propensity to cause the extrapyramidal reactions, dyskinesia, motor restlessness and parkinsonism. Because these neurologic reactions can occur with therapeutic doses of the more potent phenothiazine drugs the importance of prompt recognition and management of them cannot be overemphasized. Their development demands immediate action in the form of dose reduction and the addition of an antiparkinsonism drug such as Cogentin, 1 or 2 mg. once or twice a day.

Dyskinesia or dystonic reactions are characterized by abrupt onset of retrocollis, torticollis, facial grimacing and distortions, dysarthria, labored breathing and involuntary muscle movements. This may be accompanied by scoliosis, lordosis, tortipelvis and the characteristic gait of dystonia. This neurologic response usually occurs in women given large single doses in the first week of treatment. Thereafter it is rare. Because of the spasm of the neck musculature, the dysarthria and the difficulty in breathing dyskinesia may be misdiagnosed acute encephalitis or tetanus. Dyskinetic reactions can be relieved promptly by the intravenous administration of a short-acting barbiturate or the intravenous or intramuscular injection of 1 to 2 mg. Cogentin. The occurrence of dyskinesia is not a contraindication to further phenothiazine deriviative therapy. It seldom recurs, especially if lower doses of the drug are prescribed.

Motor restlessness or akathisia is often described by the patient as the jitters. He reports that he feels compelled to walk or pace the floor. When sitting he constantly shifts his legs or taps his feet and complains of feeling jittery and anxious. Motor restlessness usually manifests itself after the third day of phenothiazine drug therapy. The larger the dose, the more likely is it to occur. If the drug is continued, akathisia is replaced by parkinsonism. Most patients are annoyed by motor restlessness and will not tolerate it long. The fastest relief can be achieved by 1 to 2 mg. Cogentin intramuscularly. It can also be allayed by 1 to 2 mg. Cogentin orally twice daily, often without altering the dose of the drug.

Motor Restlessness

Physicians unfamiliar with motor restlessness may feel that the tranquilizer has not controlled the patient's anxiety and increase the dose. This should not be done. Instead, lower the dose or give an anti-parkinsonism drug simultaneously with the ataractic. Motor restlessness also may cause the uninitiated doctor to discontinue the drug, feeling that it is not a tranquilizer, since it increased anxiety rather than produced the anticipated tranquility. Such is not the case. Motor restlessness usually means individual hyper-sensitivity or too much drug. It frequently disappears with simple reduction of the dose.

The more potent the phenothiazine derivative the safer it seems to be and the wider its range of application. The potency and type of side effect the drug causes should be seriously considered when choosing a phenothiazine derivative, especially for ambulatory patients. When sedation in addition to tranquilization is desired, Thorazine or Vesprin are the drugs of choice. When sedation is undesirable, as is frequently the case in ambulatory patients, Stelazine, Trilafon, Dartal or Compazine are the preferable drugs.

Since there is a correlation between the dosage of a phenothiazine derivative and the frequency and the type of side effect it causes, the less of the drug needed the more likely are serious side reactions to be avoided. This is a most important clinical consideration in choosing a phenothiazine compound since serious side effects interfere with therapeutic results. This factor partially accounts for the divergent therapeutic results obtained with phenothiazine drugs.

The phenothiazine drugs are not curative—they provide relief from such target symptoms as anxiety, tension and psychomotor excitement and thus render the patient more amenable to psychotherapy and lead to his return to a more normal and useful life.

Rauwolfia Derivatives

Serpasil, Sandril, Rau-Sed, and Harmonyl are rauwolfia derivatives. They are described as slow-acting drugs when compared to the phenothiazine derivatives. This applies only to behavioral effects and not to therapeutic effects; i.e., phenothiazine derivatives induce a placid state more quickly than the rauwolfia derivatives. This is important only when treating acutely disturbed patients. Otherwise, in properly selected patients the rauwolfia derivatives produce results similar to the phenothiazine derivatives.

Unlike the phenothiazine drugs which vary markedly in potency and frequency of side effects, the rauwolfia derivatives are equi-potent and cause the same side reactions. Since they have no effect on the blood-forming elements or liver function they can be substituted for phenothiazine derivatives which cause allergic reactions such as agranulocytosis. On the whole rauwolfia derivatives are safe compounds. Serious side reactions to them have been rare. Nasal congestion, gastric irritation and diarrhea are their most common physiologic effects. These can be managed by counteracting drugs. Because they increase gastric secretion they should not be administered to ulcer patients.

For a while the most serious objection to rauwolfia derivatives was the charge that they cause depressions. These drugs are not depressogenic *per se*. Like the phenothiazine derivatives they can aggravate and unmask a pre-existing depression but they do not cause depression. As with all tranquilizers the rauwolfia derivatives should not be given to depressed patients.

The rauwolfia derivatives may be prescribed in divided daily doses or the entire daily dose can be taken at one time. Neurotic or mildly disturbed psychotic patients should be started on 0.5 mg. or 1 mg. daily. Since rauwolfia derivatives are slow in taking effect, to prevent overdosage, the dose should be increased gradually, usually weekly, until the patient's therapeutic level is reached. The patient should continue on this dose until he appears to have achieved maximum benefit. Then the drug is discontinued by reducing the dose gradually over several months. If a relapse occurs, the patient should be restarted on his previous therapeutic dose. As with the phenothiazine derivatives a small number of patients require a maintenance dose of a rauwolfia deriviative to prevent a relapse.

Some patients are unresponsive to a phenothiazine or rauwolfia derivative. These same patients may respond favorably to another phenothiazine or rauwolfia derivative. The physician should be cognizant of this. However, he should not switch from one drug to another until the first drug has had a trial of at least 6 months in adequate doses.

The Mild Tranquilizers

These are suitable primarily for treating the non-psychotic patient. They differ markedly from the phenothiazine and rauwolfia derivatives as to site and mode of action in the central nervous system. Like the more potent ataractics, they are not beneficial for depressives, hysterics and character disorders. Their main function is to relieve anxiety in those patients for whom short-term drug therapy is indicated. As a rule they can be used for those disorders for which the physician formerly prescribed barbiturates.

Atarax

Atarax appears to be the safest of the mild tranquilizers. Troublesome side effects and allergic reactions to it are rare. It can be administered to children or adults in doses ranging from 50 to 400 mg. daily. This drug is well suited for school children and working adults since therapeutic doses rarely cause drowsiness or clouding of consciousness. Because it so seldom produces psychomotor retardation, Atarax is especially well tolerated by obsessional neurotics and patients with phobic reactions. This is an advantage since normally these individuals are difficult to treat with tranquilizers.

Miltown

Miltown may be prescribed in doses of 200 to 400 mg. 3 or 4 times a day. The prime indication for this drug is anxiety of recent origin in patients suffering with an acute situational stress reaction. In chronic neuroses it is of limited value for long-term therapy but may be profitably prescribed to abate an acute episode of anxiety in such patients. Miltown also may be used alone or in conjunction with other anticonvulsants to control petit mal and myoclonic seizures. It should be prescribed with caution for grand mal epileptics because of the danger of increasing seizures.

Several combinations of Miltown and other drugs are now available. The efficacy of these combinations in psychosomatic disorders has not yet been established by critical clinical studies. Until this has been done we must reserve judgment on their value or superiority over their predecessors.

Originally heralded as a safe drug free from harmful side effects, it is now well-known that Miltown is not an innocuous compound. There have been reports of serious allergic reactions, purpura, drowsiness, gastro-intestinal reactions, convulsions and addiction to it. Admittedly these have been infrequent; nevertheless, Miltown should be administered with the utmost discretion, particularly to patients with an allergic history, grand mal epilepsy or compulsive drinking. If a patient has once had an allergic dermatitis from Miltown he should not be given this drug again.

Suavitil

Suavitil is recommended for anxiety reactions and obsessional states and as an anti-depressant. The usual dose is 3 to 9 mg. daily. Higher doses are often needed but are not advised because of the likelihood of troublesome side effects. Because of its anti-cholinergic action Suavitil causes a variety of physiologic side reactions such as muscular weakness, tachycardia, blurred vision and dryness of the mouth. This drug also may cause an increased anxiety and thought blocking which the patient describes as a sudden inability to think and a loss of time sense. Thus far, clinical trials of Suavitil indicate that its effect in neurotic conditions is unpredictable and quite variable.

Ultran

Although recommended for anxiety states Ultran's value for this and other neurotic conditions is unknown. Likewise, until further studies of this drug are completed, its specific indications, contraindications and side effects remain to be determined. Thus far we know that it is a weak tranquilizer which allays anxiety in some patients. Whether this can be attributed to therapeutic activity of the drug or to placebo reactors and suggestion also is unknown. For the present it is best to restrict the use of Ultran to short-term therapy for the milder emotional states of recent origin.

Comment

The successful use of tranquilizers for ambulatory patients requires constant supervision of the patient, not so much to detect promptly side effects but to insure adequate dosage at all times. An illness is never static and sick people react to changes in their environment. For these reasons the dosage of the drug must be flexible and adjusted to suit the changing requirements of the patient. It is not good medi-

cine to hand an emotionally disturbed patient a prescription for a tranquilizer with instructions to come back to the office in a month or so. These patients need to be seen at regular and frequent intervals for their proper care.

No patient should be treated with a tranquilizer alone. The drug is but a part of his total therapy. A physician can be as much of a tranquilizer as any drug, providing he is interested in the patient's welfare, listens willingly to his complaints, is compassionate, patient and understanding, and tries to help in any way he can. Patients have many needs in addition to a tranquilizer. To ignore these needs is to invite therapeutic failure. On the other hand, drug therapy combined with common sense, counseling and environmental manipulation can prevent many individuals from becoming chronic neurotics and psychotics and reward the doctor with a relieved and grateful patient.

6231 York Rd.
Baltimore 12, Md.

On Not Giving Medicines

"The AMA ought to give a medal, occasionally, to doctors who refuse to order medicines for some of their patients! Many preparations in use today are potentially harmful, and many are valueless. Many pills are prescribed but never taken. Many of the pills that are prescribed are unnecessary for restoration of the patient's well-being. Except for our knowledge that patients expect them, is there any reason why we keep doling out more and more pills? . . . Many physicians are simply too busy to sit down and explain to the patient why he does not need any medication. One young doctor spent 30 minutes explaining to a patient whose complaint was a three-day-old bee sting that salves were unnecessary. Subsequently, he decided that if such a situation were to recur, he would prescribe an innocuous salve and save himself 25 minutes. . . . It would seem that we should honor the brave doctor who does not prescribe antibiotics for every cold, and who does not give shots to every patient who complains of fatigue. Let us remember that physicians who prescribe too freely don't treat their patients; they treat themselves."

EDITORIAL
in *Journal of Iowa State Medical Society*
p. 472, August, 1958

Good Manners in Medical Writing

Readers are entitled to expect educated writing from medical authors, members of what Osler called, in the language of his day, "the profession of a cultivated gentleman." They are entitled to expect that facts and ideas will be clear in a writer's mind before he commits them to paper, and that he will try to express them in the best and most appropriate words. This is just a matter of good manners, but, as Sir Arthur Quiller-Couch has said, "Style in writing is much the same thing as good manners in other human intercourse." We must consider the reader and put ourselves in his place if we are to communicate with him effectively. We shall then see that it is rather cheap to offer him unreliable data or muddled ideas; that it is presumptuous to expect him to understand our personal jargon words and phrases and our unorthodox abbreviations; that it is offensive to confront him with crudities of expression and the ambiguities inseparable from faulty grammar and sentence construction.

EDITORIAL
in *The Medical Journal of Australia*
p. 131, July 26, 1958

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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TOO MANY MEETINGS?

QUITE a bit of discussion has arisen as a result of the editorial entitled "Meetings Can Kill Us," originally printed in the *Kokomo Tribune* on December 30, 1958, and reprinted in the Fourth Estate column in the February issue of *The Journal.*

The tenor of the editorial was to the effect that attendance at too many meetings (type not specified) was detrimental to the health and might even prove fatal. The man who was anonymously quoted in the editorial emphasized that he did not think that the meetings themselves were bad. In fact, he stated that many of them were necessary and were the only means of getting something constructive done.

Obviously his point was that there are not necessarily too many meetings; merely too few people willing to attend and get the work done.

This situation is pretty well standardized in all walks of life. One will always find a few individuals in each organization who are willing to do the organizational and committee work; and a lot of individuals who are not willing to do so.

If participating in civic and public-spirited enterprises is actually conducive to an early demise, which we doubt, there are a lot of people who will assuredly live a very long time.

Whether extracurricular work is bad for the health or not, it would certainly be advantageous if there were more willing workers. One result of spreading the tasks around would be a diminution in carping criticism. It is usually those who do not participate who contribute most of the anvil chorus of nonconstructive criticism.

STUDY HOSPITAL ADMISSIONS

WHY DO PATIENTS enter hospitals? Does overuse or misuse of hospitals exist today? Where does proper use of a hospital stop and where does overuse begin? What does the public expect of hospital service?

The answers to the above questions and many other questions like them are sorely needed today.

Before the questions may be answered much more information about hospitals and their current use is necessary. Changes in the role of the hospital, changes in the public's attitude toward the hospital, changes in the physician's attitude and practice, and the advent and tremendous growth of hospital insurance, all have made the answers especially important in the administration and expansion of the hospital system.

A $200,000 study to be done for the Health Information Foundation during the next 2½ years proposes to gather together the basic information which will help to supply the answers.

"How Hospitals Are Used Today," published as a special article in this issue of *The Journal,* was prepared, to outline the problem, by the National Opinon Research Center of the University of Chicago. The Research Center and the Health Information Foundation will work jointly on this study.

Hospital admissions in Massachusetts will provide the study material. While no one area in the United States could be considered typical of the entire country, it is felt that the investigation in this area will provide data which can be useful in most other locations. The Massachusetts Medical Society, the Massachusetts Hospital Association and the Blue Cross-Blue Shield plans of that state have approved the project and will cooperate in its accomplishment.

A statistically representative sample of admissions will be studied thoroughly to "attempt to determine the non-medical factors and family situations which lead to hospital utilization as well as medical reasons given by physicians." The length of stay in the hospital will be investigated on the same basis.

The study will not attempt to evaluate current use of hospital service, "but rather will describe it and thus be of value to those concerned with defining what may be considered justifiable and legitimate use of hospital care."

The survey is one of a group of major studies of voluntary health insurance sponsored by Health Information Foundation. The Foundation was organized in 1950 as a contribution by the drug, pharmaceutical, chemical and allied industries to research and education in the social and economic aspects of medical care.

THE PATH OF SOCIAL SECURITY

SOCIALISM sounds nice and soft and easy —when one individual considers what it will be able to do for him. It's when it involves more and more people, and finally engulfs everyone, that it becomes ugly and rough. People of the United States, at least some of them, think that social security is a fine scheme. It guarantees a small pittance for a retired worker, possibly on a minimal amount of contribution. And, when one person is concerned it looks like a bargain; if this one person hasn't contributed enough to the fund to support his own pension, then money is available from some other worker's contribution or, if need be, the money will be borrowed and ultimately paid by the next generation.

No one likes to see his friends, for instance the people of Michigan, in deep socialistic troubles, but maybe it is a good thing their mess has developed as it has. It will serve as "The Horrible Example." It may be so horrible that it will serve as a danger signal for the rest of the country. Let's hope so, for this is the only good thing that can possibly be derived from such a catastrophe.

No better condemnation of socialism is presently evident than that which is outlined in the following editorial taken from the *Indianapolis Star* of March 1.

The Horrible Example

A lot has been written in recent weeks about the bankruptcy of the state of Michigan under

Governor Soapy Williams. But few of those commenting have drawn the conclusion that occurs to us.

Michigan went broke because its government spent more than it could get back in taxes, because the recession increased the financial burdens of the state, because the Governor and the legislature, urged on by Williams' mentor Walter Reuther refused to count the cost of the welfare state they were building. Now Williams has been forced to go begging to the very big business, against which his administration has directed harassment and punitive legislation, to bail him out of immediate bankruptcy with advance tax payments. Both Williams and Walter Reuther are, at the same time, demanding that the Federal government step in and bail Michigan out of its self created mess. Neither Williams nor Reuther show any indication that they have learned anything from the plight to which they have brought the state. Neither are advocating any measures of self denial that would reduce state expenses, reduce state services, cut back state spending and permit Michigan to live within its income.

It seems to us that Michigan is a perfect example of what will happen not only to a state, but to the whole nation if Walter Reuther's socialistic ideas keep on gaining more and more ground in Washington. If the Federal government keeps on spending beyond its income, keeps on proliferating its bureaus and agencies, keeps on punishing business success and rewarding business and farm inefficiency, no other result is possible but bankruptcy—just like Michigan's.

But who will be there to bail out the United States when it spends itself broke? Nobody. At present industries in Michigan have a choice. They can move to Indiana where the taxes are lower and the climate is more friendly to them—as they are doing. But where can American business and industry move when the Federal government, going down Michigan's path, takes us to the shared poverty of national socialism?

It's a good question, isn't it?

Any doctors for social security?

MEDICINE TODAY

THE DOCTOR cannot know everything about medicine, but he keeps trying. And, because he does, the American physician today is the most respected member of the world's medical profession.

This is truly the "Golden Age of Medicine." Experts estimate that more than one and one-quarter million Americans are alive today because of new treatments developed in the last ten years. It is a fact, an almost unbelievable one, that three out of four prescriptions written today could not have been written before World War II because the drugs called for simply didn't exist. This is progress . . . fantastic progress.

Soon a large segment of the population will be more than 65 years old, for the number of healthy oldsters is growing every day. This is, indeed, a triumph of medical research, but the situation presents a problem.

At the present, more than ten million persons are receiving Social Security benefits, and the number is increased by approximately one million each year. There may be developing a sort of geriatric isolation from the mainstream of the economy.

Let us look at another phase of medicine. There are 123 million persons in our population participating in some form of protection; that is, approximately seven out of ten people today have some type of medical insurance.

This has brought about a marked increase in hospitalization. Several years ago only the wealthy, or the very poor, could have adequate hospital care. Now, with the insurance programs, the middle-income group has enjoyed the same privileges.

Unfortunately, medical costs have risen with

Dr. Wilkins has been a member of the Editorial Board of *The Journal* for many years. This year he is also President of the Marion County Medical Society. The above is reprinted from his President's Page in the Marion County Medical Society *Bulletin* of February, 1959.

the increase in hospitalization and this is what makes state medicine a public issue in the first place.

The greatest danger confronting us today, however, is not state medicine. We have seen what this type of practice has done in other countries and I believe the American people will not fall in line with such a program. But another forceful factor is presenting itself . . . the union.

Unions are dictating, or attempting to dictate, to government, industry and private enterprises. Medicine is the next front to be attacked.

At a recent public relations meeting in Chicago a representative of the AFL-CIO stated that if doctors would not conform to fixed fee schedules and prepaid medical care as governed by the union, clinics would be established and free choice of physician would be eliminated.

When asked how these clinics would be staffed, his answer was, "A salary high enough would be offered so that a long line of doctors would be waiting to get one of the positions."

Think this over. It is a real threat to the medical profession today.

What is the solution?

There is only one answer. Restore the personal touch in medicine!

Throughout the years the personal touch in medicine has been the family doctor. This important relationship between the doctor and his patients gradually has become obsolete and with it a definite loss of individuality. There is a loss of feeling of warmth and understanding which is a vital ingredient in the art of medicine.

Specialization is necessary. No one doctor can know it all, but, with the explosive expansion of scientific knowledge, specialization has overwhelmed the general practitioner. Specialists know more about the heart, the pancreas, the liver, the brain, etc., but someone must know about the human being, who is greater than the sum of his parts. Someone must be responsible for the physical and mental health of a man's family if he becomes sick or, despite all the specialists, he dies. Nothing can be more dangerous than to treat him like the efficient machine he is not.

The danger of specialization, like the danger of state medicine, or union-controlled medicine, is that the patient may be treated that way and fall apart.

We have learned that fear and anxiety are important in all types of illness and this, plus the basic organic pathology, produces a violently sick person who needs help. How can this be relieved? In the first place, by a desire to restore the close personal relationship which once existed between doctors and patients. This desire, I am convinced, is shared by both the medical profession and the public.

Secondly, there must be an attempt at greater teamwork. No particular member of the team, whether he be a general practitioner, a surgeon, or a medical specialist, should be considered the "All-American" entitled to the lion's share of prestige and reward. In short, every member of the team should be a person considered worthy of his hire, not simply in the financial sense, but in terms of professional recognition and public appreciation.

No matter how complex or specialized medicine may become in the decades ahead, and no matter what may be the predominant pattern of medical practice . . . individual physicians, medical groups, health centers, or hospital outpatient clinics . . . there always will have to be the equivalent of the family doctor.

Irvin W. Wilkens, M.D.

Overconscientious Anonymity

To refer to an article of my own . . . may I suggest I am immodest. That is a risk of using the first person. Yet avoiding "I" by impersonality and circumlocution leads to dullness, and I would rather be thought conceited than dull. Articles are written to interest the reader, not to make him admire the author. Overconscientious anonymity can be overdone, as in the article by two authors which had a footnote, "Since this article was written, unfortunately one of us has died."

RICHARD ASHER, M.D.
in *British Medical Journal*
p. 503, Aug. 23, 1958

President's Page

April, designated nationally as cancer month, should not only make us cognizant of cancer, but should endeavor to make all of us reflect about our knowledge of cancer. We should give thought as to how we can better educate the public and our patients to seek diagnosis and treatment for the early signs of cancer. We must try to prevent any delay between the time of possible early diagnosis and the definitive treatment required for we can cure more cancers by earlier diagnosis and treatment than we are now doing. We must guard against giving improper prognosis for patients and families of patients. Having been told that the involved person is to die in anywhere from days to several months and then have that person live for months or years afterwards has caused some financial gain to quacks.

I testified at a trial involving the government against a cancer quack and learned that this man was able to exploit the saying of the patient or his family that "the doctors gave him up" and now the patient is well because of the quack's useless medicine. One case I know about happens to illustrate this point.

Members of a child's family were under the impression that their doctor told them the child would not live to Christmas which was 3 months away. The child received x-ray therapy to a recurrence of a Ewing's tumor and a good response had occurred at the time the child was taken to the cancer quack. The child temporarily improved and then finally died about 8 months after the Christmas deadline. The family still believes the cancer quack helped their child, but obviously this is not so. The child was photographed when first seen and then advertised as a cure months after recurrence and death. This quack publicly had claimed he cured this child after "the doctors gave her up" which prompted many patients to go to this quack and resulted in many hardships of physical misery and financial suffering. The lesson to be learned is that each one of us should be careful of giving a specific prognosis, for an individual case can surprise everyone.

This part of this page is unpleasant for me to write for I feel somewhat dedicated in regard to the fight against cancer. The American Cancer Society has passed an edict by its national body that all local community chapters must abide by all their dictates and policies so that the local chapters become nothing but collection agencies. I do not believe that we people, interested and dedicated to cancer, deserve that kind of treatment. I believe that the officers and board members of the national organization are also dedicated people, but even they can make mistakes. The cold facts are that the national officials have been intransigent in the decision of fund raising and all decisions of the local chapters. I have heard at least one official say that the national society's policy is irrevocable and would not even listen to the protests of local chapters. This type of policy is expected in a dictatorship country, but not in a republic such as the United States of America.

The Indiana State Medical Association at its House of Delegates meeting in

October, 1958, passed a resolution advocating that the method of fund raising for voluntary health agencies be determined by local communities. This resolution was presented to the House of Delegates of the American Medical Association and was approved by that body in December, 1958. It was hoped that the national officers of the American Cancer Society would give some consideration to the feelings expressed from the doctors at the grass roots.

It would seem to me that we in local communities, especially in Indiana, may develop the spark to ignite a study of all health agencies to arrive at a better plan than now exists of having about 100 kinds of health drives. The multiple drives results in excessive waste of money spent on organizational duplication and fund raising instead of the important area of research and education. There have been a few minor studies of health agencies in the past few years, but there is need now for a major study of all phases including the means of raising funds. The doctor must be kept in a prominent position of directing the medical phases of all of these programs locally and nationally and this can be done without giving up all policy and organizational activities to a national body of lay people or doctors.

Kenneth L. Olson M.D.

AMA Plans Huge Atlantic City Convention; Suggests Early Registrations for June Meeting

The AMA is urging all physicians to register for the annual meeting at Atlantic City by writing to 535 N. Dearborn Street, Chicago, as soon as possible. Advance registration is a great time-saver, and is especially advantageous this year since over 15,000 are expected to attend the meeting.

The dates are June 8 to 12. This will be the 108th AMA annual meeting, and the 16th meeting for Atlantic City.

The scientific program will be presented by over 500 essayists in the form of scientific papers or by symposium or discussion groups. More than 300 scientific exhibits will be set up in the Convention Hall.

Medical motion pictures and televised surgical operations will supplement the regular program.

For the fourth year, high school students who have won special AMA awards in the National Science Fair will show their prize-winning work at the scientific exhibit.

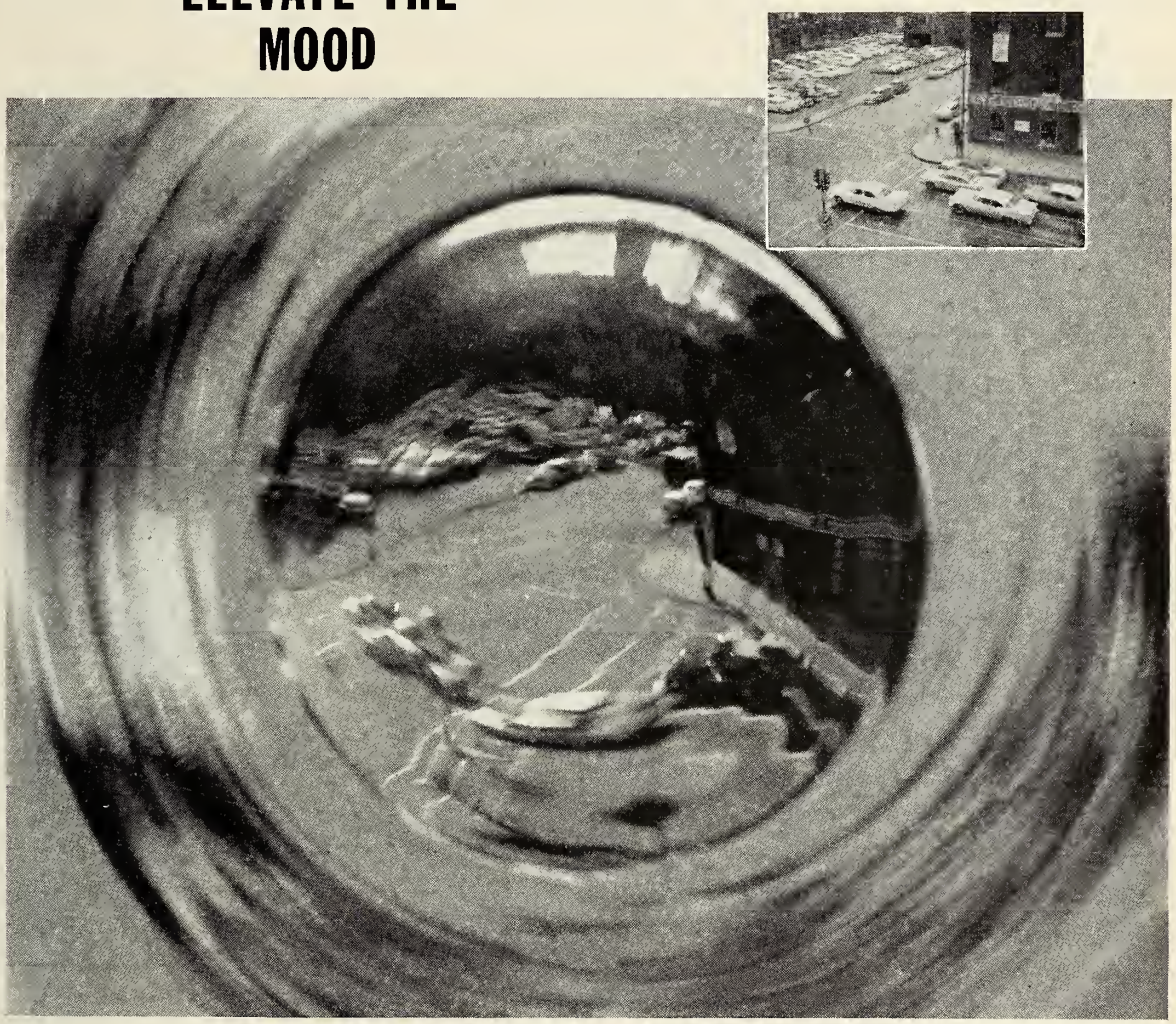
Atlantic City, with its many superb hotels and excellent meeting rooms and Convention Hall, is an almost perfect setting for a large medical gathering. However, even its lavish accommodations are strained by an AMA meeting, so those who plan to attend should make their hotel reservations by use of the special form in the *AMA Journal*.

Doctors to 'Engulf' Steel Pier in June



Skyline overlooking world-renowned Atlantic City Boardwalk as seen from the vantage point of famous Steel Pier is one of the scenes AMA conventionaires will be seeing in June. More than 15,000 physicians and their families are expected in Atlantic City for the 108th Annual Meeting of the American Medical Association.

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*Pratt, R. T. C., and McKenzie, W.: Anxiety States Following Vestibular Disorders, Lancet *2*:347 (Aug. 16) 1958.

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Research in the Service of Medicine **SEARLE**

Medicolegal Aspects of Blood Extraction

CLEON H. FOUST*
LT. CHARLES A. DAVIS**

THE STATE'S SEARCH for more authentic evidence either to convict or acquit in criminal cases is perennial. However, as the search produces new technics and methods of proof, the defense resistance develops in familiar patterns. For example, the offense of driving a motor vehicle under the influence of alcohol requires proof of an exceedingly subjective condition, i.e., "under the influence." The latter has been defined as any indulgence which has lessened the ability of the driver in the slightest degree—something less obvious than "drunk" or "intoxicated." Clinically and legally such a determination is difficult. But more recently, if alcohol is suspected, chemical tests are available to corroborate or negate the suspicion and to determine the blood alcohol level of those who have imbibed. The use of these chemical tests has evoked mediocolegal problems of serious personal and constitutional proportions. In any accident or upon any arrest where alcohol is a suspected factor, the police officer is understandably anxious to obtain the specific proof offered by a chemical test; otherwise, he is restricted to clinical observation and opinion. At the same time the potential arrestee or defendant in a damage suit is even more anxious to save his reputation, his freedom, his pocketbook and his driver's license. Whatever may be his sympathies,[2] that leaves the one conducting the test somewhere in the middle.

In response to several requests from physicians and from police officers to identify the legal problems involved in blood testing in particular, it is proposed to consider briefly the obligation of the police, the defense attorney and the legal position of the physician who assists.

The Enforcement Officer

From the police viewpoint, as Sgt. Friday says, "we just want the facts!" It is not the responsibility of a police officer to obtain convictions; he merely presents the facts to the court and the jury for their consideration—they do the convicting or acquitting. There are many different pathological conditions which produce symptoms similar to those observed in a person under the influence of alcohol. Can we expect a police officer to evaluate symptoms when even a physician may be unable to do so? There is a definite need for chemical tests for intoxication if only to help rule out the few cases encountered in which the symptoms are produced by an organic disorder. The shock and trauma, both psychic and physical, which result from an automobile accident, make the interpretation of observable symptoms extremely difficult. Breath tests are often impractical in such circumstances; both the police investigator and the medical investigator need to know the blood alcohol level if proper evaluation of the condition of the victim is to be made. It is even more important to find a low blood alcohol level—one that would not produce the observed symptoms—than a high blood alcohol level.

Obtaining blood samples for chemical tests for intoxication is only one part of the problem for the police investigator. He also needs to determine the level of narcotic or other drug intoxication. Search for poisons absorbed into the system is of vital importance. Blood for determination of the major blood group is often necessary. A suspect may have blood stains on his clothing or on a weapon in his possession; he usually says it is rabbit blood. Serologic tests for species of origin in dried blood stains can

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be made. If the suspect admits that human blood is on his clothing and says that it is from an individual other than the victim, it is necessary to try to substantiate the story by determination of the major blood group of the stains (we can go no further on dried blood). The police investigator must know the major blood group of the victim; in many cases it is also necessary to know the major blood group of the suspect—particularly if he has been injured.

The police investigator is not concerned with paternity disputes; however, he is often concerned with the act which precipitates such disputes. Sexual assaults produce problems in determination of major blood groups of both the victim and assailant. Seminal fluid contains group specific material in about 85% of our male population; these are the "secretors." Saliva, gastric juices and other body fluids of the "secretor" also contain group specific material. If tests rule the suspect out, this information is of importance to the police investigator but it is of even greater importance to the suspect.

Operation of a motor vehicle while under the influence of alcohol is one of the causes of accidents and every effort should be made to establish the facts in such cases. How big a factor alcoholic intoxication is in traffic problems can be determined only by statistical analysis of the results of chemical tests obtained from adequate sampling. In other words, it is just as important to establish the frequency with which alcoholic intoxication is *not* a factor as it is to establish the frequency with which it is a factor in traffic cases. The police officer is charged with the responsibility for the protection of life, limb and property of the citizens of the state. Obtaining blood samples for laboratory examination is one of the means by which the innocent can be protected. Police technicians are often called in civil litigations to testify concerning the results of blood alcohol analyses; the testimony may be in behalf of the plaintiff or defendant. In order to protect the innocent and evaluate alcoholic intoxication as a traffic problem, many more samples than are now obtained must be taken for chemical tests.

The Defense

It is the duty of the attorney representing an accused person to protect and defend his client's rights and interests under the constitution and statutes of the state in which the chemical test has taken place. As a defense attorney in a criminal action, it is his obligation to establish that the test sample, whether blood or other body substance, was obtained according to law; that it was properly analyzed and interpreted; and, finally, that the evidence is presented in a manner such as not to prejudice the position of his client. However, this is not the full extent of his duty. It extends to a protection of the civil rights of his client and to a determination if, when a particular sample is extracted, his client has suffered a legal wrong for which the law will allow him a remedy.

In our court systems the state or plaintiff must prove its case beyond a reasonable doubt in criminal actions and by the preponderance of the evidence in civil actions. The defense attorney has a sacred obligation to his client; he is often the only barrier between outraged public sentiment and injustice. His duty is a personal one to the defendant he represents, as well as to the ends of justice. It is a duty of the highest calling in this country where personal rights are cherished. Therefore, this problem must be viewed, as so many legal problems are, from the standpoint of balancing the interests between personal liberties on the one hand and the public welfare on the other. The legal problems concerning both the defendant and the physician are expanded in the paragraphs which follow.

The Physician

In the interest of brevity the following discussion will be limited to blood testing and more specifically to the investigation of the legal responsibilities of a physician, technician or nurse (and possibly the clinic or hospital) who extracts blood for blood alcohol tests.[2] The temptation to designate that person as the needler has been resisted. Hereafter he (or she) will be known collectively as the extractor.

While it is true that the admixture of alcohol and gasoline has made the problem acute, there are other situations where a blood sample may serve its forensic purpose. Specifically then, what is the civil responsibility of anyone who

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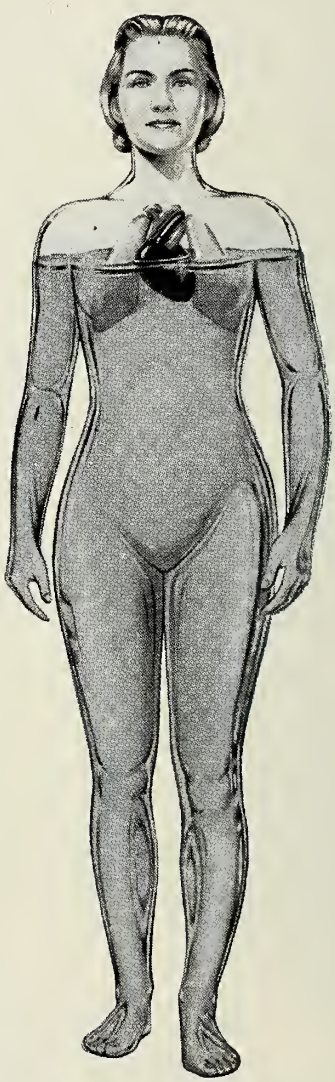
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HYDRODIURIL (HYDROCHLOROTHIAZIDE)

- highly-active derivative of chlorothiazide
- similar qualitatively to chlorothiazide but 10 to 12 times more potent
- loss of potassium is clinically insignificant in the great majority of patients on normal diets

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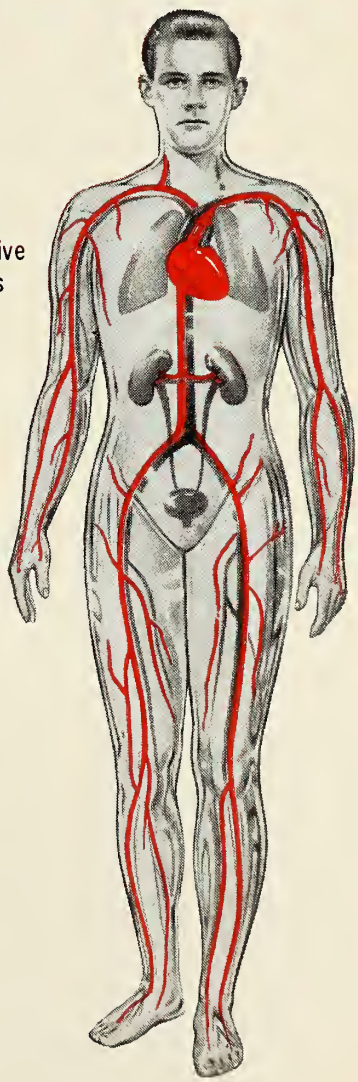
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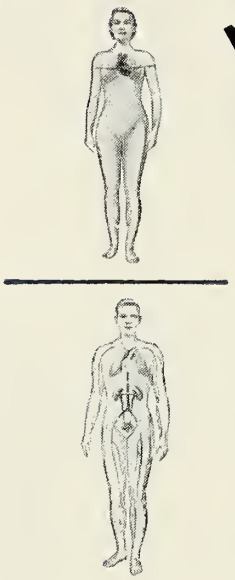




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Additional information on HYDRODIURIL is available on request.

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Medicolegal Aspects

Continued from 532

takes or directs the taking of a blood sample for one of several purposes: (1) for blood grouping in paternity cases, (2) to establish identity by blood grouping, (3) for comparison with blood stains on a victim, a weapon or some object and (4) most often, to establish blood alcohol content? It should be noted also that what is said about blood extraction would seem to apply generally to extraction of urine, saliva, or in a rare case, spinal fluid.

Unfortunately, law like medicine, is not nearly as exact a science as the average layman thinks. Lawyers suffer mightily from lack of specific answers. Prediction of a result in law is much more often a question of probabilities than certainties. With that caveat in mind it is safe to say that the physician's responsibility in this new problem area will largely be controlled by well established legal principles as applied to the new fact situations. One or two over-simplified legal postulates can serve as a starting point.

The *unpermitted* touching of another is a civil battery for which damages are recoverable at least in nominal sum even though there is no injury. A civil battery may be defined as any intentional and unpermitted touching of another. It may be harmful or nothing more than an indignity.[3] Likewise, such a contact may be the newer and less well-defined tort called invasion of privacy.

One *permitted* type of touching in law is, of course, that accomplished with the patient's consent. This factor is that which prevents operations or simple examinations from being civil batteries or invasions of privacy. Consent is the very foundation of the physician-patient relationship. To be operative legally, consent must be freely given upon full information by one having the intellectual capacity to understand the nature of the anticipated physical contact. It is safe then to say this much with certainty, that so long as consent is freely given with full knowledge and understanding of the nature and purpose of the bodily contact, the extractor has nothing to worry about except, of course, proof of the consent. With the latter in mind, in doubtful cases, it would seem always wise to have a witness present.

But implicit in the description of consent are three lesser pitfalls: (1) Age. Suppose a physician is requested to draw a blood sample from a teen-age boy for blood grouping or alcohol content. No arrest has been made but the youngster expresses assent to the extraction. Is he legally capable of giving consent? Capacity in this situation does not necessarily correspond with majority. For example, it cannot arbitrarily be said that no one under 21 could legally consent. On the contrary, the probabilities are that with respect to this non-dangerous type of bodily contact, consent would be possible at a much earlier age. But when? The safe procedure in case of doubt is also to obtain the consent of the minor's parent.[4] (2) Mental condition. Whatever the cause, if the potential subject is mentally incapable of understanding the nature of the proposed contact, his consent is probably not effective.[5] This incapacity might arise from intoxication itself. (3) Non-disclosure or fraud. For example, blood is extracted with the patient's consent for typing or routine diagnostic purposes but some of the blood is delivered to the police.[6] What then of the patient's consent? This is somewhat analogous to unauthorized use of the other information obtained from the patient such as pictures, x-rays, etc.[7] If any use of the blood other than diagnostic is to be made, the safe thing is to inform the patient and obtain consent.

As soon as the extractor moves out of the area of consent, his position becomes somewhat perilous. The real problem, then, lies in the non-consensual extraction of blood.

A second type of *permitted* touching is a legally privileged although nonconsensual one. For example, the paternity cases in Indiana offer no threat of liability to the physician so long as the blood sampling follows the statute and is done under court order.[8]

The physician's emergency privilege is another type. Of course a physician has a privilege to treat a patient in an emergency where the patient's consent is unavailable. The Restatement of Torts[9] describes the privilege as arising where: (a) for physical or other reasons consent is unobtainable from the patient or another empowered to consent for him, (b) there is an actual or apparent emergency for the medical procedure, (c) the procedure is reasonably believed to be beneficial and (d) no reason is known why this particular patient would not

consent. By definition, any emergency to test for blood alcohol where the results are to be used against the patient would seem to be excluded.

Nevertheless, the extractor who takes blood either with consent or under the emergency privilege for regular diagnostic purposes should be and will be protected if he is later required to testify as to the results.[10]

In the absence of consent, statutory authority or an emergency privilege, the extractor may still be protected by a non-statutory legal privilege—the privilege to make a reasonable search incident to an arrest.

First consideration will be given to the case of a conscious person from whom blood is extracted by force or threat of force, assuming further that the technician or physician does not participate in the force or threat of force except for the extraction itself. There have been a number of these cases but unfortunately most of them have involved the admissibility of the blood test result into evidence in a criminal case rather than the question of the extractor's civil liability. Usually, in those cases, the defendant raises one or more of three possible objections to the admission of the evidence:

1. It violates the self-incrimination (Fifth Amendment) provisions of the Federal Constition and its Indiana equivalent. The majority of the cases hold this evidence is not to be excluded because of self-incrimination provisions. It is generally said that the Fifth Amendment applies only to testimonial evidence of the accused and not to so called "real" evidence such as a fingerprint, a paraffin, a handwriting or blood test.[11] Furthermore, the language of those Fifth Amendment decisions gives very little indication concerning civil liability for forcible extraction. Nevertheless, courts are aware of the tremendous hazards of driving while under the influence. Likewise, they are aware of the availability and value of blood tests for various purposes. The same policy considerations which persuade a court that forcible extraction and use is not self-incrimination are powerfully persuasive in favor of a "battery free" privilege to take the sample.

2. The second objection usually made is that the evidence was obtained as a result of an unreasonable search and seizure and is therefore inadmissible. Is the forcible extraction of blood



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an unreasonable search and seizure and, therefore, a violation of the Fourth Amendment of the Federal Constitution?

It is well established that there is a legal privilege to execute a reasonable search of the person incident to a lawful arrest.[12] Recent decisions, particularly in the lower federal courts, indicate that a search of the person may in fact be a pretty embarrassing and harrowing experience for the person searched but still be a privileged search. For instance, in a recent federal case,[13] the persons suspected of smuggling were plied with both castor oil and epsom salts in order to dislodge heroin in rubber sheaths which they had swallowed. The search was held lawful but the court soberly added, "Obviously it would be a most mischievous thing should the customs officers subject every returning traveler to the indignity of a search of this character, . . ."

Incidentally, the statute authorizing search warrants for certain things in Indiana makes no mention of blood, breath, urine or saliva[14]—nor did the California statute[15] at the time of People v. Duroncl ay.[16] Whether, if the question were raised, the courts would say there could be no search incident to an arrest for something which could not be obtained on a search warrant, is conjecture.

But such a search of the person can be made only as an incident to a lawful arrest.[17]

In short, the trend of cases would indicate that forcible extraction of blood for testing purposes (and the same reasoning would apply to breath, urine and saliva) will be upheld against the contention that it is an unreasonable search and seizure: where (1) there is a pretty clear indication that alcoholic liquor is involved in the circumstances and (2) the blood is not taken before nor too long after the arrest. What is too long after would depend upon the circumstances of each case; but, as indicated in a recent Indiana case, the Supreme Court approved a search of a motor vehicle incident to an arrest although made approximately an hour after the arrest.[18]

Although the fact situations akin to those here mentioned frequently appear in the United States Supreme Court, usually the facts have been brought to that court on appeal from state courts and involve only the admissibility of the evidence obtained. If the particular state in whose courts the case was first heard does not require the exclusion of evidence obtained by an unlawful search and seizure (and the majority of states do not), the United States Courts will follow the state rule. In Wolf v. Colorado[19] the United States Supreme Court said states were free to enforce whatever rules against unreasonable search and seizure they wished. The rules could take the form of exclusion of evidence so obtained or *damages actions against the perpetrators of the illegal search* or both. Consequently the most recent Federal Supreme Court decision is not particularly helpful. In Breithaupt v. Abram[20] a blood sample was extracted from a driver suspected of intoxication while he was unconscious following an accident. The Supreme Court said the evidence would not be excluded on the grounds of illegal search because New Mexico, the state of origin of the case, would admit the evidence whether illegally obtained or not. But if it should turn out that the search is unreasonable there is little doubt that the



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searcher (in this case the extractor) is civilly responsible for a battery.[21]

It is entirely arguable that anyone who draws blood at the request or order of a police officer should be protected even though the officer had no privilege—that the order plus good faith should be a shield. The Kentucky court many years ago in a similar situation said:

> "There is something which instantly strikes the moral sense as being wrong when told that a citizen is regarded as a trespasser for conscientiously aiding to execute the law, as he conscientiously belived at the time."[22]

But the results in the actual cases are not clear on this point.[23]

Until this point in the development of the problem we have assumed a conscious person who has not consented to a blood test. If the blood is taken from an unconsicous person, the same considerations are present except, since the subject is already immobilized, it would be more difficult to establish that an arrest had taken place. This difficulty of the proof of arrest has not been considered in the cases.

3. The third objection ordinarily raised is that the forcible taking of blood is a violation of due process—the Fourteenth Amendment of the Federal Constitution. The use of this ground for the exclusion of the evidence is necessary in those states where evidence cannot be excluded on the sole ground that it was obtained by an illegal search and seizure. The leading case involving the Fourteenth Amendment in this context is Rochin v. California[24] in which the search of the defendant's person was characterized by the United States Supreme Court as a "brutal" and "shocking" instance of obtaining evidence. In that case, the police officers had invaded the defendant's room without warrant, saw him swallow a couple of capsules and, after arresting him, forcibly pumped his stomach. It is to be noted that in this case the police were in the wrong from the very inception. Under those circumstances there can be little doubt that what happened to Rochin was a battery exposing the police and perhaps civilian assistants to civil liability. However, there is a clear indication the United States Supreme Court does not propose to extend due process protection indiscriminately: in the later Breithaupt[25] case where blood for testing was taken from an unconscious driver by the New Mexico State Police, the Supreme Court said the search was not so brutal or shocking as to violate the due process clause.

The legal implications of two other factual patterns should be mentioned. One is the extraction of blood from a body. Suppose, for example, the victim of an auto accident is dead and the physician is asked to take a blood sample. If the request were by the coroner, who would have authority to order an autopsy,[26] the extractor would undoubtedly be protected. If the request were by police officers, would the physician incur any civil responsibility? For reasons of sentiment the Indiana court has said the next of kin have some *quasi* property rights in the body of a deceased. Without their consent and lacking a legal autopsy, the civil implications of an unauthorized interference with the body are apparent.[27] The other is the capture of "free" or "spilled" blood from a bleeding subject (alive or dead). It is not believed this raises a very substantial problem of liability. If there is no touching of a live person the battery possibilities certainly are exceedingly remote. Property rights in spilled blood would seem to be *de minimis* even though the blood is now a transferable commodity.[28] On the other hand, if the circumstances of the capture were such as to constitute a serious intereference with personal dignity or to outrage the sensibilities, such conduct might be an invasion of privacy or allied wrong. On the other hand, if the next of kin are protected sentimentally against a violation of the corpse by the fiction of a *quasi* property right, it is arguable there is a *quasi* property right in one's spilled blood.[29]

What then is the conclusion?[4] Under the present state of development of the law in this area, without the consent of the patient, the extractor's legal position is dependent upon a privilege which is not yet fully described and which is raised by the facts and circumstances of each individual case. The safest measure at present is to be sure consent is obtained and is provable.

The next safest is to make sure: (1) An arresting peace officer is present, (2) The arrest has been made (preferably on a charge to which blood testing would be reasonably relevant), (3) The peace officer requests a blood sample as

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Medicolegal Aspects

Continued

a part of the search of the person and incident to the arrest, and (4) No more force than necessary is used.

Ultimately the Kentucky court may have hinted at the remedy—legislation which would protect one assisting a police officer in his search so long as the extractor acts non-negligently and in good faith.

Addendum

Alder v. State (Ind. Supreme Court #29711, Dec. 12, 1958), which was decided since this article was written, is of interest to physicians. In that case a physician who was "on call" in the emergency room of a hospital, extracted blood for typing from the defendant who had been brought in unconsicous after an automobile accident and who apparently was then or might be in need of a transfusion. A state policeman who was present requested that the physician obtain some blood for a blood alcohol test. The physician extracted a total of 15 cc. and gave half of it to the policeman. The Supreme Court said since the professional physician-patient relationship had been established the physician could not, over defendant's objection, testify on trial concerning the blood sample given to the policeman. The court carefully emphasized the professional relationship and its confidential nature in so far as the physician's testimony is concerned. No broader implications than its exact holding are suggested in language of the case.

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Medicolegal Aspects

Continued

4. Smith, Antecedent Grounds of Liability in the Practice of Surgery, 14 *Rocky Mtn. L. Rev.,* 233 (1942).
5. Restatement, Torts § 59 (1934).
6. See State v. Alexander, 7 N. J. 585, 83 A.2d 441 (1951); cert. den. 343 U.S. 908, 72 S.Ct. 638, 96 L. Ed. 1326 (1951).
7. Banks v. King Features Syndicate, Inc., 30 F. Supp. 352 (S.D.N.Y. 1939). Of similar import is the liability of the physician for unauthorized disclosure of confidential communications of the patient. See e.g., Smith v. Driscoll, 94 Wash. 441, 162 P. 572, L.R.A. 1917C, 1128 (1917).
8. The Indiana Statute is § 1, ch. 161, p. 575 Acts 1953, § 3-658 Ind. Anno. Stat. (Burns' 1946 Repl.). It is unlikely this statute would be found unconstitutional. See Cortese, 10 N.J. Super. 152, 76 A.2d 717, 1950; anno. 46 A.L.R.2d 1000 (1956). There have been no test cases in Indiana of the constitutionality of this statute or of § 861, ch. 157, p. 416 Acts 1949, § 35-1312 Ind. Anno. Stat. (Burns' 1949 Repl.). The latter requires a serological test for pregnant mothers.
9. § 62 (1934).
10. Smith v. Driscoll (Supra Note 6). Cf. Simonson v. Swenson, 104 Neb. 224, 177 N.W. 831, 9 A.L.R. 1250 (1920); Munzer v. Blaisdell, 183 N.Y. Misc. 773, 49 N.Y.S.2d 915 (S.C.N.Y. Co. 1944).
11. Holt v. U. S., 218 U.S. 245, 31 S.Ct. 2, 54 L. Ed. 1021 (1910); O'Brien v. State, 125 Ind. 38, 25 N.E. 137 (1890). Contra, U. S. v. Jordan, 7 U.S.C.M.A. 452, 22 C.M.R. 242 (1957) (urine sample). In Spitler v. State, 221 Ind. 107, 46 N.E. 2d 591 (1943) the court said if a drunkometer test was voluntarily taken, the Fifth Amendment and its Indiana equivalent (Ind. Const. Art. I, Sec. 14) was *waived.* The admissibility of the result of an involuntary test was not passed upon. A review of the cases is found in 32 Notre Dame Law, 730 (1957).
12. Brown v. State, 229 Ind. 470, 99 N.E.2d 103 (1951); Campbell v. State, 198 Ind. 231, 153 N.E. 397 (1926); Haverstick v. State, 196 Ind. 145, 147 N.E. 625 (1925).
13. U. S. v. Michel and King, 158 F. Supp. 34 (S. D. Tex. 1957). See also, Blackford v. U. S., 247 F.2d 745 (9th cir. 1957); People v. Duronclay, 48 Cal.2d 766, 312 P.2d 690 (1957).
14. § 1, ch. 110, p. 224 Acts 1955, § 9-601 Ind. Anno. Stat. (Burns' 1956 Repl.).
15. § 1523 and § 1524 Cal. Pen. Code (1949).
16. Supra Note 13.
17. E.g., State v. Weltha, 228 Iowa 482, 292 N.W. 148 (1940); State v. Height, 117 Iowa 650, 91 N.W. 935, 59 L.R.A. 437, 94 Am. St. Rep. 323 (1902); Schnett v. MacDuff, 205 N.Y. Misc. 43, 127 N.Y. Supp.2d 116 (S. C. Orange Co., 1954); State v. Kroenig, 274 Wis. 266, 79 N.W.2d 810 (1956).
18. White v. State, 152 N.E.2d 894 (Ind. 1958).
19. 338 U.S. 25, 93 L.Ed. 1782, 69 S.Ct. 1359 (1949).
20. 352 U.S. 432, 77 S.Ct. 408, 1 L.Ed.2d 448 (1957).
21. Busher v. Krause, 200 F.2d 576 (7th cir. 1952); Grumon v. Raymond, 1 Conn. 40 (1814); William Small and Co. v. Londegan, 81 Kans. 48, 105 P. 27 (1909); Sanford v. Nichols, 13 Mass. 286 (1816); See Wolf v. Colorado, 338 U.S. 25, 31, 93 L.Ed. 1782, 69 S.Ct. 1359 (1949); Lair v. Abrams, 5 Blackf. 191 (Ind. 1839).
22. Reed v. Rice, 2 Marsh. 44, 19 Am. Dec. 122, 125 (Ky. 1829).
23. Compare, Gran v. Forge, 183 Ky. 521, 209 S.W. 369, 3 A.L.R. 642 (1919), with Hebrew v. Pulis, 73 N.J.L. 621, 64 A. 121 (1906), Anno. 45 A.L.R. 605 (1926). See Dietrichs v. Shaw, 43 Ind. 175, 179 (1873).
24. 342 U.S. 165, 72 S.Ct. 205, 96 L.Ed. 183, 25 A.L.R. 2d 1396 (1951).
25. Supra Note 20.
26. Appropriate request by the coroner should be sufficient legal authority since he could order an autopsy. § 5 ch. 189, p. 587, Acts 1945, § 49-2943, Ind. Anno. Stat. (Burns' 1951 Repl.). See Opinion Ind. Atty. Gen. 1955, p. 24.
27. Aetna Life Ins. Co. v. Burton, 104 Ind. App. 576, 12 N.E.2d 360 (1937); Meek v. State, 205 Ind. 102, 185 N.E. 899 (1933); Orr v. Dayton, Tr. 178 Ind. 40, 96 N.E. 462, 48 L.R.A. (N.S.) 474 Anno. Cas. 1915B 1227 (1915); Renehan v. Wright, 125 Ind. 536, 25 N.E. 822; 9 L.R.A. 514, 21 Am. St. Rep. 249 (1890); Hamilton v. City of New Albany, 30 Ind. 482 (1868); Bogert v. City of Indianapolis, 13 Ind. 134 (1859). See Fretz v. Anderson, 5 Utah 2d 290, 300 P.2d 642, 646 (1956). Harper and McNamara, The Law of Dead Bodies, 3 *Notre Dame Law,* 141 (1928).

 The allegations of the complaint in Aetna Life Ins. Co. v. Burton (supra), are worth noting: . . . "said surgeons and doctors, acting as the agents, workmen and employees and representatives of said defendants, with large steel knives, steel saws, steel pliers and steel instruments of various kinds, cut, sawed, mutilated, lacerated and opened the dead body of plaintiff's said husband, removing therefrom the stomach, bowels, heart, lungs, arteries, and other organs, which were cut into, lacerated, and mutilated by said surgeons and doctors, . . ." and . . . "by reason of the horrible and gruesome cutting, laceration, mutilation, tearing, and sawing of the flesh, veins, heart, lungs, and other vital organs of her said husband, the memory of which is continuously in her mind, haunting her every move and action. . . ."
28. Compare Vreth v. Chicago Title and Trust Co., 307 Ill. App. 243, 30 N.E.2d 126 (1940) in which the court said one had no property right in his life—it could not be transferred.
29. See Aetna Life Insurance Co. v. Burton, supra note 27; 1 Harper and James, *The Law of Torts,* § 9.6 p. 681 (1956).

'Third Party' Interference, the Practice of Medicine and the Market Economy

JAMES L. DOENGES, M.D.*

Anderson, Indiana

IN VIEWING the prevailing inclination of the economic aspect of medical practice, one cannot fail to wonder at the rate and direction of change and to question the influence of such change upon the practice of medicine and the economy as a whole.

The idea that all change is progress has, to a lamentable degree, been accepted by the general public. Physicians seem prone to reject serious consideration of the eventual results of changes in the economic pattern of medical care. This lack of interest and concern may prove to be a tragedy for the medical profession and our entire economy.

Just as an understanding of the entire problem of each patient is a prerequisite for successful treatment, at least a very limited understanding of certain changes in the general economy is required for a reasonable opinion in the economics of medical practice.

The "trend" we observe today is neither an isolated nor a new phenomenon. It is part of the picture which has been developing for many years. Its fruitation is in the future—but that future appears uncomfortably near.

Behind the trend is more than a century of complex changes. Only recently has the impact of these changes been felt by our profession in this nation.

Individual Responsibility

Until recently, in our nation, the pattern of economic responsibility had, to a large extent, resided in the individual, the family or local charitable institutions. This pattern continued long after the Civil War. We enjoyed freedom from the paternalism, the serfdom and the feudalism of the old world.

Our nation grew and prospered under the system of checks and balances of a limited Federal Government. There was a predominance of religious idealism. Never before had the importance of the individual been admitted by the people of a nation and emphasized so much.

In the thirty years following the Civil War, our nation enjoyed a steadily declining cost of living which encouraged thrift and personal responsibility, as well as an ever increasing quantity of production from our industries operating with limited Federal interference.

During this period, less than 0.1% of our population was in the "poorhouse." Self-sufficiency and family solidarity was the characteristic of the day.

This was not true elsewhere. In Europe, still suffering from the violence of the French Revolution, the economic as well as the political situation was in an extreme state of re-adjustment. A great battle was developing between Communism, the established order, and that "housebroken"* version of Communism known as Socialism. The fallacy that Socialism and Communism were conflicting ideologies has continued in the minds of many even to this day.

Marx and his associates had issued the "Manifesto"—a direct threat to the established order. The divided German states were being drawn together by Bismarck, assisted by the Franco-Prussian war and the threat of Socialism (Communism).

Before our great industrial development was

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*Prof. E. Merrill Root.

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Continued

well under way, the burgeoning German industrial expansion was fairly well established. In contrast to this development in our nation, the German industrial expansion was given enormous financial assistance through the reparations extracted from France after the Franco-Prussian war. This expansion and these reparations were used by Bismarck to help unify the German States.

However, the Marxian philosophy was a dark cloud on the horizon and Bismarck was well aware of its presence. As reparations diminished a new source of funds was needed. Communism became more of a threat than ever, for instead of the idolatry of the state which had been fairly well established, Marx proposed the idolatry or deification of labor. Marxian socialism became a real threat to the German Empire.

"Socialism" vs "Socialism"

This threat produced one of the most amazing reactions conceivable, the development of "Monarchial" Socialism to prevent "Marxian" Socialism. The only difference, in the final analysis, was whether the state or labor should be given credit for the various changes which were taking place, and which should control the people.

Adolph Wagner who occupied the chair of Economics at the University of Berlin "sold" Bismarck on "Social Insurance" as a means of emphasizing the strength and magnanimity of the "State," a purpose to which Bismarck was devoted. Neither, as near as we know, fully appreciated the extent to which the tapping of this new source of money-power could benefit the State.

We have not space to discuss the mechanics of the German "Social Insurance." Suffice to say it divided the population into classes according to income (something never done before), taxed the poor more heavily and in so doing produced many unexpected results, provided benefits above and beyond cost and expectation, and eventually played an important part in maintaining "iron clad" control over the entire German population, helped finance World War I, and established "Socialized" (Communized) medicine in Germany.

Most European countries followed suit adopting Socialism to combat Communism, the fallacy par excellence of the last hundred years.

Many of these practices were well established in Europe by 1910. Few of them entered the United States prior to that time.

In the early years of this century a series of changes patterned after the European programs developed in this nation. However, even these, for the most part, were voluntary.

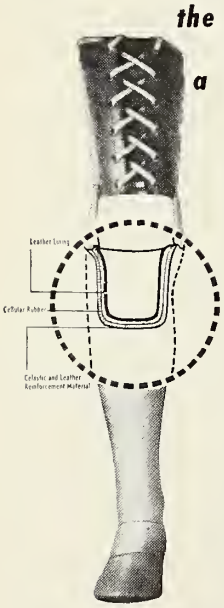
Sickness Societies to Panels

Sickness and burial "societies" sprang up in great number. Many went bankrupt, for evident reasons, by 1920. However, by this time "panel" and similar systems of controlled medical practice were well established in Europe.

Although the pattern in our nation has not been rigid and there are many variations, we may outline briefly the changes to the present day as follows.

Early "sickness" insurance contracts were between the patient and the insurance company. Physicians were not involved. These contracts did not introduce the "third party" into the patient-physician relationship but established a

Continued on 549



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separate relationship between the individual and the insurance company completely isolated from the physician.

Soon insurance contracts between the patient and company (including Friendly Societies, fraternal organizations and all kinds of Mutual organizations, etc.) began requiring reporting or certification by doctors. Benefits were still paid to the patient.

These programs were followed by others, quite similar in most respects, but having benefits paid to or assignable to the physician or paid to the patient and physician jointly.

The next important step was the addition of fixed fee schedules to the above with schedules accepted by individual physicians, small groups, ("clinics") or entire "societies" (county or state) of physicians.

"Service Plan" and "Third Parties"

This led to "Service Plan" contracts which completely ignore the traditional patient-physician relationship.

During the development of these programs, the government entered the field with similar plans provided by government for special groups (veterans, dependents of military personnel, certain Social-Security beneficiaries, etc., etc., etc. until they number about 34 million to-day).

The next step merely requires the addition of other groups (civil servants, more Social Security beneficiaries and dependents, etc.) until the entire population is included. At this point, private insurance, as well as the private practice of medicine, is a thing of the past.

These changes have resulted in rather general acceptance of the "third party payer" in the practice of medicine. Some believe, quite erroneously, that the interest, influence and control of the "third party" can be restricted to the payment of fees. The informed know this is impossible. Regardless, the entrance of a "third party" into the practice of medicine has produced the most serious problem the medical profession must face today. We must face and solve that problem now![1]

Results of "Third Parties"

What are the inevitable results of the entrance of the "third party" into the field of medicine?

Highest quality medical care cannot survive under any system in which there is "third party" interference. This has been and will be true, always, regardless of the promises of politicians or business men, the misrepresentations of labor union leaders, or the compromises of some in the medical profession.

All are acquainted with the numerous difficulties and objections reported regarding the operation of "third party" National Health Insurance schemes, such as the "redtape"; the innumerable forms which require more time than the patient receives; the sky-rocketing costs with the associated tax increases; the increasing demands for non-essential services and supplies; the abuses which defy elimination; the ever-increasing waiting lists for hospital admissions; the unreasonable delays in every area; the decreasing hospital services; the dissatisfaction among patients, hospital personnel and physicians; as well as the wasteful operation and other evils to which every bureaucracy is heir. Bureaucratic systems are not confined to governmental agencies. They can and do exist in most businesses, labor unions and some medical organizations.

These facts alone provide sufficient concrete



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[1] Exner, F. B., Northwest Medicine, Vol. 54, pp. 149-155, Feb. 1955.

Third Party

Continued

reasons why government, and other "third party" "health programs" via "insurance" or "service" plans historically result in less satisfactory and inferior quality medical care.

However, there are other and more important factors which make it impossible for medical care supplied through "third party" programs to equal or even approach the quality of medical care supplied through private practice operating under the market economy.

The Moral Basis

The practice of medicine has a moral basis which is much older and of greater importance than is its scientific basis. The ethical practice of medicine involves as much morality as science.

The first principle of liberty is that man has a right to life. If this first principle is accepted, one must accept the second principle; i.e., if man has a right to life he has a right to maintain life. It is in the area of this second principle that medical care enters the picture.

The primary objective of the physician is to assist the patient in his attempt to remain well or to recover his health, if possible; to alleviate suffering; to advise and direct; to counsel; to understand; in short, to try to help the entire individual maintain life and health. Thus, the rendering of medical services to the individual is intimately bound into one of the very first of the basic "Rights" of man.

No ethical physician would claim that he healed the patient's wounds or made the patient well. None can do more than assist the natural processes. If the physician were the final authority, every patient would recover quickly and none would die. No physician can fail to realize his personal limitations. He must admit the existence of a Greater Power. No other profession renders services in this intimate area in which the individual faces life and death. This brings the physician into a more intimate relationship with the patient than exists between the same individual and any other professional person. Complete mutual understanding and confidence is essential and seldom exists outside this area of intimate contact.

That which is in the best interest of the patient is, in the final analysis, in the best interest of medicine. The personal interest of the physician must and does (in most cases) occupy a position of secondary importance.

Some fail to comprehend that "ends" do not justify "means"; and that good "ends" cannot result from evil "means." This confusion has permitted some to espouse causes inimical to the best interests of the patient.

Best Interest of the Patient

The best interest of the patient requires that the individual patient-physician relationship be held inviolate in every area. This includes every contact between the patient and his physician, whether it involves the history, examination and treatment, or the area of compensation for services. Concerted effort is being made and has been made to destroy this personal relationship. These are all part of a complete "unit" and cannot be separated without damaging the entire practice.

One of the most aggressive and dangerous attempts to bring the practice of medicine under "third party" control is found in the present Social Security law with its numerous amendments. Space does not permit discussion of this



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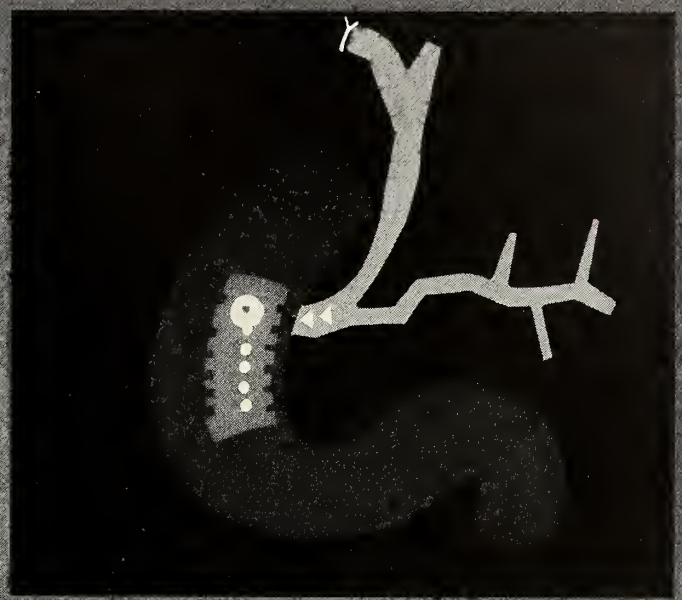
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Third Party

Continued

subject but every physician would do well to obtain a full understanding of this scheme for in it lies the pattern of destruction of the private practice of medicine.

In the final analysis only two individuals are involved in medical care: the patient, who has chosen the physician to whom he will entrust his care and actually his life, and his physician, who has freely agreed to provide such care. (Due consideration is given to those individuals for whom another acts *"in loco parentis."*) No other person, no "third party," is required. When any "third party" enters the picture he is an intruder and can only reduce the uninhibited rapport and confidence which must exist between patient and physician.

The patient-physician relationship is the most intimate which normally and ordinarily exists outside the immediate family. This relationship is made possible only through an appreciation of the moral responsibility of both individuals. Lacking this relationship, successful medical care is impossible. No one can remove the personal responsibility of each to the other. The areas of responsibility cannot be separated or divided.

Another essential feature of quality medical practice is that the patient is and must be regarded as an individual—a moral being. Individuality is the very basis of the practice of medicine. All medical tradition emphasizes the fact that every patient is an individual, that his ills are singular, and that he must be so regarded and treated. Health and disease are strictly personal matters.

Mutual Responsibility

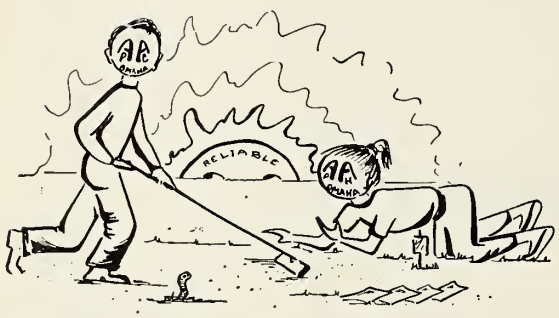
Personal responsibility, upon which all freedom depends, is another basic essential in the successful practice of medicine. It applies to the patient as well as to the physician.

The patient's responsibility cannot be eliminated or violated. If he withholds information or misrepresents facts to his physician he removes one of the basic requirements for good care. He ties the physicians hands. If the physician does not share the confidence of his patient he cannot treat the patient adequately or properly and his chances of helping are greatly reduced. If the physician disregards the facts, the patient suffers. Medical care is not a mechanical function!

The history of moral stability has always been the history of personal understanding and assumption of responsibility for one's acts and for the fulfillment of one's needs and desires. Attempts of the individual to delegate his responsibility to the group has always led, and always must lead to moral decay. Responsible physicians cannot condone any scheme for the transfer or division of the basic human responsibility for self maintenance.

Limiting "Freedom of Choice"

"Third party" medical care always results in control of the patient and the physician by limiting the free choice of the patient in selecting his physician and by interfering with the individual patient-physician relationship. Physicians are frequently classified, not according to ability, but on an arbitrary and unrealistic basis such as membership in certain organizations or other interesting but relatively unimportant details. Experience, results, ability, confidence of patients and personal interest are relegated to a minor position. Physicians are rated by "third party"



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agencies as to the type of practice they may perform and the type of disorder they may treat.

Freedom of choice is further limited because the services which may be rendered by any classification are controlled and regulated by the "third party."

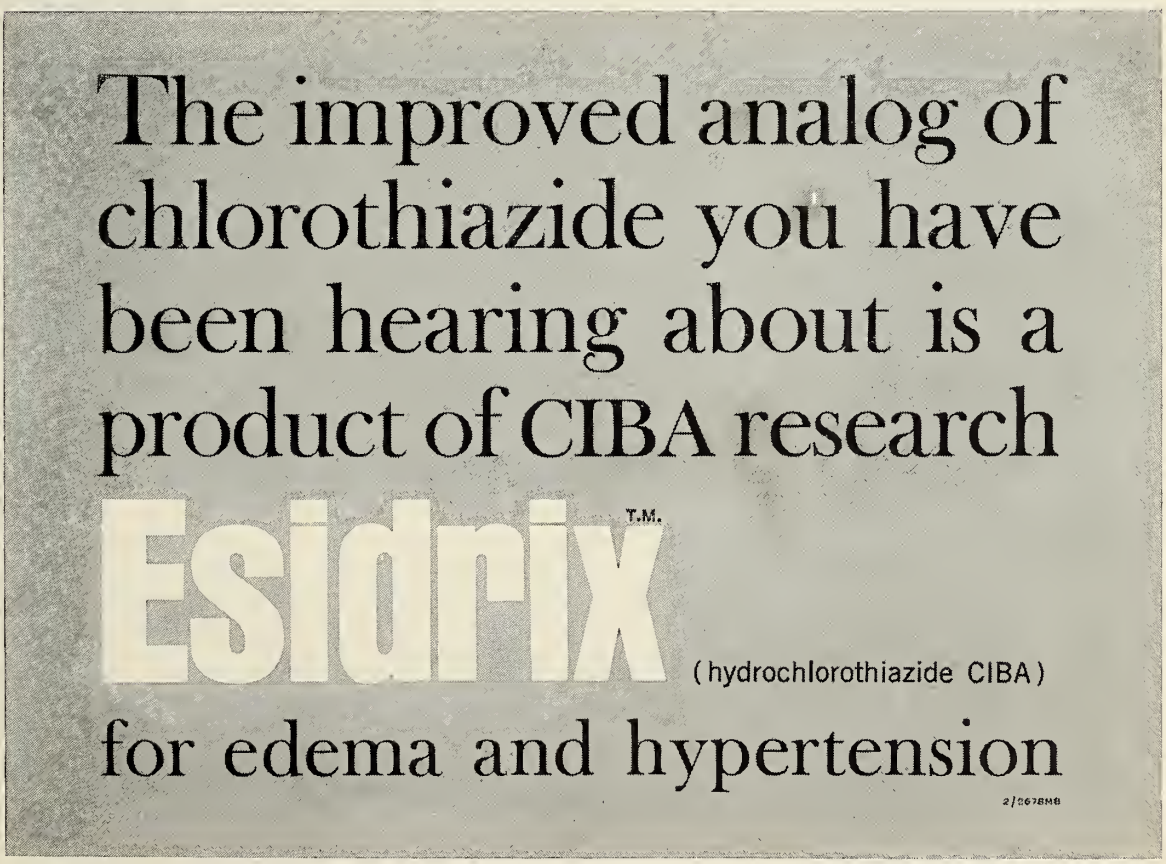
Freedom of choice is limited by the fact that the tax deduction or the sums withheld to support these "fringe benefit" or "service" programs eliminates, in most cases, the patient's financial ability to seek medical care from other than "third party" physicians. The "third party" taxes all of the group but does not pay benefits if the individual desires to secure services from a physician, who, for good and moral reasons, refuses to work for the "third party." These are usually the "best" physicians.

Under "third party" control, physicians are paid according to classification regardless of whether it is on a fee for services, per capita, panel, hourly or salary basis. All "third party" programs eventually utilize the principle of "fixed fees." The amount of the fee or type is totally unimportant, after all, the "third party" can change it at any time! The effects of fixing fees (even if they should be fixed at ten times the prevailing rates) are absolutely certain and always destructive.

Physicians who participate in such schemes must agree to render totally unknown and unpredictable quantities of service for a predetermined fee. The "taxpayer" is promised by politicians or "third party" officials that physicians will deliver any and all services for a fee set by the "third party." In the final analysis the "third party" always establishes the fee to *its* satisfaction! This procedure inevitably and obviously places the emphasis on the quantity of medical care and relegates quality to a position of secondary importance.

"Third party" medical programs in an attempt to economize, eventually limit and control the type of drugs which may be used—regardless of merit. Types of "permissible" surgical procedures are likewise classified and controlled. In this manner, the "third party" actually places its "judgment," through regulation and edict, above that of the physician.

We must evaluate the "third party" programs in their full extension. If we accept the idea



Third Party

Continued

that the "third party" is better qualified to choose the individual's physician than is the individual, as some of them bluntly claim to be, then we must admit that the "third party" may, with equal validity, claim to be better qualified to choose the individual's attorney, his minister, the teachers for the schools, municipal, county, state, and national officials. In fact, they could just as well and quite as correctly claim to be better qualified to control every activity of the "average" citizen.

"Third Party" Control

Make no mistake about one fact. Those in charge of "third party" programs are, in the final analysis, authoritarians and many of them would not hesitate to accept the role of dictator over our profession and every other group! If we accept "third party" control in medical practice we must in principle be prepared to accept the authoritarian philosophy in every area.

"Third party" programs force the physician to accept a position which is definitely unethical as all "third party" programs require that the public be informed of "participating physicians" through the publication of lists which are sent to the patients and made public and posted in such places as post offices and other public buildings, union offices, etc. This constitutes a definite "black listing" of those physicians who refuse to become "third party" employes. This results in promotion of those listed and in the obvious damage of those not listed. Frequently rumors are circulated implying that "failure to participate" is identical with some inadequacy or "excessive charges" thus constituting a force which threatens the non-participating physicians' reputations.

The deliberate purposive restriction of the patient's freedom of choice in the selection of his physician, to whom he will entrust his health and life, damages the moral fiber of the profession.

There is a serious moral question involved in accepting a position in which a "third party," non-professional and *not bound by ethical consideration* is accepted as a normal part of the doctor-patient relationship.

Moral and Ethical Concepts

All the laws in the world cannot make a person ethical! The ethics of medicine are based upon and require a deep appreciation of, and sincere respect, for morals and their attendant responsibilities. These qualities cannot be legislated. Ethics is something totally foreign to and not required of the bureaucrats and other functionaries who become the "third party" operatives.

Highest quality medical care cannot exist if the traditional moral and ethical concepts of medical practice are violated. The key to good diagnosis, is good, honest and complete history. The knowledge that information confided to the physician will not be divulged to others permits even the most timid patient to give the most personal, intimate and confidential information to his physician. Consultants are frequently denied this same information which is freely given to the patient's "own" doctor.

For thousands of years physicians have fought for the right to hold inviolate from all probers and other curious individuals facts elicited in the medical history and examination. These rights of privileged communication, granted and enforced by courts of justice, are essential for

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successful treatment. Any system in which "third party" probers may demand and secure any of this information automatically precludes its attainment.

The practice of "third party" medicine produces a situation in which dishonesty is accepted. When a "third party" enters the picture, considerable latitude is extended to fact, and many facts are avoided or ignored by both patient and physician.

The "third party" forces additional dishonesty upon the relationship since it is dishonest to forcibly divorce a service from its proper frame of reference, thereby disguising its true comparative value.

For a "third party" to set a price on a professional service, based on the technical procedure demanded by the service, is to prostitute the idea of responsibility entirely, or, in effect, to denounce as non-existent any convertible value of the moral and personal responsibilities assumed and discharged.

It would be more realistic to attempt to place a price on the order of personal responsibility accepted and to disregard the mechanics, but "third parties" do not deal in human attributes. Giving simple medication under certain circumstances entails assumption of responsibility as great as the performance of certain major surgical procedures.

Standardized Illness

Every "third party" medical program is dishonest because through classifications, fixed fees, and regulations, it indicates to all that illness can be standardized! This position is false because it ignores such individual variations as diagnostic requirements, time, complications, circumstances of treatment, response to treatment, severity of the disease and reactions, as well as many other factors. All medical teaching, tradition and experience repudiates this idea.

"Third party" medical programs are dishonest because they indicate that doctors of certain classifications can be standardized, and imply that all of these doctors are equal in training, knowledge, personality, judgment, technics, ability, results and all personal care of the patient. It implies to the patient that one doctor is no better than the next and that the patient is inadequate in determining which physician pro-

Continued to 558

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The New Patient *(no previous antidiabetic therapy)*

1. Initial daily dose 500 mg. (2 tablets of 250 mg. each) with breakfast.

2. In elderly patients, initial dose 250 mg. (1 tablet) daily.

3. CONTROL PERIOD

(a) If blood sugar reaches normal levels after three to seven days, or if glycosuria disappears, lower daily dose of 500 mg. to a level between 250 mg. (1 tablet) and 375 mg. (1½ tablets of 250 mg.) with breakfast daily. In elderly patients, dosage may be reduced to as low as 100 mg.

(b) If hyperglycemia or glycosuria persists or develops, increase the daily dose from 500 mg. to 625 mg. (2½ tablets of 250 mg.) with breakfast daily. In elderly patients, dosage should be increased from 250 mg. according to patient response.

(c) Continue weekly adjustments during first month of therapy until maintenance dose has been established. Adjustments below 250 mg. daily are best made in steps of 100 mg. (one 100 mg. tablet). The maintenance dose may occasionally be as low as 100 mg. (one 100 mg. tablet daily) or, rarely, as high as 1.0 Gm. (four 250 mg. tablets) daily. Do not exceed daily dose of 1.0 Gm.

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Third Party

Continued from 555

vides him with the best care and produces the best results for the patient. This damages the patient's confidence in his physician.

"Third party" medical programs promote the false claim that physicians are "tradesmen" peddling a "service" which is not worthy of individual evaluation.

"Third party" medical programs inevitably result in the falsification of records. An ethical physician cannot agree to any scheme, a factor of which is the promise to divulge the patient's history, derived from them under the implicit (legally explicit?) promise of confidence inviolate. Such a practice is so eminently and openly dishonest as to brook no discussion. The physician must agree to give any information about the patient to a lay person who is bound by no code of ethics. The records of the patient's history and the results of examination become available to and part of the records of a non-privileged lay organization.

Relinquishing Responsibility

Under any system of "third party" medical programs the patient must accept the "third party" into the patient-physician relationship in every area, not in the area of fees alone.

The physician is required to accept the "third party" by reporting or certifying illness to someone other than the patient himself. This begins the deterioration of and destruction of the confidential nature of the patient-physician relationship.



"I lost my rifle in the struggle, but luckily I had my doctor's bag!"

The patient feels justified in relinquishing his responsibility in return for the "third party's" payment of fees. The physician also begins to look to the "third party" in this area of responsibility and justifies his attitude by the requirement of supplying the "third party" with information. The physician even begins to hold the "third party" responsible for what he regards as the "proper" use of the funds removed from the patient not infrequently by force, by dues, royalties, taxes or other means.

These practices encourage the patient to divorce himself from his sense of personal responsibility to his physician in the area of fees. This divorcement of responsibility of the patient to discharge his financial obligations to his physician is one of the first and most important steps in the destruction of the patient-physician relationship. It encourages the patient to believe that someone else may be made responsible for his financial obligations in all areas. Having accepted the idea that someone else may rightly assume his responsibility, it becomes a matter of indifference to the patient, and eventually to the physician, who assumes this responsibility.

Concrete evidence of the deterioration and the destruction of the patient's sense of responsibility and of his desire to be relieved of all responsibility is found in the growth of the idea that persons should be able to secure "insurance," regardless of source, which covers their obligations and responsibilities "in full."

Flight from Responsibility

At the point where the physician accepts such an agreement he joins his patient in flight from personal responsibility and accepts the idea that a "third party" is responsibile for the payment of the patient's bills, and in so doing, grants to the "third party" the right to establish his fees and the category in which he may function.

The attempt to establish "third party" medical programs is a definite attempt to destroy the market economy.

Any argument in favor of "third party" medical programs may be used, by changing a few words, with equal validity to promote "third party" control of every other profession; every

other need and desire; in short, of every segment of the economy.

A different but related approach to control of the practice of medicine through this same system has received the support of some physicians. Some physicians are supporting, unwittingly(?), the inclusion of doctors in the Social Security System. They apparently do not know or do not care that Social Security retirement funds and Social Security (Government) medical care are parts of one program. They cannot support Social Security benefits for doctors without, in principle, supporting Social Security medical benefits for all. The inconsistency of those who claim to be against government (Socialized-Communized) medical care but for government retirement benefits requires mental gymnastics of which few knowledgeable physicians are capable. However such gymnastics are no greater than those required of physicians who believe quality medical care can be maintained under any "third party" program.

In the market economy, the physician must be free to state his own true estimate of the value of his services. The patient must be free to accept this value, persuade the physician to change it, or seek the services of someone else. Whenever this arrangement is eliminated the free market is destroyed in that area and is weakened in every other area. All care of the patient, all treatment, even the fees, must constitute part of an agreement acceptable to both patient and physician. Even though fees for similar services are ordinarily approximately the same, the important feature of the market economy in this area is that they constitute an agreement between the individual physician and his individual patient.

The socialization of this nation and Government control of the practice of medicine can not be accomplished if individual responsibility is realized and accepted. Ethical physicians, of all people, should insist upon retaining individual responsibility in every area.

Only Physicians can Supply Medical Care

Those who would destroy all freedom have chosen the field of medicine as a prime objective because of the enormous emotional appeal and the almost universal experience of need or desire in this area. Few fail to become emotional in one way or another when illness is present. Every

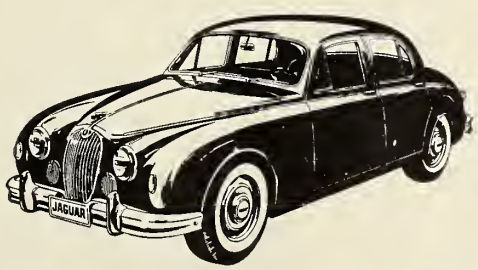
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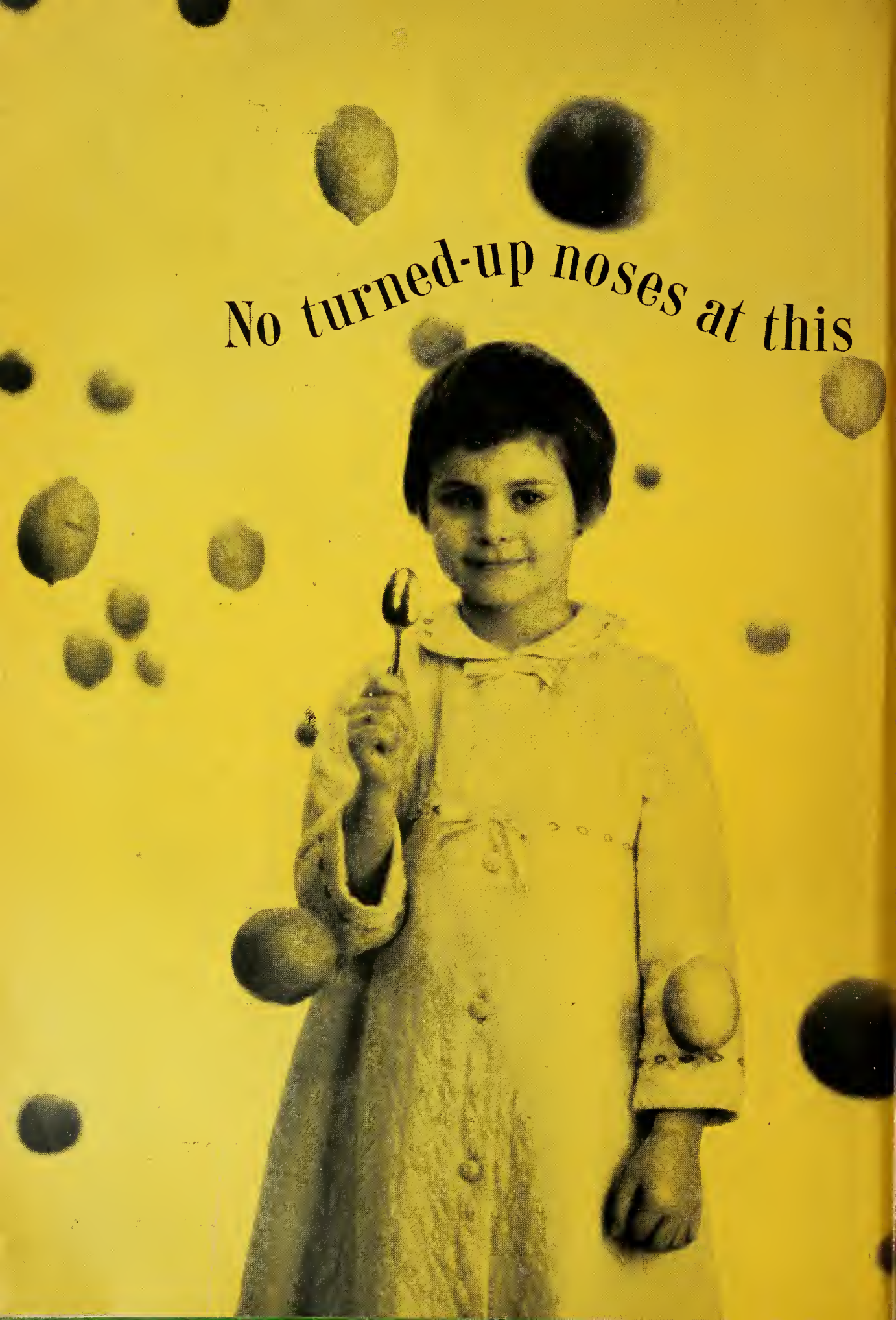
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Third Party

Continued from 558

person needs and desires, at some time, the care or attention of a physician.

Most people want to be well. The physician is their hope of remaining well or of regaining health should illness be present. Illness, regardless of type, is usually associated with discomfort, inconvenience, or at least a variable amount of displeasure.

Illness is one item with which few are prepared to cope. Most necessities can be secured through various agencies in reasonable time; however, *only human beings, trained and experienced in the healing arts, can supply the necessary judgment to render satisfactory care to those who are ill. No government, or other "third party" agency, can supply medical care.* It has to be provided by living, acting, individual human beings.

In view of the importance of confidence, trust, responsibility, and reliance, we must admit that he who controls those who are to administer to the individual when he is ill or when his emotions in regard to illness in himself or another are involved, is in a position to control the individual.

If the medical profession can be controlled by a "third party" all others will succumb. If the medical profession cannot be controlled it will remain an island of freedom which will cause a resurgence of the love of freedom in every other group. The intimate, personal and confidential nature of the patient-physician relationship must be destroyed before the collectivists can achieve their goal.

I am completely disgusted with medical apologists. Our profession has no reason to apologize. Under our system of private practice, we have delivered the greatest quantity and highest quality of medical care the people of any large nation have ever known, and all this at extremely low costs. Why anyone should apologize for this, I cannot see.

It is totally inconsistent to see the men who achieved such high standards fearfully retreating before the onslaught of those few who would destroy the private practice of medicine and change our free economy to one of socialistic control. To placate these forces of evil is below the dignity and intelligence of the profession and is so degrading that every ethical physician should refuse to participate in those destructive schemes.

The "third party" is any individual, organization, group or political unit—any entity which in any way violates the absolutely personal patient-physician relationship.

Every statement which has been made applies with equal force and validity to all governmental units, every labor union plan, and all insurance programs. It applies equally to private, profit-making, tax paying insurance companies as well as so-called "not for profit" mutual companies! Unpleasant as it may be, the facts must be applied in evaluating even the so-called "Doctors Plan"—for control is control, regardless of who exercises it!

Unfortunately, a group of doctors can be just as arbitrary, dictatorial, and vicious as can a group of local, state or federal bureaucrats or labor officials. Evaluate all of these groups and plans by the same measure—and let your unemotional judgment decide. The result is the same—the destruction of the private practice of medicine!

Remember one thing: *Only doctors can deliver medical services. Only individuals trained and experienced in the healing arts can fill the medical needs of the people of this nation.* There is no reason why we, as individuals or as a profession, should not state, in fact we are morally obligated to state, the circumstances under which our services will be delivered.

Our Obligation

Our obligation and responsibility is to the individual patient. All agreements must be with each individual patient!

We must re-examine the moral responsibility of our profession, close ranks, and as one man say "NO" and mean it—to every program which violates the basic moral responsibility of our profession and is inimical to the best interest and care of each patient.

We should never refuse to deliver services to our patients but those services should be delivered to individuals as our own private patients, not as wards of the government, a union, any insurance company or any other "third party." This is an appeal to every ethical physician for just that type of action.



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References:

1. Alexander, L.: J.A.M.A. 166:1019, March 1, 1958.
2. Current personal communications; in the files of Wallace Laboratories.
3. Pennington, V.M.: Am. J. Psychiat. 115:250, Sept. 1958.

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'How Hospitals Are Used Today'

Prepared as background material for a study to be conducted for the Health Information Foundation by the National Opinion Research Center of the University of Chicago.

THE LAST TWO decades have witnessed major changes in the patterns of hospital utilization. Almost two-thirds of the population now have some protection against hospital costs through Blue Cross plans or private insurance contracts. In 1940, fewer than 10% had such protection. During the same period, the admission rate to general hospitals has more than doubled. Coincidentally, with the development of more effective medicines and the trend toward early ambulation, there has been a sharp reduction in the average length of hospital stay.

But in spite of a shorter average length of stay, both the cost per patient and the cost per day have approximately doubled in little more than 10 years. As a result of these sharply rising hospital costs, and of the steadily mounting admission rate, hospital insurance has had no recourse but to raise subscriber premiums. There is thus presently much concern that voluntary health insurance must soon "price itself out of the market."

'Overuse' and 'Abuse'

Allegations have been made that "overuse" or "abuse" of hospital insurance by both patients and doctors has in itself contributed substantially to the rising costs which now so bedevil the insurance plans. It is argued that many patients who do not really require hospitalization are nevertheless placed in hospitals, or their stay is extended, purely for their own convenience or that of the doctor, because the hospital charges are covered by insurance. It is said that doctors often hospitalize insured patients for diagnostic tests which could be performed just as well outside of a hospital, but the truth is that facts are not known.

In consequence, a number of research efforts have been and are being made to ascertain the degree of overuse of hospital facilities. In one study a sample of hospital case records was transcribed and presented to a panel of eminent physicians for evaluation. Another research team is collecting pairs of cases hospitalized by the same physician for the same condition, but who differ substantially in the length of their hospital stay—and is then asking the doctor to account for the difference.

Perhaps the most ambitious attempt is currently getting under way in Michigan, where medical criteria for hospital admission and discharge for selected major diagnoses have been agreed upon by panels of physician-specialists. It is next planned to sample hospital records to ascertain the proportion of admissions and discharges which failed to meet these criteria, and then to interview the physicians concerned with these deviant cases in an effort to understand the factors.

What is Proper Use?

But aside from such problems as size and representativeness of the samples, the competence of small panels of doctors to speak for the total medical profession and the difficulty of judging otherwise unknown cases solely from clinical records, the value of all of these approaches is sharply limited by a lack of consensus as to just what constitutes "overuse" of hospital facilities. Even if it were found that large numbers of hospitalizations fail to meet the medical criteria, and that the attending physicians were often guided by non-medical considerations, the question remains: Is this a proper or improper use of hospital facilities?

It is generally conceded that the overwhelming majority of hospital admissions are required for legitimate medical reasons, and it is equally conceded that there will inevitably be occasional in-



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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

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Third Party

Continued

stances of flagrant abuse of insurance. But between these extremes, there is a large area in which individual judgment must necessarily play a part. In deciding whether or not to hospitalize a patient at a particular time, the physician's decision will very often be affected not only by the medical circumstances of the case, but also by a host of personal and social factors.

Among these are the doctor's own habits, beliefs, experiences and predispositions; the quality and accessibility of hospital facilities or of alternative facilities outside the hospital; the patient's own attitudes toward hospitalization, his home and job situation, his ability to meet hospital costs, etc. The same non-medical factors will also, in many cases, affect or even determine the patient's length of stay and the date of his discharge.

A 'Life-saving' Institution?

The extent to which hospitals are considered to be "overused" or insurance benefits to be "abused" ultimately depends, therefore, upon one's definition of the *role and function of the hospital.* If, at one extreme, the hospital is regarded as a "life-saving" institution, to be employed only when other alternatives have failed, one is likely to find today a great deal of "overuse." If, on the other hand, the hospital is regarded as a community facility to be utilized whenever its services can help provide better medical care than could be obtained outside, the amount of "overuse" one finds is likely to decline very sharply.

Before there can be any meaningful measure of the amount of *"overuse"* of hospitals, much better and fuller information is required concerning the ways in which hospitals are actually *used* today and the needs which they serve. It is evident that, for a variety of reasons, the hospital today plays a different role from the one it played 20 years ago. Public attitudes toward hospitalization have changed; physicians' attitudes and practices with respect to hospitalization have similarly undergone changes; and hospitals themselves are in constant evolution.

At present, we know very little about the extent to which non-medical considerations actually affect hospital admission and discharge. What is needed is to examine a representative group of hospital cases, and to *reconstruct the chain of events and decisions which led to their admission and discharge.* Such an approach requires interviews not only with the attending physicians, but also with patients themselves.

A study of this type is proposed. It would be primarily *descriptive* rather than evaluative. It would aim to supply the insistent need for information on the present role and function of the hospital and for systematic data on the factors affecting hospitalization decisions. It would not attempt to define the amount of "overuse" nor to set standards for hospital utilization. But the facts it discloses should improve and sharpen present concepts of what a hospital is for.

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Faith Healing and Healing Faith

A sermon preached by
the REV. D. RICHARD WOLFE*
July 27, 1958

HALFORD LUCCOCK, better known to readers of the *Christian Century* as Simeon Stylites, in his book, *Marching Off the Map,* describes the medical treatment of the King of England about the middle of the 17th century. The account reads like this: "One pint of blood was drawn from the left arm of the King, and a half-pint of blood was drawn from the right arm of the King." The account concludes with the words, ". . . and the King died" to which Luccock adds, ". . . of course he died, what else could he do after that treatment except die!"

Medical science has made tremendous strides since the days of blood-letting and has, as Luccock suggests, marched completely off the map. But another significant development, at least in the realm of medicine, is that the map is continually getting larger and the scope of the problem of healing increases with each passing day. We are confronted with diseases and physical conditions which, so far as we know, were completely non-existent in the middle of the 17th century, so that we cannot speak of victory in the struggle against disease, but only of advance. There are still millions of people suffering from various maladies for whom there is no medical cure, and like the King, they too die. For them there is neither promise nor hope.

In many hopeless cases, hopelessness gives rise to desperation; and drowning men do clutch at straws. Faith healing is one such straw, which, if we may believe the reports, many are clutching today in desperation. If you have any doubt concerning the reliability of the reports, you have only to turn on the television set at 4:00 this afternoon, and there you will see for yourself the parade of hopelessly ill, the incurables, who in their desperation, have come to be healed through prayer and faith.

One of the most frequently asked questions asked today is "What do you think of Oral Roberts?" Or Katherine Kuhlman? Or any of the other healers who are at work in the world? And many who ask the question are either hopelessly and incurably ill or know someone very close to them who is so afflicted. Now what I may think about Oral Roberts or Katherine Kuhlman or any of the rest really doesn't matter because mine is the opinion of only one man. But these questions pose some very serious problems both for the church and the medical profession since the "healers" are challenging both the church and the doctor of medicine. On the other hand, it is suggested that if the church were more faithful to its mission, it could heal the diseases of many; and on the other hand, there is at least the inference that the practice of medicine and those who receive its ministrations are totally lacking in true faith. The implication being that if everyone had true faith, we would have no need of doctor, medicine or hospital.

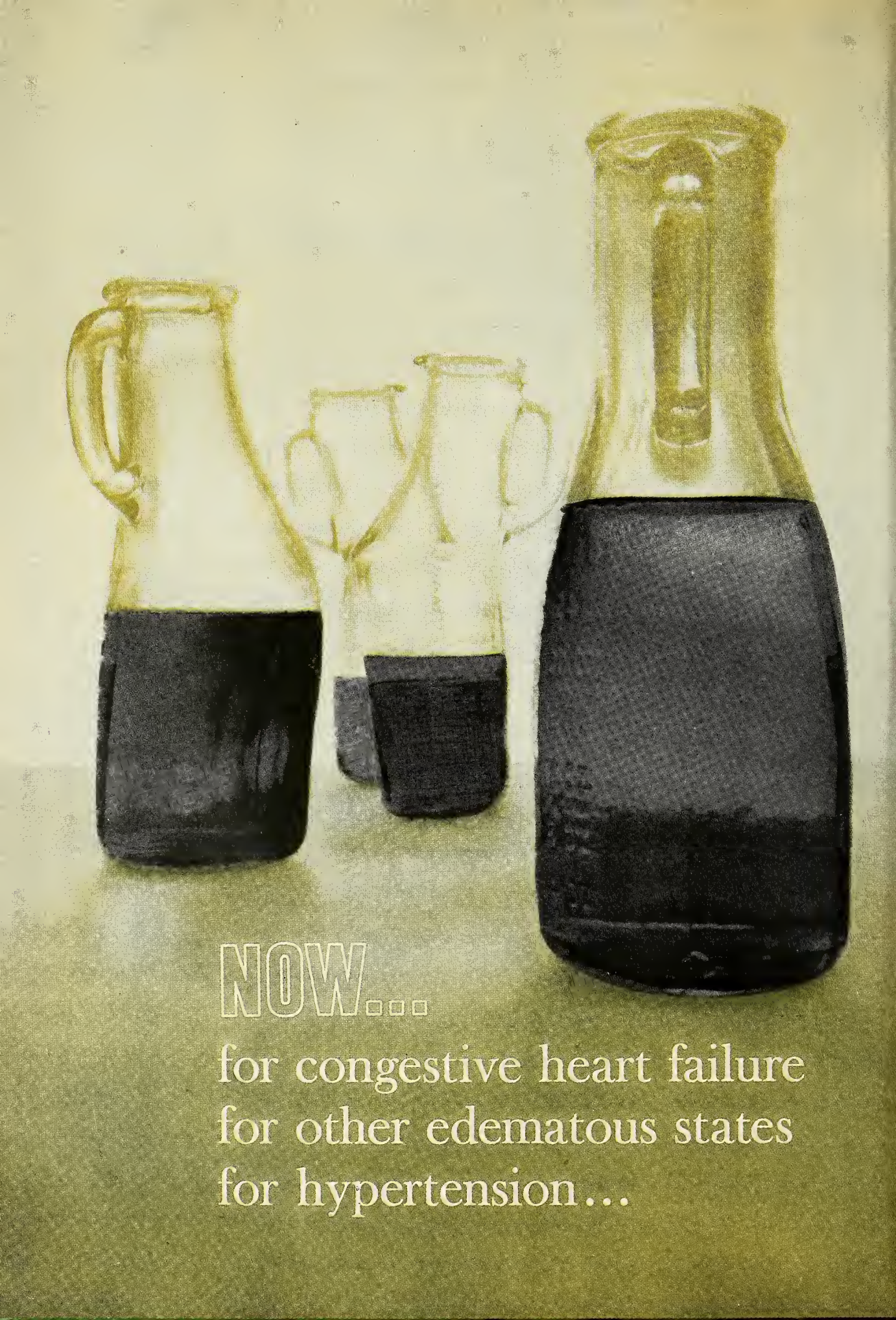
Since this problem is very closely related to the Christian faith, it is very important to know just what our faith teaches in regards to faith healing and its place in the lives of the faithful.

Faith Healing Not New

Before we confront the problems involved and seek answers to these vital questions, there are 2 or 3 basic facts to be noted which have a direct bearing upon the issues involved. (1) The first thing we ought to note is that the problem of faith healing or attempts at faith healing is not

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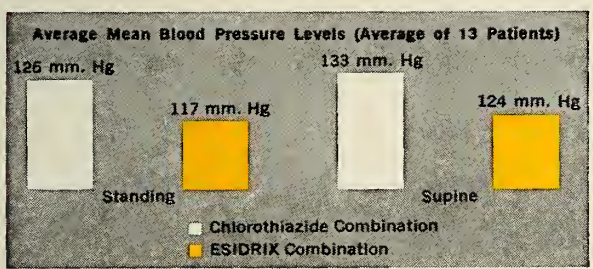
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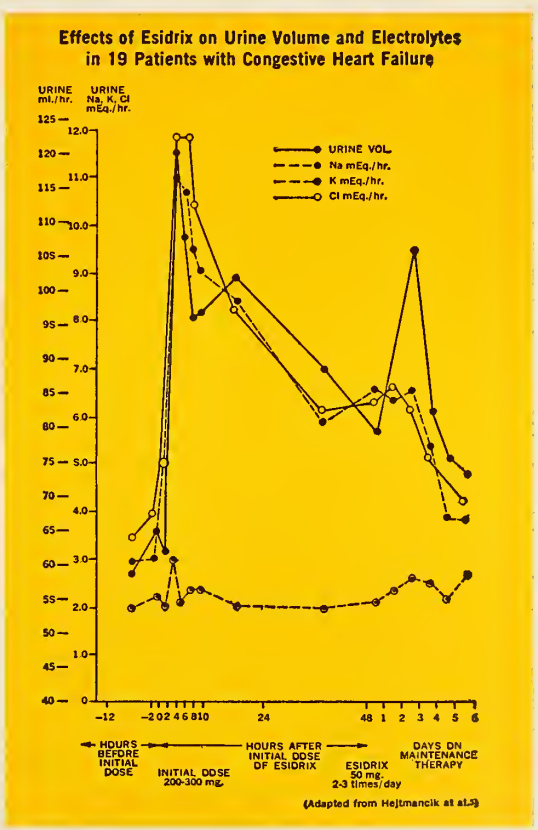
(hydrochlorothiazide CIBA)

Produces greater average reduction in blood pressure: Eleven of 13 hypertensive patients[4] were treated initially with a chlorothiazide-mecamylamine-reserpine combination (10 patients had 1000 mg. and 1 patient 500 mg. chlorothiazide daily); 1 patient had been treated with hydralazine and 1 had no previous medication. Nine were then transferred to an Esidrix-mecamylamine-reserpine combination and 4 to an Esidrix-reserpine combination for periods of 3 to 7 weeks (12 patients had 100 mg. and 1 patient 50 mg. Esidrix daily). Average mean blood pressure levels were recorded in the standing and supine positions. As shown in graph below, left, there was a further drop in blood pressure after patients were transferred to Esidrix.



(Adapted from Dennis[4])

Exceptional safety . . . reduced likelihood of electrolyte imbalance: While Esidrix markedly increases sodium and chloride excretion, it has far less effect on excretion of potassium (see chart at right) and bicarbonate. Hence, there is little likelihood of disturbing electrolyte balance when recommended procedures are followed.



DOSAGE: Esidrix is administered orally in an average dose of 75 to 100 mg. daily, with a range of 25 to 200 mg. A single dose may be given in the morning or tablets may be administered 2 or 3 times a day.

SUPPLIED: *Tablets,* 25 mg. (pink, scored); bottles of 100 and 1000. *Tablets,* 50 mg. (yellow, scored); bottles of 100 and 1000.

Faith Healing

Continued from 567

a new problem common to the midpoint of the 20th century. The folklore of the human race is replete with stories of seemingly supernatural and miraculous intervention in the physical lives of men. Even the most cursory glance at the Old Testament will bring us face to face with such stories as the healing of Naaman or the extention for 15 years of the life of King Hezekiah. And it should also be noted in this connection that until recent times the practice of religion and the practice of medicine were both the domain of the religious leaders of the community. These included the priest and prophet in ancient Judea, and the soothsayers in the other less familiar civilizations.

It should also be noted that the vast majority of the hospitals now in existence throughout the world were first founded and maintained by some branch of the Christian church. The church has never been opposed to healing; quite the opposite, the church has been in the foreground in the battle to save men's lives.

(2) The problem of faith healing is not at all peculiar to the Christian faith. Even as among the Christians, there are among the Mohammedans, the Buddhists and nearly every other religious group, men and women who, working outside the normal limits of the religious community, proclaim healing and practice their own interpretation of faith and prayer. And it is also worthy of note to remember that the official position of these non-Christian religious groups is approximately the same as that of the Christian church.

And we must also remember that the practice of faith healing is not limited to those of religious convictions or motivations. There are many outside the pale of any religious group or organization who practice various types of healing with no reference to God or His power. This fact we will meet again as we seek to evaluate the faith healing movement as a whole.

(3) And perhaps the most important fact which we many times tend to forget is that most sick people get well without ever visiting a faith healer, and many get well without ever going to a doctor. So actually the only valid consideration we have are those who are healed or purported to be healed who were originally diagnosed as incurabe and hopeless by the medical profession.

What About These 'Healers'?

With these three basic facts before, let us now ask ourselves the question: What about these "healers" and what about their claims? Here, it seems to me, we must be as objective as possible, in spite of what we may think or what we would like to think regarding the practice of faith healing. The temptation, of course, is to jump to a hasty conclusion and let this be our considered opinion. Having declared our intention to be objective, we are immediately confronted with a very serious problem:

It is exceedingly difficult to be objective about this problem for two reasons: (1) very few objective studies have ever been made or can be made. Objectivity means a thorough medical examination of these people before they visit the healer and follow up examinations after they have been healed. But when we remember that these people come from all over the country, and in many cases, all over the world, it is very difficult to follow them up individually, even if it were possible. (2) The second difficulty is that very few, if any, of the faith healers will allow medical doctors to examine these people before they are "healed." Their argument is that this questions their sincerity and somehow takes away from the faith of those about to be healed. So that the best we can do is to follow through on some and seek to discover what happened to them after they visited the faith healer and were declared cured.

There are two rather complex studies of this kind which I would like to quote in some little detail. The first was an investigation following a healing mission of C. S. Price in Vancouver, British Columbia. This investigation is reported by A. C. Gaebelein on pages 88 and 89 in *The Healing Question*. The investigating committee consisted of 11 ministers of various denominations, 8 well-known Christian physicians, 3 university professors and a lawyer. They took months for the most painstaking investigation. Briefly stated, this is their finding: 350 persons, who professed to have been healed, were checked and double-checked. Of these, there was absolutely no physical change in symptoms or conditions in 301 cases. Thirty-nine died within 6 months following the healing mission. Five became insane. And 5 others, suffering from various nervous diseases, apparently had been cured.

Continued



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Faith Healing

Continued

In another similar investigation, reported by C. R. Brown on page 36 in his book, "Faith and Health," of 100 cases in which serious maladies were reported to have been cured, two-thirds or about 66 of these persons died in less than 2 years of the malady from which they were "cured."

The findings of these two investigations can be repeated over and over again.

It is a proven fact that all faith healers, without exception, Christian and non-Christian, religious and non-religious, have a very high percentage of failures and these failures form a pathetic array when we learn the full story. The healers, by and large, blame lack of faith for their failures, suggesting that they can only operate with those who have sufficient faith to be healed.

Pittsburgh Fraud

By the same token there are numerous evidences of fraud sometimes perpetrated by the healer and at other times by those who claim to be healed. In one very carefully documented and sworn case in the city of Pittsburgh, at least one person was paid to give testimony to having been healed when the fact was the person had never been sick at all. This in itself is not sufficient evidence for us to consider all faith healers frauds, but is certainly sufficient evidence to put us on our guard against their claims.

One of the most revealing aspects of this whole problem of faith healing lies in the realm of percentages, and this is directly related to the previous reference made to the religious and the non-religious faith healer. On the basis of all available evidence, the percentage of failures and the percentage of cures is exactly the same with the religious faith healer and the non-religious faith healer. Now again let me hasten to add that this is not sufficient for us to draw an inviolable conclusion, but is interesting to note that those who claim to have a special gift from God are no more successful than those who make no reference to God whatsoever. And while this does not answer the question whether they heal or do not heal, it seems to suggest that if healing occurs, it does not occur because they had a special blessing from God. Else, how do we explain the fact that those who make no pretense of seeking help from God produce identical results?

One of the greatest dangers at this point is that we may take what evidence we have accumulated and jump to the conclusion that there are no significant results achieved by the faith healers and so preclude that healing which is beyond our understanding does not occur. This we have no right to declare. There are many instances in which people have responded beyond any reasonable expectation for which there is no emperical answer. So we must be very careful that we do not say "Cures do not occur," for cures may very well occur without any aid from human agencies.

We are still faced with the fact that there are numerous references in the New Testament to healings performed by Jesus, his Apostles and leaders in the early Christian church, and these are not too different from those described by many of the faith healers of today. On several occasions Jesus instructed his closest Apostles in the art of healing and sent them forth to do just that. These accounts are part of the tradition of the Christian church, and even today, the Christian church still teaches and practices a healing faith, that in many respects resembles that proclaimed by the faith healers, but in certain specifics contradicts the practice of faith healing. So what we really have here is a problem not of practice but of theology.

The church does teach the efficacy of prayer and the power of faith, but never as ends in themselves. Health is not the only product of faith and prayer. It is in fact one of the lesser products. There are recorded instances in the New Testament where faith and prayer did not relieve human suffering or cure human disease. Two very outstanding examples are the cases of the Apostle Paul and the young preacher Timothy.

Malady Not Cured

Paul, himself, writes that he besought or prayed to God three times that his affliction might be removed. His affliction was not removed, his malady was not cured. He received rather the assurance from God that "My grace is sufficient."

And Timothy, writing to Paul, makes reference to what appears to be a stomach ailment, and Paul instructs him not to pray, but to take

a little wine for his stomach's sake. Whatever share in the healing power of faith, it is doubtful the reasons were that Paul and Timothy did not that we can ascribe this to lack of faith on their part.

The basic differences between the position of the Christian church and the position of the faith healers lies in both principles and predicates or what has been referred to previously as a question of theology. Faith healing seems to asume that perfect health is the will of God for all people and the only condition required for enjoying perfect health is to have sufficient faith. Now on the surface, this is both a desirable condition and a reasonable conclusion. But carried to its final and logical conclusion, if God wills perfect health for all people, and if lack of faith is the only deterent to perfect health, then God is capricious in dealing with his children, and in the final analysis is himself responsible for all illness and evil, since he has it within his power and has ordained it within his will to provide perfect health for all men. But a very careful examination of the New Testament reveals that God has not promised perfect health to all people, with or without perfect faith, but quite the opposite. In the twenty-first chapter of the Revelations the promise is made that sickness and pain and death and tears shall pass away. This is a very specific reference to the final coming of God's kingdom and his absolute reign upon earth. This book was addressed to believing Christians, who themselves were suffering untold hardships because of their faith. And the only promise they received is that when God establishes His kingdom, these things shall pass away.

It is a very serious and perhaps sinful thing to "try to arouse people's faith in a promise God never made." As followers of Christ we have a perennial obligation to reflect the compassion of God as best we are able with those who are afflicted. Jesus lays it upon each one of us to visit the sick, but he has not commanded us to heal them.

At this point we must be very careful that we do not deny the possibility that God can and does intervene in human affairs in ways that we do not know or understand. God may very well do just that. But God is not ours to command nor to direct. Whether God heals or not is not our problem. Our problem



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Faith Healing

Continued

is to communicate the love of God to those who are not healed as well as to those who are healed. For in true faith, we are truly persuaded that "neither death nor life, nor angels, nor principalities, nor powers, nor things present, nor things to come, nor height, nor depth, nor anything else in God's creation shall be able to separate us from the love of God which is Christ, Jesus, our Lord." As regards the process of healing, the blind do see today, the lame do walk, the sick are healed not by those who claim to have a special power from God, but in institutions of healing where, with the help of men and women who have given their whole lives to the knowledge and study of human affliction, they are able to restore those functions of life which disease has crippled, impaired or destroyed. While it may not be true that God works only through the practice of medicine, we may be sure that this ministry of healing bears the imprint of God upon it. And for those who may not or cannot yet be healed through the efforts of medicine, God's grace is still sufficient.

GIVE GENEROUSLY

TO A.M.E.F.



Photo Courtesy Indiana State Police

Safe Driving Habits:

Don't get careless on familiar roads!

(85% of all Hoosier accidents in 1957 were within 25 miles of drivers' homes!)

Abstracts:

OBSTETRICS AND GYNECOLOGY. 589 pages. By J. Robert Willson, M.D., Philadelphia, Pa.; Clayton T. Bechman, M.D., Philadelphia, Pa.; Isador Forman, M.D., Philadelphia, Pa.; Elsie Reid Carrington, M.D., Philadelphia, Pa.

C. V. Mosby Co., St. Louis, Mo.

A middle-of-the-road text on OB-Gyn covering all of the major aspects of the subject.

It is well written and easily understandable by the G.P. and student. A complete knowledge of the subjects presented could well be the envy of our OB-Gyn specialists.

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The plates relating to Breech delivery are clear and concise and the chapter by Dr. Willson on Analgesia and Anesthesia in itself is well worth the cost.

A well written and conceived volume in an important field.

W. L. Portteus, M.D.
Franklin

THE MANAGEMENT OF OBESITY

Cornell Conferences on Therapy: New York State J. of Med., Vol. 58:79-87, 1958.

This "Cornell Conference on Therapy" expresses thoughts about obesity sound enough to bear repeating and unorthodox enough to be stimulating, starting with the suggestion that some individuals may be better off obese than not.

From Dr. Albert Stunkard, "The current preoccupation with problems of overweight has long since passed beyond any reasonable concern with health benefits to assume the proportions of a national neurosis." "The results of treatment are pretty much the same regardless of the method used. There is growing evidence that the treatment of obese persons is not only fairly ineffectual but that under certain circumstances it is likely to be dangerous. In the Nutrition Clinic survey fully 50 per cent of the patients reported the presence of symptoms which they attributed to their dieting. The most common symptoms were, in this order, nervousness, anxiety, restlessness, weakness, and irritability. After my first experience with a patient who became psychotic while trying to reduce I decided to wait until the patient was exerting tremendous pressure for a reducing diet before I would prescribe it. The treatment of obesity is likely to become more successful the less the physician concerns himself with obesity and the more he concerns himself with the obese person and his problems in living. If all three of these criteria are favorable, that is, if the patient has lost weight before, if he feels well after starting the diet, and if he is not showing the night eating syndrome his chances of losing weight are pretty good. Life insurance company statistics do not conclusively prove that weight loss increases life expectancy."

Following is from the summary by Dr. Solomon Garb: "Most obese patients will not remain in treatment. Of those who do remain in treatment most will not lose significant poundage and of those who do lose weight most will regain it promptly. People who become fat on a high carbohydrate, low fat diet are much less prone to develop atherosclerotic and thrombotic complications than those on a high fat diet. Drugs designed to reduce appetite may seem effective at first but are generally unsuccessful in the long run."

Stephen L. Johnson, M.D.
Evansville

INFECTIOUS DISEASES OF CHILDREN. By Saul Krugman, M.D., New York, and Robert Ward, M.D., Los Angeles.

326 pages. Price $10.00. The C. V. Mosby Co., St. Louis, Mo.

This is a volume well suited for the G.P. and medical student, providing a course description of the common infectious diseases of children. Each subject is excellently covered as to Etiology, Pathology, Clinical Manifestations, Complications, Diagnosis, Epidemiology and Immunity, Treatment and control measures.

This volume adequately covers the major ills of children and is especially informative in the widening field of viral infections.

Surely a must for the progressive G.P.

W. L. Portteus, M.D.
Franklin

CONSIDERATIONS IN THE DIAGNOSIS OF HIRSUTISM

McPherson, Harry T.: N. Carolina Med. J., Vol. 19:68-72, 1958.

Hirsutism in the adult female is a fairly frequently encountered problem which may be either a sign of disease of the pituitary, ovary, or adrenal cortex, or far more commonly benign or "idiopathic." When hirsutism is associated with other signs of "virilism" the probability of endocrine disturbance is greatly increased. The author's working classification is an excellent one. His first group, which he terms iatrogenic, is made up of patients who have been given androgen for one reason or another. This may usually be determined by the history, and in these patients urinary steroid analyses were normal. Mention is made of the occasional occurrence of hirsutism as a side effect from dilantin.

The adrenal cortex may be responsible for hirsutism through either glucocorticoid or androgen hyper-secretion, the former leading to the picture of Cushing's syndrome, the latter to virilizing syndromes. Cushing's syndrome may be the result of either hyperplasia or secreting tumor of the adrenal cortex but at present time it is most commonly seen following administration of steroid hormones. The virilizing syndromes likewise may be on either a hyperplasia or neoplasia basis. The author's sum-

Indiana State Board of Health

DIVISION OF COMMUNICABLE DISEASE CONTROL

A. L. MARSHALL, JR., M.D., *Director*

MONTHLY REPORT – FEBRUARY, 1959

Disease	Feb. 1959	Jan. 1959	Dec. 1958	Feb. 1958	Feb. 1957
Animal Bites	189	331	227	56	118
Chickenpox	752	622	606	395	817
Conjunctivitis	53	71	61	26	54
Diphtheria	0	0	0	2	0
Dysentery, Unspecified	19	31	29	39	1
Impetigo	65	38	77	23	38
Infectious Hepatitis	49	32	56	33	39
Infectious Mononucleosis	21	22	12	2	5
Influenza	1011	730	616	1222	178
Measles (Rubeola-Rubella)	755	643	456	2064	1137
Meningitis, Meningococcal	2	2	5	8	2
Meningitis, Other	7	6	10	16	2
Mumps	227	246	127	458	251
Pertussis	137	186	61	36	39
Pneumonia	257	275	163	146	133
Poliomyelitis	0	0	8	0	2
Streptococcal Infections	1048	547	292	555	617
Tinea Capitis	45	13	21	31	35



provides therapeutic levels . . . for 24 hours . . .
with low incidence of sensitivity reactions . . .
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Sulfamethoxypyridazine Lederle
0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION
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AMERICAN CYANAMID COMPANY, Pearl River, New York

Abstracts

Continued

mary of the clinical pictures, steroid excretion patterns, and x-ray investigation of this group of patients is quite well done.

Another, though much rarer group of patients, have hirsutism based on ovarian disease with hyperplasia or neoplasia of certain specific cells or again more frequently with the so-called Stein-Leventhal syndrome. Very rarely the pituitary may be directly involved in hirsutism in the instance of basophil carcinoma or in acromegaly.

In the author's series of 76 patients, 25 fell into one or another of the above classifications, and the remaining 51 patients were considered idiopathic. No common clinical picture was seen in this larger group. There was some family history of hirsutism but hormone secretion studies implicated no endocrine glands. Therapy is not too satisfactory. Patients appearing to belong to the idiopathic group need reassurance as to the absence of serious disease. Some cosmetic advantage may be obtained by epilation, shaving, and bleaching of the hair. Treatment in this group with hormone has proven disappointing.

Stephen L. Johnson, M.D.
Evansville



running noses



and open stuffed noses orally

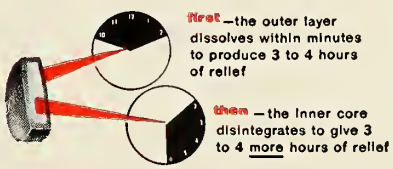
with TRIAMINIC, the oral nasal decongestant

- in nasal and paranasal congestion
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- in postnasal drip
- in allergic reactions of the upper respiratory tract

safer and more effective than topical medication

- reaches *all* respiratory membranes systemically
- avoids "nose drop addiction"
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- provides longer-lasting relief

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



Each* TRIAMINIC *Tablet provides:

Phenylpropanolamine HCl . . . 50 mg.
Pheniramine maleate 25 mg.
Pyrilamine maleate 25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

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Also available: For the occasional patient who requires only half dosage: timed-release TRIAMINIC JUVELETS. Each Juvelet is equivalent to ½ of a Triaminic Tablet.

For those patients who prefer liquid medication: TRIAMINIC SYRUP. Each 5 ml. tsp. of this palatable syrup is equivalent to ¼ of a Triaminic Tablet.

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NEWS NOTES—from State and Nation

Youth Atom Conference Instituted This Year

An initial national Youth Conference on the Atom has been planned for April 30 and May 1 in Atlantic City. Purpose of the conference is to present an authoritative picture of the peaceful atom in all its various applications to the nation's most able high school science students and teachers.

Another, and probably more important purpose of the conference, is to help advance interest in the study of science among the nation's youth.

More than 500 students and teachers will participate, representing winners of local science fairs, special written examinations and, in other ways, top science students of America.

Distinguished leaders in the field of atomic energy participating in the program include John A. McCone, chairman of the Atomic Energy Commission, and Dr. John Laughlin, chief, division of physics, Sloan-Kettering Institute for Cancer Research. The latter will speak on the role of the atom in medicine.

While this project is the result of many cooperating organizations, the idea for such a conference was instituted by the electric utility industry and the conference is being sponsored by approximately 60 investor-owned electric companies.

Indiana Surgeons Hold Regents' Meeting

The Indiana Division of the United States Section, International College of Surgeons, will hold its Annual Regents' meeting at Indiana University Medical Center, Indianapolis, May 6, 8:55 a.m. to 4:30 p.m.

A full day of scientific papers by prominent physicians and surgeons has been planned. No Registration Fee.

There will be a social period at 7 p.m. followed by a banquet at the Sheraton-Lincoln Hotel with a talk on "Sputniks, Space, and You" by Robert J. Kryter, consulting engineer. All surgeons, medical practitioners and their ladies and guests are invited to attend.

Simon Reisler, M.D., 318 Bankers Trust Building, Indianapolis, treasurer of the organization, may be contacted for further information.

Otolaryngology Courses Announced

An Annual Otolaryngologic Assembly will be conducted September 18-26 by the Department of Otolaryngology, University of Illinois College of Medicine, as one of two special postgraduate courses to be offered this fall.

It will consist of a series of lectures and panels concerning advancements in otolaryngology. Some sessions will be devoted to surgical anatomy of head and neck and histopathology of ear, nose and throat. Guest lecturers will participate in an entire day's program reviewing the latest advances and principles of temporal bone surgery.

Chairmen of the Assembly are Maurice F. Snitman, M.D., and Emanuel M. Skolnik, M.D.

A course in laryngology and bronchoesophagology, under chairmanship of Paul H. Holinger, M.D., is scheduled November 9-21.

Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk St., Chicago 12.

Chest Physicians to Meet

The American College of Chest Physicians will hold its Silver Anniversary meeting at the Ambassador Hotel, Atlantic City, June 3-7, 1959. The scientific program will include prominent speakers on all aspects of heart and lung diseases. In addition to formal presentations, there will be a number of symposia, round table luncheon discussions, postgraduate seminars and motion pictures.

Fireside Conferences, inaugurated in 1955, will feature more than 60 experts in chest disease leading discussions on topics of current interest.

Ex-Hoosier Receives Award

One of the 9 Borden Foundation Awards for 1958 has been granted to W. James Harper, Associate Professor of Dairy Technology, Ohio State University. Dr. Harper is a native of Lafayette, Ind., received two degrees, B.S. and M.S., from Purdue University and was a Fellow at Purdue in 1945-46. The award was for meritorious scientific contributions valuable in the practice of dairy production and dairy manufacturing.

Continued

new for total management of itching,[1,2] inflamed,[3,4] infected[5,6] skin lesions

Mycolog ointment

Kenalog, Spectrocin and Mycostatin in Plastibase

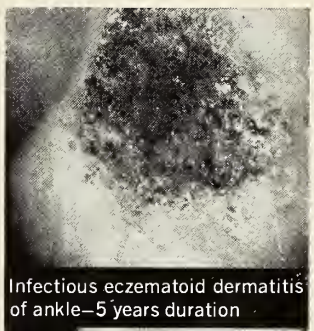
antipruritic/anti-inflammatory/antibacterial/antifungal



Dermatitis repens [with staph and monilia] 7 weeks duration



Cleared in 5 days



Infectious eczematoid dermatitis of ankle—5 years duration



Cleared in 20 days

Mycolog Ointment — containing the new superior topical corticoid Kenalog — reduces inflammation,[3,4] relieves itching,[1,2] and combats or prevents bacterial, monilial and mixed infections.[5-7] It is extremely well tolerated, and assures a rapid, decisive clinical response for most infected dermatoses.

> "Thirty-one of 38 patients . . . obtained excellent or good control of dermatological lesions . . . [Mycolog] was highly effective, particularly in the management of mixed infections. Several recalcitrant eruptions which had not responded to previous therapy were remarkably responsive to the daily application of this preparation over periods of 2 to 3 weeks."[5]

For total management of itching, inflamed, infected skin lesions, Mycolog contains triamcinolone acetonide, an outstanding new topical corticoid for prompt, effective relief of itching, burning and inflammation[1-4] — neomycin and gramicidin for powerful antibacterial action[7] — and nystatin for treating or preventing Candida (Monilia) albicans infections.[8,9]

Application: Apply 2 to 3 times daily. Supply: 5 Gm. and 15 Gm. tubes. Each gram supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base, 0.25 mg. gramicidin, and 100,000 units nystatin in PLASTIBASE.

References: 1. Shelmire, J.B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Derbes, V.J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R.C.V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T.H.: Newcomer, V.D., and Reisner, R.M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: Monographs on Therapy, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr.; Zawisza, R.J., and Blank, H.: Monographs on Therapy, 3:111 (Nov.) 1958. • 7. Monographs on Therapy, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: North Carolina M.J. 19:449 (Oct.) 1958. • 9. Bereston, E.S.: South. M.J. 50:547 (April) 1957.

And whatever the topical corticoid need, a suitable Squibb formulation is available—Kenalog-S Lotion—7½ cc. plastic squeeze bottles. Each cc. supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base and 0.25 mg. gramicidin. Kenalog Cream, 0.1%—5 Gm. and 15 Gm. tubes. Kenalog Lotion, 0.1%—15 cc. plastic squeeze bottles. Kenalog Ointment, 0.1%—5 Gm. and 15 Gm. tubes.

RELIABILITY

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Squibb Quality — the Priceless Ingredient

'SPECTROCIN'®, 'MYCOSTATIN'®, 'PLASTIBASE'®, 'MYCOLOG' AND 'KENALOG' ARE SQUIBB TRADEMARKS

AMA Warns All Medical Assistants Against Being Duped by 'Flashy' Mailings

CHICAGO (AMA Release)—Have you been intrigued by those "flashy" mailings that have been coming into your doctor's office offering you membership in various registries for physicians' aides?

Several of these organizations are regularly circularizing physicians' offices across the nation, promoting enrollment of doctors' office aides in registries of various types and offering pins, titles and correspondence courses as inducements for membership.

One of the most active groups currently is the American Registry of Doctor's Nurses. In the past few months this mail-order operation has sent out several promotion pieces. The organization's first mailings were postmarked Marianna, Fla.

The American Nurses' Association, Inc., in a memo to all state nurses associations, stated recently that this organization appears to be a commercial enterprise.

On April 21, 1958, the Florida State Board of Nursing sent the following memo to the Florida Nurses' Association, the Florida Hospital Association, the Florida League for Nursing, the Florida Medical Association and the Licensed Practical Nurses' Association of Florida which said in part:

"The attorney for the American Registry of Doctor's Nurses has advised the Attorney General, the Honorable Richard W. Ervin, that this Association has temporarily suspended its program in the State of Florida."

Now the American Registry of Doctor's Nurses is mailing its promotions from Washington, D.C.

Another organization which has been regularly circularizing doctors' aides for several years is the National Registry of Medical Secretaries in Boston, Mass. Many inquiries about this group and the qualifications of the people connected with it have been directed to AMA. Its executive secretary is not a licensed physician; he is registered as a physical therapist and a pharmacist.

Those who write to the American Medical Association inquiring about these organizations want to know whether they will receive real value from membership in such organizations. Though such schemes sound intriguing, ask yourself these questions before rushing to send in your check:

1. Is this organization endorsed by recognized medical organizations?
2. Will I really reap benefits that compensate me for my investment?

Information on groups of this type is available from your local medical society on request. The American Medical Association urges all physicians' aides to "look before you leap"—into membership in such organizations. The organization most closely identified with the medical profession is the American Association of Medical Assistants, whose aims and objectives were commended in a resolution passed by AMA's House of Delegates in 1956.

Convention Time Nears For Medical Assistants

Convention time for the Indiana State Medical Assistants Association is drawing near. Medical assistants are reminded to circle April 25-26 on their calendars so they will remember to be at the Van Orman Hotel, Fort Wayne, on those days.

Medical assistants throughout the state are invited to attend. Registration fee, which cannot be returned for cancelations received April 20 or after, is $7. More information may be obtained from Mrs. Trudy Cleckner, 210 Edgeknoll Lane, Fort Wayne.

Interesting workshops have been planned for Saturday afternoon with a social hour and banquet following to give medical assistants opportunity to become acquainted.

Sunday will be devoted to business meetings, election of officers and installation ceremonies of newly elected officers. (Complete program in last month's *Journal.*)

Officers nominated include: Mrs. Jean Blance, Fort Wayne, and Mrs. Margaret Pegg, Richmond, president-elect; Alma Southard, Evans-

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News Notes

Continued

ville, and Mrs. Trudy Cleckner, Fort Wayne, recording secretary; Mrs. Evelyn Montgomery, Shelbyville, and Mrs. Kathryn Phillips, Indianapolis, treasurer.

Directors for 2-year terms from the 3 new component societies will be Mesdames Marjorie Beller, Muncie, Margaret Murphy, Columbus, and Vivian Dodson, South Bend.

Slate from which four directors for 2-year terms will be elected includes: Marcella Becker and Patricia Savage, Fort Wayne; Mary Webb and Jean Nowicki, Indianapolis; Doris Shaw and Mary Ellen Damm, Evansville; Thelma Firsich, Shelbyville; Dorothy Morgan and Mary Ellen Mull, Logansport; and Letha Glunt and Izetta Blose, Richmond.

Mrs. Bettye J. Fisher, Evansville, is chairman of the nominating committee.

$100 Awards Offered For Best Ob-Gyn Papers

Two $100 awards for the best original investigative or clinical work in the field of obstetrics and/or gynecology is being offered by District V of the American College of Obstetricians and Gynecologists.

Papers may be submitted by any resident in an accredited hospital within the confines of District V (Ontario, Michigan, INDIANA, Ohio and Kentucky).

For consideration this year, papers must be received before Aug. 1, 1959. They must be submitted in triplicate without author identification on any copy. A covering identifying letter should be addressed to: Dr. Edwin S. Hoffman, Chairman, 766 Fisher Building, Detroit 2.

Oregon Cancer Conference in July

The Oregon Cancer Conference will be held on July 16-17 in Portland under joint sponsorship of Oregon State Medical Society, Oregon Division of the American Cancer Society, University of Oregon Medical School and Oregon Academy of General Practice.

Outstanding authorities will present essays and also participate in panel discussions. The complete program and hotel reservation blanks may be obtained by writing Mr. Roscoe K. Miller, 1115 S. W. Taylor St., Portland 5, Ore.

Rocky Mountain Cancer Conference Slated

The 13th annual Rocky Mountain Cancer Conference will be held in Denver on July 22-23. Guest speakers of national reputation will present a two-day scientific program. The meeting will be in the completely air-conditioned Brown Palace Hotel. Members of the ISMA are invited to attend. Brown Palace has reserved a block of rooms for the conference. Reservations may be made now.

Tri-State Medics Meet

A meeting of the Northern Tri-State Medical Association will be held May 7 at the Schuler Hotel, Marshall, Mich. A full day of scientific discussions has been planned along with a program for the ladies.

Rooms have been reserved at both Schuler Hotel and Howard's Motel, Marshall. Make reservations direct.

For program reservations, write Francis Elliott, M.D., secretary-treasurer, 130 North Fulton St., Wauseon, Ohio. Registration fee and dues for the annual meeting is $5.00. Luncheon tickets are $5.00 per person.

Lilly Adds Hoosier on Staff

Dr. David F. Stone, of Indianapolis, has joined Eli Lilly and Company's medical division to handle the clinical use of products in the field of sedatives, analgesics and allergy.

For the last 4 years Dr. Stone has been associated with the Indiana State Board of Health and was director of its Bureau of Special Health Services for the last year and one-half. Previously, he had spent 8 years in Indianapolis in private practice limited to diseases of the lungs.

The First International Medical Conference on Mental Retardation will be held at the Eastland Hotel, Portland, Maine, from July 27 to 31, 1959. Essayists from England, Germany, Austria, France and the United States will participate. Facilities for simultaneous translation will be available for the general sessions.

The national meeting of the Association of American Physicians and Surgeons will be held in Fort Worth, Texas, April 2-4. Members of the ISMA are invited to attend. The program will consist of papers and discussions of medical socio-economic problems.



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Culling from the Columnists:

Need your battery charged? Like to quote from a recent column, "My Window," by Myrtie Barker in the *Indianapolis News*.

"A stimulus (the mental sort) is vital. But never more so than at the tag-end of winter. Snow has lost its thrill. Instead of mud and slush, we yearn for green grass—even dandelions. But the gray days lag. Spirits slump. And our morale needs a boost.

"However, the needed inspiration is not far away. It's as close as your next meeting—Rotary luncheon, Missionary Circle, or neighborhood coffee 'klatsch.' "

Miss Barker ended her column with, "From our friends we derive living energy, stimulus by which to replenish our alacrity. To put it bluntly —charge our battery."

My hat off to Myrtie Barker. I think she hit a mighty important point on the proverbial nose. We all need our "batteries charged" now and then—whether you are a busy doctor up to your ears in trying to heal patients or a *Journal* editorial secretary up to her ears in shuffling the million papers necessary in the publishing of such a magazine.



"I'd say you were improving . . . you're making a much better grade of paper dolls!"

Last month the *Journal* quoted an editorial about how meetings are killing us. We all know too much of anything can kill us off—so we need discretion. But when we get so involved in our single line of endeavor, that, too, can kill us. We need diversion, communication with our fellowmen outside the scope of our singular endeavors even tho' such outside interests might have a connection.

For instance, my business is in the publishing field, yet I find attending meetings of the Woman's Press Club of Indiana and the Indiana Industrial Editors Association most stimulating. They "charge my mental battery," for I get to exchange ideas in this field of communications and meet others whose endeavors go into many facets of the business—learn more of what's going on outside my comparatively narrow scope of helping put out a medical journal.

At the last Press Club meeting Miss Augusta Stevenson gave a talk. She's outstanding in the field of authoring children's books with 32 books to her credit, some of which have been translated in 7 languages—no small achievement in the book world! She is credited with beginning the patriotic series of children's books some 25 years ago which have been copied by many.

Miss Stevenson's talk on her experiences and the problems of writing children's books, the remarks and queries she gets, was intriguing, informative and enjoyable—and sorta' charged that mental battery for me.

And—it helped me understand a little more about the problems confronting those of us in the active business of communications ("active" because everyone, *everyone,* is in the business of communications, actually—with spouse, with children, friends, acquaintences, business associates, the man on the street and, with you, doctor, the all-important communication with your patients!)

Misery Loves Company!

So, meeting with authors, with newspaper women, is stimulating tho' it still is related to my work. Same principle applies with the industrial editors. We can exchange problems and



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

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Continued

incidents, listen to others in some branch of active communication—learn from them, enjoy the fact that, as the old saying goes, "misery loves company," for we find everyone has similar problems. And we can get a better understanding of those outside influences affecting our profession (if I may be so bold as to call mine a profession!).

I'll bet many doctors who are active in county society and state association work feel the same way. It may take more time from already overloaded agendas, but I can't help but believe they are stimulated by meeting some of the outside influences affecting medicine today and working to overcome the problems facing medicine.

And I'd also bet they get a better understanding of their doctor-patient relationship from it, for it gives them the opportunity of getting close to the socio-economic problems of the population —with which every patient is faced—and a better understanding of patients' attitudes thru exchanging experiences with fellow doctors.

This sort of thing can be overdone, as I've admitted, but I think it behooves all of us to recharge our batteries by attending a few pertinent meetings and being active in the work going on. I probably learned as much about my work from being active in the Northern California Industrial Editors Association as anywhere else —by helping to work for better understanding of communications.

That sort of thing charges my battery better than a vitamin pill. It's a "pep pill" that can't be beat.

My thanks to Myrtie Barker for bringing this out.

From the sublime. Now I "cull" from "The Things I Hear" by Lowell Nussbaum, *Indianapolis Star,* and I quote:

"Golfers at the Mayport (Fla.) Navy airfield course are having trouble with seagulls.

"It seems the gulls go goofy over golf balls. Brings out the mother instinct in them and they steal the balls and try to hatch them."

This must cause an awful frustration complex in the poor gulls.

Anyone a seagull psychiatrist?



(Postscript)

Like I said, meetings are stimulating. Just returned from an editor's luncheon today where we had an extremely "stimulating" conversation —all about the trials, tribulations and joys of bringing up a pet monkey called Darwin! (Honest!)

Speaker was interesting, too; a talk subtitled, "You, too, can be a stinker!" I really don't think I need any further study and instruction on that subject, but it was nice hearing someone else reflect my reflections!

Some more culling. While we're in the mood to quote other publications, why not pull a few wise words from our own.

"*Informed patients are cooperative patients*" is a sentence well worth thinking about from the scientific article on tranquilizing medications in this month's *Journal* by Frank J. Ayd, Jr., M.D.

And from the same article, "*A physician can be as much of a tranquilizer as any drug, providing . . .*" The remainder of that sentence has even more food for thought. Look it up and see if you don't agree.

And then there was the story. In the *Indianapolis Star* it was reported that Dame Irene Ward rocked the staid House of Commons of England by coming out with "Oh, Edith, you really are an ass!"

First off, a member of the House is addressed only as "The Honorable Member," no matter what nasty names the caller has in mind.

But of interest to physicians should be the fact that the remark was addressed to Dr. Edith Summerskill during a debate on the National Health Service when she claimed "American companies were among firms flooding the British market with high-priced drugs," according to the AP release.

A Good Laugh Cures Many Ills Dept.

When a man called a veterinarian in a nearby town the operator asked, "Is this a personal call?"

"Of course not!" snapped the caller. "It's my dog that's sick."—*Indiana Telephone News*, Indiana Bell Telephone Co.

In a middle western city the other day, a police officer signaled a driver to the curb and asked to see his license.

"But, officer," protested the motorist, "I wasn't doing anything wrong!"

"Yeah, I know," agreed the cop, "but you were driving so cautiously, I thought maybe you didn't have your license with you."—*News & Views*, Gen'l Motors Acceptance Corp.

The new medical officer, young and very green, was doing his best to ignore the baby-blue eyes of his patient, the prettiest civil service employe in headquarters. With great dignity, he prepared to give her a routine checkup and in the process dropped his stethoscope.

"Is anything the matter, sir?" she asker sweetly, enjoying his discomfort.

"Of course not," he replied, collecting himself and his equipment. "Now, then," he ordered in his most professional tone, "deep breathely."—*Capper's Weekly*.

After that mind-tiring discussion of Darwin, the pet monkey, best I write "30" to this before I drop my typewriter. I might say something worse than "deep breathly!"



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l-Lysine Monohydrochloride	25 mg.
Rutin	25 mg.
Ferrous Fumarate	30 mg.
Iron (as Fumarate)	10 mg.
Iodine (as KI)	0.1 mg.
Calcium (as $CaHPO_4$)	157 mg.
Phosphorus (as $CaHPO_4$)	122 mg.
Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Copper (as CuO)	1 mg.
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Zinc (as ZnO)	0.5 mg.

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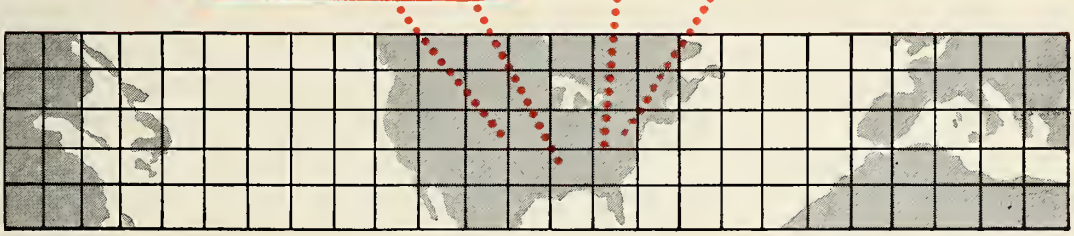
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For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
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Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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County Society and District Reports

Tenth District

Members of the 10th District will meet May 13 at Parramore Hospital for their annual meeting.

Mark H. Lepper, M.D., professor and Head of the Department of Preventive Medicine, University of Illinois College of Medicine, will present the subject "Staph Infection." In addition, films of the March 18th Grand Rounds, sponsored by Upjohn Company, will be shown.

Dinner will be served at 7 p.m. Parramore Hospital is located one mile north of Crown Point on Highway 55.

Adams

Decatur's Fairway Restaurant was meeting place for Adams County Medical Society Jan. 6. Thirty members were present to hear Mahlon Miller, M.D., discuss Blue Cross-Blue Shield.

Boone

Fifteen members were present at the Witham Hospital, Lebanon, for the Boone County Medical Society meeting held March 3.

Clay

Clay County Medical Society meeting of Feb. 17 was hit by bad weather with only 7 in attendance. A program of cooperation with the tuberculosis association was agreed upon and a discussion of welfare and township fee schedules was held.

Elkhart

Phillip Lewin, M.D., orthopedic surgeon of Chicago, discussed "Problems of the Back" at the Elkhart County Medical Society meeting Feb. 5. Fifty members were present when plans were made for a trip to the Lederle Laboratories, New York, in May.

A Valentine dinner-dance was held for doctors and dentists at the Hotel Elkhart Feb. 12.

Floyd

W. C. Adams, M.D., assistant professor of Pediatrics, U. of L., spoke on "Poisoning in

Continued on page 600



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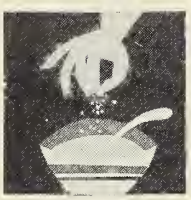
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Niacinamide	25 mg.
Calcium Pantothenate	3 mg.
Vitamin B_{12}	5 mcg.

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SPONTIN IN SERIOUS

A Special Report from Abbott
to the Medical Profession
on a Year's Clinical Experience
with SPONTIN®
(Ristocetin, Abbott)

In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

Few more dramatic records have been written in such a short space of time. SPONTIN has proved itself to be a good answer, perhaps the best answer at present, to the resistant staphylococcal problem—and of real value in other serious coccal infections. It may well be your answer when you're confronted with a serious infection.

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STAPHYLOCOCCAL INFECTIONS

Excerpts from Reports Read at the Antibiotics Symposium

Spontin In Treating Severe Respiratory Infections —"In 13 of 20 patients the results were excellent, with clinical response being evident within one to four days after institution of therapy. In three additional patients, there was some degree of improvement in pneumonic processes superimposed on tuberculosis in two cases and on pulmonary neoplasm in one. In all other cases, serious antecedent pathology undoubtedly influenced the negative or equivocal response to ristocetin therapy.[6]"

Spontin In Treating Staphylococcal Infections—After successfully treating 28 patients, the authors wrote, "Ristocetin or Spontin has proved to be bactericidal and bacteriostatic, particularly for the *Staphylococcus aureus,* which is often resistant to many other antibiotics.[5]"

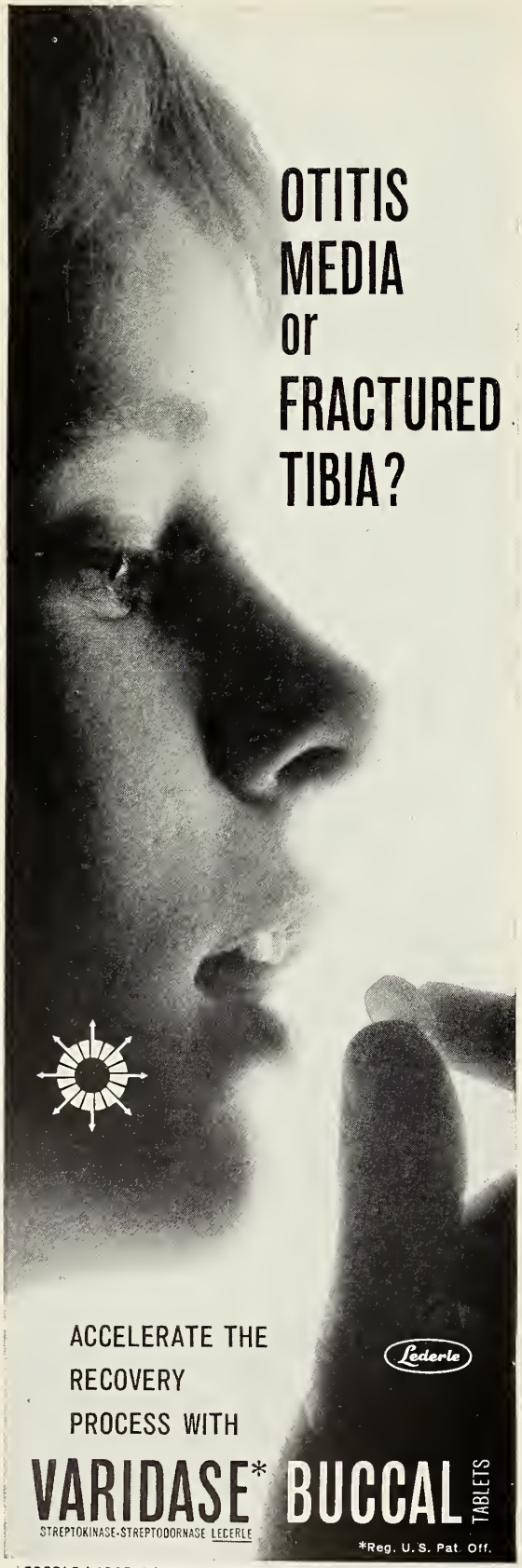
Spontin In Treating Seven Difficult Cases – "Ristocetin has produced excellent results in eradicating, mitigating or preventing infection in seven selected difficult cases. Six of the seven cases involved *Staphylococcus aureus* which did not respond to chemotherapy with other antibiotics.[7]"

Spontin Blood Levels In Children – "Ristocetin was administered as a single intravenous injection of 12.5 milligrams per kilogram. This resulted in serum levels ranging from 1.3 to 10.6 mcg. after two hours with a gradual fall to a level of 0.7 mcg. per cubic centimeter or less after 12 hours.[8]"

Spontin In Treating Staphylococcal Pneumonia —"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults – "Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.
2. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
3. Romansky, M. J., and Holmes, R., Successful Short-Term Therapy of Enterococcal and Staphylococcal Endocarditis with Ristocetin—Seven Patients. Preliminary Report, Antibiotics Annual, 1957-58, p. 187.
4. J. A. M. A., 167:1584, July 26, 1958.
5. Bush, L. F., et al., The Use of Ristocetin (Spontin) in Staphylococcal Infections, In Press, Antibiotics Annual, 1958-59.
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7. Miller, J. M., et al., Ristocetin in the Treatment of Seven Selected Difficult Cases, In Press, Antibiotics Annual, 1958-59.
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Society Reports

Continued from page 596

Children and Operation of a Poison Control Center" at the Feb. 13 meeting of Floyd County Medical Society. Present were 23 members. It was reported that since abandoning the emergency roster system at the previous meeting, a new system of each physician accepting responsibility is working well.

Fountain-Warren

Seven members of the Fountain-Warren County Medical Society were present for the March 5 meeting at the Attica Hotel, Attica.

Lake

A panel composed of Drs. David Morton, Beatty Hospital, John Ferry, chairman, Lake County Mental Hygiene Clinic, Philip Frank, and Judge Fred Egan, discussed "Admissions to State Mental Institutions" at Lake County Medical Society's Jan. 14 meeting. There were 110 present for the program.

Lake County had 90 present Feb. 11 to hear Eugene Derlacki, M.D., Dept. of Otolaryngology, Northwestern U., speak on "Speech and Hearing Problems in Children." The program was provided by the Crippled Children's Society.

LaPorte

Henry H. Morrison, M.D., was guest speaker at the Feb. 17 meeting of LaPorte County Medical Society held at LaPorte. Business of the meeting consisted of diabetes committee, county welfare schedule, science fair and a talk by L. E. Converse on Blue Shield.

Hamilton

"Use of Radiologic Diagnosis in Intestinal Obstruction" was subject of Chester A. Stayton Jr., M.D., at the Feb. 10 meeting of Hamilton County Medical Society with 20 members present.

Hancock

Hancock County Medical Society's Jan. 26 meeting consisted of a discussion of "Head Injuries" by T. Luros, M.D., Indianapolis, with 17 members present.

On Feb. 23, Wilbur Beeson, M.D., talked on "Medical Missionary in Africa" before 19 members. Both meetings were held at the Hancock County Memorial Hospital.

Hendricks

Legislative problems were discussed at the Feb. 12 meeting of Hendricks County Medical Society with 14 members and guests present.

Howard

A dinner for physicians and their wives was held at the Frances Hotel for the Howard County Medical Society March 3.

Orange

Orange County Medical Society members met March 3 at Spring Mill Inn to discuss welfare rates and elected grievance and credentials committees.

Parke-Vermillion

William Bannon, M.D.. discussed "Anemias" before members of Parke-Vermillion Medical Society Feb. 18 at the Vermillion County Hospital.

Perry

L. C. Lohoff, M.D., presented "Diagnosis and Treatment of Supracondylar Fractures in Children" before members of Perry County Medical Society March 3 at the Nursing Center, Cannelton.

Pulaski

Members of Pulaski County Medical Society surveyed county health needs and summarized some objectives of the society Jan. 14.

Mr. Cosgrey, Beaver Hospital Associates, was guest speaker at the Pulaski County Feb. 19 meeting.

Putnam

Dick Stander, M.D., discussed "Control of Post Partum Hemorrhage and Allied Problems" March 13 before 12 members of Putnam County Medical Society.

Rush

"Recent Developments in Cardiovascular Surgery" was discussed by Harris B. Shumacker Jr.,. M.D., before 15 members and 2 guests of Rush County Medical Society March 12.

Whitley

Whitley County Medical Society met Feb. 10 to hear John Vogel, M.D., internist, discuss "Vector Electrocardiography." Thirteen members were present.

In March, 16 members heard Joe Mishler, M.D., discuss "Differential Diagnosis of Jaundice."

Continued

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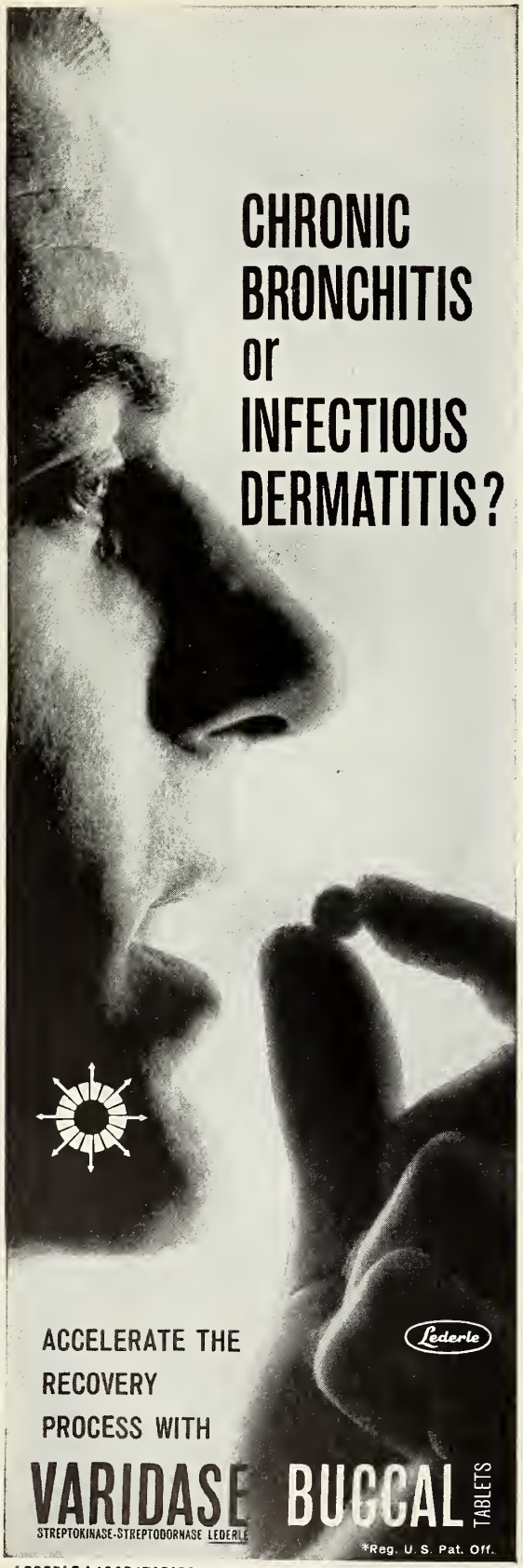
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Wayne-Union

James Oscar Richtey, M.D., presented "Present Day Interest in Serum Lipids and Arteriosclerosis" before 41 members of Wayne-Union Medical Society March 10. Discussions were held on the newly drawn constitution, school children vaccinations, etc.

A special meeting was held April 7 for discussion of county health officer problems.

GIVE GENEROUSLY

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Association Reports

Executive Committee

February 18, 1959

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Kenneth L. Olson, M.D.; Earl W. Mericle, M.D.; O. W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*, and J. A. Waggener, executive secretary.

Guests: Andrew C. Offutt, M.D., State Health Commisioner; Leroy Staunton, Wolf Management Engineering Company.

Membership Report

Number of members Feb. 18, 1959	3,477*
Number of members Feb. 18, 1958	3,433
Gain over last year	44
Number of members December 31, 1958	4,201

*Includes 38 in military service (gratis)
163—$10 members (residents and interns)
328—senior members
30—members, dues remitted by Council
1—honorary member

Treasurer's Office

The treasurer reported on the financial condition of the Association.

Statements of Receipts and Expenditures for the second quarter of 1958 and for January, 1959, were approved by consent.

Headquarters Office

Mr. Staunton of Wolf Management Engineering Company gave a progress report and recommended that remodeling of the present office facilities be undertaken immediately.

Upon motion of Drs. Olson and Covalt the Committee voted that the Association adopt the recommendations made by Mr. Staunton and that Dr. Olson clear this with the Building Committee before proceeding.

The secretary reported that during the month of January 541 Medicare claims were received and that billing for January totaled $59,040.57.

A quotation from International Business Machines Corporation for trading in the typewriter currently being used in Medicare was presented and the secretary was instructed to trade this typewriter, upon motion of Drs. Olson and Mericle.

Legislative Matters

Dr. Wood reported on legislation at the national level, and upon motion of Drs. Olson and Covalt, the Association will have its annual dinner for the Indiana Congressional delegation and their secretaries at the National Press Club on Monday night, April 27. Those who will attend will be the President, President-elect, the co-chairman of the Commission on Legislation, chairman of the Council, and the secretary.

Dr. Wood gave a report on the progress of the bills currently pending before the Indiana State legislature and was complimented by the committee for his fine work.

Organization Matters

Letter from Professional Insurance Administrators, Inc., was referred to the Committee, together with a recommendation from the Subcommittee on Insurance, and upon motion of Drs. Mericle and Covalt this matter is to be referred to the Council. Dr. Richard P. Good is to be requested to attend the Council meeting on April 5, 1959.

Letters from the Indiana Home Economics Association and DePauw University regarding exhibits were referred to the Committee and by consent it was agreed that the county societies should be asked to supply these exhibits at their expense.

Letter from the Lincoln National Life Insurance Company regarding the recent organization meeting of the Indiana Committee of the Health Insurance Council, in which it was suggested that the aims of this Council be distributed throughout the state to all component societies, was read, and upon motion of Drs. Mericle and Covalt, the distribution of these aims was to be left to the discretion of the president and executive secretary.

A letter from the Indiana Health Careers Committee concerning the organization of a full-time office for the purpose of promoting careers in the various health fields was discussed, and the Committee authorized the executive secretary to continue his stand in opposition to establishing a full-time department at the expense of the participating agencies.

The material submitted by Dr. Emmett B. Lamb, chairman of the Commission on Public Health concerning the program of the American Legion, Community Service Department, was reviewed, and by consent Dr. Lamb is to be instructed that the Association should request the Legion to help in any project the Commission might deem advisable.

Statement from the Joint Committee on Improvement of Patient Care in Indiana for annual fee of $25.00 was approved on motion of Drs. Olson and Mericle.

A letter from Dr. Martha A. O'Malley, director of the Division of Hospital and Institutional Services of the Indiana State Board of Health, concerning the naming of a representative to the Hospital Licensing Council during Dr. Clauser's illness was reviewed and upon motion of Dr. Olson, and by consent, Dr. Mericle was asked to represent the Association on this Council.

The request of Dr. Glen Ward Lee, chairman of the Commission on Governmental Medical Services, that the Association lend its name to the Workshop Planning Committee on the Care of the Mentally Ill Patients in General Hospitals, was approved by consent.

Dr. A. C. Offutt, state health commissioner, appeared before the Executive Committee concerning the problem of a county health officer in Covington.

On motion of Drs. Covalt and Mericle, the Association is to prepare a release for the public press urging the public to obtain the fourth polio shot.

The Journal

Financial statements for *The Journal* for December, 1958, and January, 1959, were approved on motion of Drs. Covalt and Mericle.

Future Meetings

Regional Conference, Committee on Insurance and Prepayment Plans of AMA Council on Medical Service, February 28 to March 1, 1959, Pittsburgh. Upon motion of Drs. Olson and Mericle the Association will stand the expense of sending Drs. E. T. Edwards and John L. Langohr, and the executive secretary to this meeting.

Medical Civic Dinner, Vanderburgh County Medical Society, March 10, 1959, Evansville. The president, president-elect and executive secretary will attend this meeting.

Recommendation of the Commission on Public Information concerning representation of the Association at the National Science Fair in Hartford, Connecticut, in May, 1959, was noted, and by consent it was agreed that Dr. Harry Pandolfo and Dr. Ralph C. Eades should represent the Association.

Letter from the United States Pharmacopoeial Convention, Inc. concerning the 1960 meeting of this organization was noted and by consent it was agreed to ask Dr. R. A. Solomon of Indianapolis to attend this meeting.

There being no further business the committee adjourned, to meet again at 12:30 p.m., March 18, 1959, in the headquarters office.



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Lighter Vein—

Don't strive to be normal—it's abnormal!—C. R. Smith, *Quote.*

A man cannot hold another down without stooping.—Rex Mobley, *Quote.*

It was a tense scene in the film. The audience sat enthralled. Suddenly the hero slapped the heroine in the face.

In the silence that followed, a little voice piped up, "Mommy," it said, "why doesn't she slap him back like you do?"—*Atlas News,* hm, Atlas Auto Finance Co.

The wife-beater had been hailed into court and fined $110. "I can understand the $100," said the man, "but what's the $10 for?"

"That," replied the old judge solemnly, "is the amusement tax."—*Pacific Oil-Motive Mag.*

The other day a friend of ours decided it was about time he had a serious talk with his teen-age son concerning Life.

A few minutes later he emerged from Junior's room, looking thoughtful and a bit shaken.

"Mary," he said to his wife hesitantly, "who is Brigitte Bardot?"—Ivern Boyett, *Quote.*

We heard of a guy on a quiz program who defined Alabaster as an illegitimate Mohammedan.—*Pacific Oil-Motive Mag.*

If nature is so wonderful, why didn't she make the mosquito a vegetarian?

"I hear that Mary is marrying that X-ray specialist."
"Really. What can he see in her?"

The girl smiled at the waiting line as she went into the phone booth.

"I won't be long," she said. "I just want to hang up on him."

If your wife wants to learn to drive, don't stand in her way.

Middle age is when you don't care where you go, just so you're home by 9 p.m.



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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

May 1959

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Medical Yearbook
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All articles must be typewritten, double-spaced with margins of one inch.

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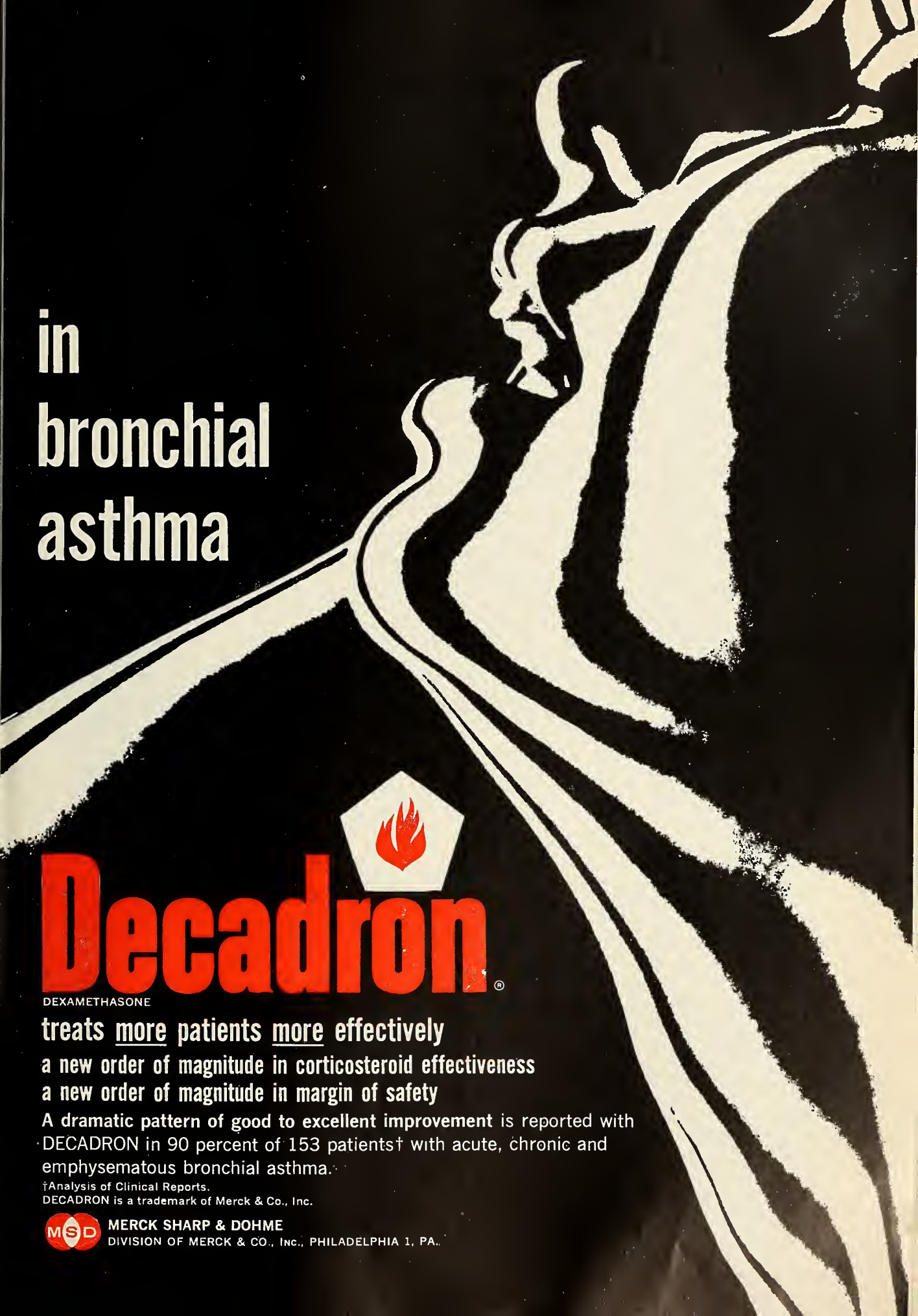
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Annual Convention—October 6-9, 1959, Indianapolis

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2	J. H. Crowder, Sullivan	Oct. 1960
3	John M. Paris, New Albany	Oct. 1961
4	Joseph E. Dudding, Hope	Oct. 1959
5	Robert K. Webster, Brazil	Oct. 1960
6	Harry P. Ross, Richmond	Oct. 1961
7	Ralph V. Everly, Indianapolis	Oct. 1959
8	Guy Owsley, (Chairman), Hartford City	Oct. 1960
9	K. O. Neumann, Lafayette	Oct. 1961
10	J. P. Vye, Gary	Oct. 1959
11	Max R. Adams, Flora	Oct. 1960
12	Maurice E. Glock, Fort Wayne	Oct. 1961
13	G. O. Larson, LaPorte	Oct. 1959

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Terms expire December 31, 1959:

Delegates	Alternates
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Wendell C. Stover, M.D., Boonville	John M. Paris, M.D., New Albany

Terms expire December 31, 1960:

Delegates	Alternates
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E. S. Jones, M.D. Hammond	Robert M. Brown, M.D. Marion
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1959-60 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	W. Lawrence Daves, Evansville	J. D. McDonald, 517 Sycamore, Evansville	May 21, 1959
2.	Fred M. Dukes, M.D., Dugger	J. S. Brown, M.D., Carlisle	May 7, 1959
3.	Robert LaFollette, M.D., New Albany	Daniel H. Cannon, M.D., New Albany	New Albany, May 6, 1959
4.	Robert O. Zink, M.D., Madison	Frank W. Hare, M.D., Madison	Madison, May 20, 1959
5.	James Richart, M.D., Terre Haute	Roy Pearce, M.D., Terre Haute	Terre Haute, May 20, 1959
6.	Frank Lewis, M.D., Liberty	John H. Smith, M.D., Greenfield	New Castle, May 7, 1959
7.	Leon Gray, M.D., Martinsville	Herbert L. Egbert, M.D.	Indianapolis, May 12, 1959
8.	Forrest Keeling, Portland	Ara Badders, Portland	Portland, June 3, 1959
9.	S. E. McClure, M.D., Monon	David C. Beck, M.D., Monticello	Monticello, May 21, 1959
10.	Ralph T. Hartsough, M.D., Remington	Kenneth Ockerman, M.D., Rensselaer	Crown Point, May 13, 1959
11.	Eugene Cook, M.D., North Manchester	C. L. Wise, M.D., Camden	Logansport, May 20, 1959
12.	F. B. Kantzer, M.D., Garrett	Max M. Gitlin, M.D., Bluffton	Fort Wayne, May 20, 1959
13.	Richard W. Holdeman, M.D., South Bend	James M. Wilson, M.D., South Bend	South Bend, Nov. 18, 1959

"It is concluded that the addition of buffering agents to acetylsalicylic acid in the concentrations used serves no clinically detectable useful purpose."[1]

[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:183, August, 1958.
Nonbuffered Material Used—Bayer® Aspirin.

I.S.M.A. Committees and Commissions for 1959-60

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Medical-Legal Review

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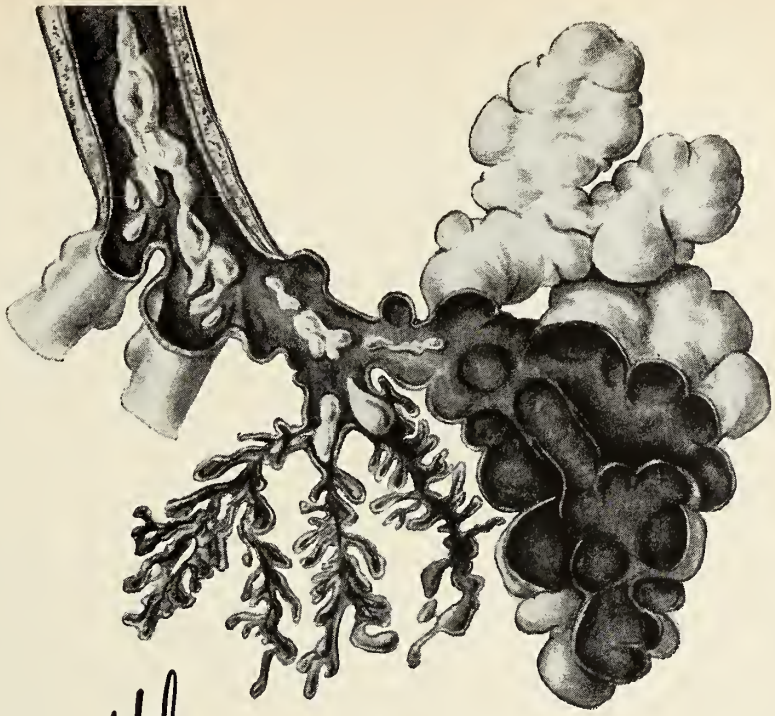
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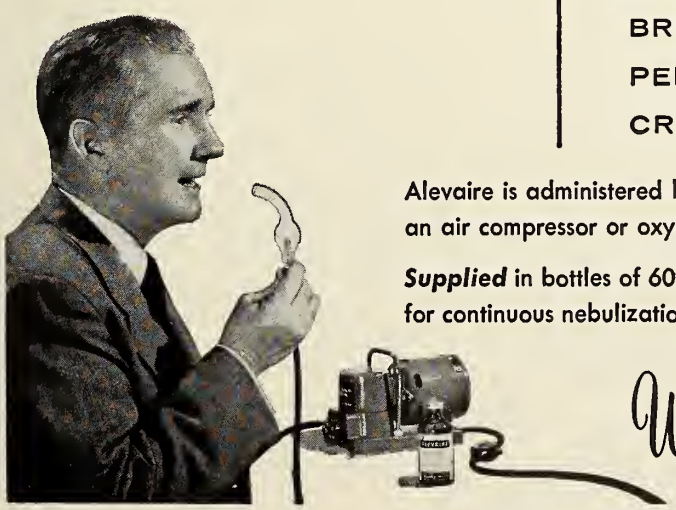
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1. Dennison, A.D., Jr.: Am. J. Cardiol. 400-403 (March) 1958.

AC-259 M

This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month preceding month of issue.

THE MONTH IN WASHINGTON

Washington, D. C. — The overriding health issue here—and one of the more debated subjects in any field—has been the dispute over radiation health hazards.

Out of the controversy, it is clear, will come a sharply stepped-up federal program of evaluating radiation levels, testing foods and determining the effects of radiation on the human body.

Already, Arthur S. Flemming, Secretary of Health, Education and Welfare, has called for such an expanded program. And key congressmen are even more insistent that the government do more work in this area.

The growing concern over radiation levels and their effect on health has prompted harsh criticism of the Atomic Energy Commission by some lawmakers who contend the agency is minimizing radiation dangers because it handles the testing of nuclear bombs.

Agency officials claim they have held back no information from the public, but they agree on the need for a government-wide survey of the entire problem to determine how it might best be handled. At present, the AEC does the bulk of the research work on the biological effects of radiation.

The AEC and the Public Health Service have reported that the amounts of radioactive strontium-90—the isotope that is released into the atmosphere by hydrogen bomb shots—have been far below estimated danger levels in food that has been tested.

However, Mr. Flemming has conceded that much more research has to be done. For example, he pointed out, little is known now about how much strontium-90 is retained within the body, though the amount consumed can be gauged.

A special advisory committee of 12 scientists and physicians that was appointed by the Health Service recommended after a year's study an exhaustive program of radiation research and protection as well as shifting prime responsibility from the AEC to the Health Service. The advisory group, headed by Dr. Russell H. Morgan of Johns Hopkins University, proposed also some sort of federal supervision over x-ray machines used by physicians.

Chairman Lister Hill (D., Ala.) of the Senate Labor and Public Welfare Committee has introduced legislation to carry out the advisory group's recommendations, and called for hearings on the measure.

Meanwhile, the National Academy of Sciences, with the backing of the Administration, has undertaken a broad new investigation of the biological effects of radiation.

*** ***

Continued



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These antihistamines block the effect of histamine on the nasal and paranasal capillaries, preventing dilation and exudation.[3] *This is not enough;* by the time the physician is called on to provide relief, histamine damage is usually present and should be counteracted.

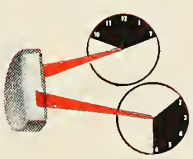
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References: 1. Sheldon, J. M.: Postgrad. Med. 14:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy 19:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. 112:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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Washington

Continued

NOTES:

The House overwhelmingly approved the Keogh-Simpson measure to encourage retirement plans for the self-employed. Sen. Harry F. Byrd (D., Va.), chairman of the Senate Finance Committee, promptly announced that he would hold hearings on the legislation this session.

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Rep. Aime J. Forand (D., R.I.), admitted that the future of his bill to provide government medical and hospital care as part of social security program is dark.

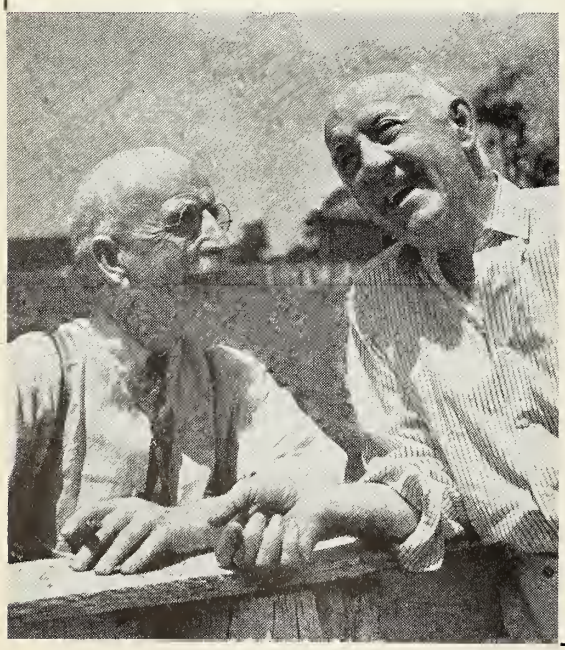
In a report to Congress, the American Medical Association noted "solid progress" in its program to improve the health care of the aged. Dr. Leonard W. Larson, chairman of AMA's Board of Trustees, said in a letter to the House Ways and Means Committee that the development of new insurance programs and expansion of existing lower cost protection for the elderly are moving forward "even faster than many of us would have dared hope only a few months ago."

*** ***

The Defense Department's handling of the Medicare program providing treatment in civilian hospitals for qualified dependents of military personnel came in for some new congressional criticism. In a report accompanying an emergency money measure, the House Appropriations Committee said it was concerned with the "high costs" and believes "that little or no efforts have been made to obtain reasonable rates for fees and expenses."

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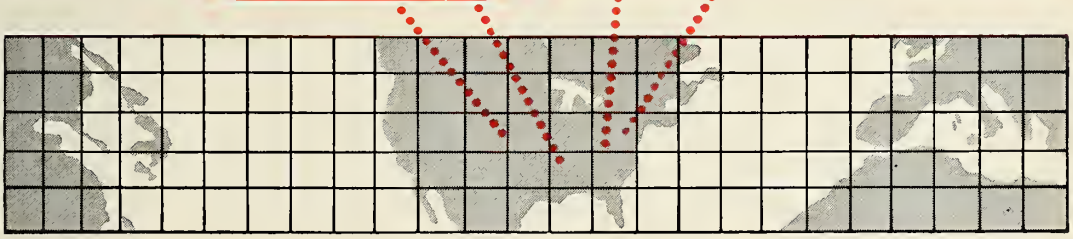
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"especially well suited for ambulatory patients who must work, drive a car, or operate machinery."[3]

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References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6.Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Out of the Hospital

Numerous mental hospitals in the United States have reached the encouraging stage of seeing the number of patients gradually diminish—not the number admitted during a year, but the number who need to be in a hospital at a given time.

This has been accomplished by more concentrated treatment, including such factors as more trained staff and use of the tranquilizing drugs. Perhaps a growing willingness on the part of patients and their families to submit to treatment also is helping to get the mentally ill into hospitals before their illness is far advanced.

The faster recovery rate and more rapid turnover in hospitals is good news, but it is no cause for state legislatures and the public to relax. It merely proves the value of more training, more staff, more special medication —an overall treatment program which is more expensive to maintain.

This is inescapable; good mental care is costly. But few tax dollars bring such satisfying results as those spent on an intelligent mental health program.

—*Kokomo Tribune*
January 28, 1959

Mental Hospitals

Three large Illinois state mental hospitals have been dropped from the accredited list of the Joint Commission on Accreditation of Hospitals. Dr. Otto L. Bettag, state welfare director, has said that this action was justified. The hospitals are Chicago, with 4,700 patients, Kankakee, with 4,000, and Manteno, with 8,000.

Dr. Bettag is to be commended for his frankness and courage, because it is not easy for an administrator to admit that his hospitals are not up to par.

The commission's principal objections—overcrowding and understaffing—cannot be blamed on Dr. Bettag. His requests for money for capital improvements have been virtually ignored. Four years ago, when he asked for 106 million dollars, the legislature gave him 13 million; two years ago he asked for 289 million and got 1½ million. Last fall the voters turned down a bond issue which would have provided 81 million dollars for state hospital improvements. Now Dr. Bettag is seeking a larger share of the 1959-61 appropriations.

Dr. Francis J. Gerty, president of the American Psychiatric Association, defends Dr. Bettag by saying that it is unfair to judge a mental hospital, as the commission does, mainly on the basis of its physical plant. If other facts peculiar to mental hospitals were considered, he said, ours would make a far better showing.

But the fact remains that a mental hospital cannot run on skill and dedication alone. It must have facilities and help. The increasing incidence of mental illness has taxed Illinois' hospitals to the bursting point, and some of their buildings are dangerous firetraps more than 100 years old. Of the 4,500 hospitals in the United States and Canada which have applied for accreditation, three out of four have been approved; of the 13 Illinois state hospitals, only two still hold this approval.

If the notification that Illinois' hospitals are below par awakens the legislature, it will prove a blessing. These needs may be met without raising taxes much, if at all, and should be weighed against the other demands for state funds. If this were done wisely, we are sure that the hospitals would be found more deserving than, say, a good deal of cross-country road construction on lightly traveled routes.

Chicago Tribune
Mar. 7, 1959

Ohio Considers Laws to Force Polio Shots

Special to *Scope Weekly*

Columbus, Ohio—Bills that would make polio immunization compulsory for every school child

Continued on page 638

"There is some evidence that triamcinolone is more effective at a smaller dosage than are other steroids in controlling both the skin and joint lesions in psoriasis, whether or not complicated by arthropathy."

"Triamcinolone appears to compare favorably with other steroids for use in those situations in which edema and sodium retention have been complicating problems."

"It [triamcinolone] may also be the steroid of choice for patients in whom psychic stimulation, euphoria, voracious appetite, and weight gain should be avoided."

"...the drug [triamcinolone] does produce the other side effects and untoward reactions common to the glucocorticoids. At therapeutically equivalent doses, the frequency and severity of clinical manifestations of hyperadrenalism — rounding of the face, fat deposition, and hirsutism — are essentially the same. Likewise, there is little indication that the relative incidence of osteoporosis is materially decreased after the long-term use of the drug."

"Triamcinolone apparently does not cause the euphoria sometimes seen with other steroids, and the occurrence of mental depressions is uncommon."

"Current evidence suggests that the drug [triamcinolone] may not produce as high an incidence of peptic ulcer as do other steroids."

"Cutaneous erythema seems to be a side effect peculiar to triamcinolone."

"The usual contraindications and precautions of glucocorticoid therapy should be followed in the use of triamcinolone, keeping in mind that prolonged therapy with this drug will suppress the function of the patient's own adrenals by interfering with the pituitary-adrenal axis."

Aristocort®

Triamcinolone LEDERLE

Supplied: 1 mg. scored tablets (yellow)
2 mg. scored tablets (pink)
4 mg. scored tablets (white)

Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Fourth Estate

Continued from page 634

in the state have been introduced here in the two houses of the Ohio State legislature.

The proposed legislation, believed to be the first of its kind in the country, includes exemptions for religious beliefs by written requests of the parent or guardian.

The bill has received the overwhelming support of public health and educational authorities and consumer groups and has been endorsed by the Policy Committee of the Cleveland Academy of Medicine. Feb. 25, 1959

Non-Profit Hospitals Face Donation Loss

Chicago (UPI)—Non-profit hospitals in many American cities may be cutting off donations, their main source of funds, without realizing it, a research organization report said last night.

The Foundation of Management Research, in a 44-page report, said "the increase in the number of hospital-financed medical office buildings is a dangerous tendency in hospital administration."

The Foundation said that 96 non-profit hospitals in 28 states are jeopardizing their tax-exempt status and the tax deductibility of donations by engaging in commercial enterprises for profit.

The 28 states are Arkansas, California, Colorado, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Montana, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Vermont, Virginia, Wisconsin and Wyoming.

The study, a revised edition of a report made last year, said that if hospitals lose their local and Federal tax exemptions, donors stand to lose heavily. This is because their contributions would automatically be ruled non-deductible by the Internal Revenue service.

"Rents are usually nominal, and these physicians are thus enabled to utilize publicly endowed facilities for private gain," the report stated. "This violates local property exemptions and the Internal Revenue code."

The Foundation added that some hospitals were expanding into restaurants, drug stores, surgical supply stores, florist shops, and other businesses, "all open to the public at large, and competing with private trade."

"This tendency to engage in commercial enterprises, not for the benefit of patients but primarily to earn a profit, is slowly undermining the tax-exempt status of non-profit hospitals," the study said.

The report said hospitals cannot afford to lose their tax-exempt status because their current expenditures are the greatest in history. For the next 20 years, the report said, general non-profit hospitals will need $501,000,000 each year in contributions for new bed space to replace obsolete facilities and match the nation's population growth.

Indianapolis Star
Mar. 6, 1959

Polio Is Gaining

Remember only a few years ago when people in this country, especially parents with small children, were almost frantic with fear of infantile paralysis, or polio?

In 1954, this disease killed or maimed 18,308 persons.

The next year Dr. Jonas Salk was able to announce an answer—the now celebrated Salk vaccine. The clamor for this vaccine bordered on hysteria. The government put up money. Doctors' offices were stormed for shots. Vaccine manufacturers worked overtime. Most of the world's supply was produced right here in Indianapolis.

In 1957, the polio casualty list was down to 2,499. People thought of polio as being virtually extinct—as well-conquered as smallpox or typhoid. But something happened. The desperation of 1954 and earlier years disappeared.

The vaccine, 85 to 90 per cent effective, was available in abundant quantities. But the alarm subsided. The vaccine isn't being used.

For details, we refer you to the interview with Surgeon General Leroy E. Burney by Scripps-Howard Science Writer John Troan in yesterday's *Times*. But we cite these statistics: Last year polio cases were up 24 per cent; in the first eight weeks of this year, they are up 55 per cent.

If your children (or you, if you are in the susceptible years) have not had the Salk shots and you think this editorial is intended to scare

only one Schering Repetab will give your patient

NONSTOP RELIEF FROM NEW YORK TO ISTANBUL



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You can prescribe these Schering products in REPETAB *form*

CHLOR-TRIMETON® REPETABS, 8 and 12 mg.
Chlorprophenpyridamine Maleate

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combined estrogen-androgen

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Chlor-Trimeton plus phenylephrine

symbol of the one-dose convenience you want for your patient

REPETABS,® Repeat Action Tablets.

PROMPT REPETAB RELIEF • LASTS ALL DAY OR NIGHT •

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*T.M.

S-111

Continued

you, that's right. This disease is a killer. It is making a comeback. What more do you need to know?

Indianapolis Times
Mar. 12, 1959

Worth a Checkup

As the American Heart Association's annual Heart Fund drive draws to a close, we are all asked to realize that there is no time limit on the giving of our dollars for vital research in this field. Heart disease and other circulatory ailments are still the great killers.

Just as the research must go on and on, just as it will benefit from a continuing flow of funds, so the ordinary citizen's precautions against these diseases must be maintained without letup.

Not long ago, under the auspices of the National Health Education Committee, eight top U. S. physicians signed a statement designed to be the basis for a broad "life-saving" effort in 1959 by the committee.

In their statement they suggested that careful attention to five listed factors might substantially reduce deaths from circulatory illness.

Research has not yet indicated flat cause and effect in the heart field. The factors they cited are those the specialists believe predispose a person to heart attack, hardening of the arteries, or stroke. Persons who suffer these afflictions, in other words, are likely to have one or more of these elements in their backgrounds.

The five factors are overweight, high blood pressure, excessive smoking of cigarets, high cholesterol level and a family history of circulatory disease.

The advice from these men, who include such experts as Dr. Paul Dudley White of Boston, Dr. Jeremiah Stamler, head of the heart disease control program for the Chicago Board of Health, and Dr. Irving S. Wright, professor of clinical medicine at Cornell medical school, is that if any of these factors shows in your record, go see your doctor.

What you learn there may keep your name out of the death notices or off the list of incapacitated. Isn't it worth a check?

Kokomo Tribune
Mar. 2, 1959

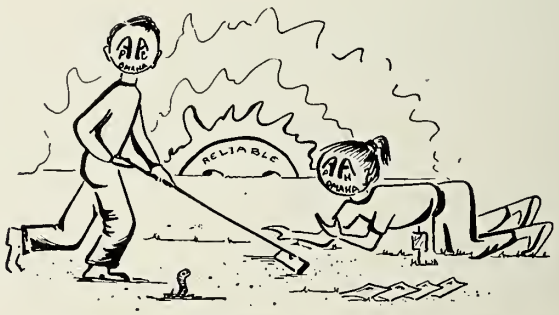
The Neurotics

Smokers, a recent study by Dr. Abraham M. Lilienfeld shows, are more neurotic than non-smokers.

Dr. Lilienfeld's report, printed in the "Journal of the National Cancer Institute," included not only the medical and social history of some 4,456 random adults, but also a series of psychological questions such as, "Do you ever feel like smashing things for no good reason?" Smokers answered "very often" about two and a half times more than non-smokers did.

That may only prove that smokers are more candid than non-smokers. Or it may also prove that smokers are just tired of hearing charges about cigarets and cancer, cigarets and heart trouble and cigarets and ashes on the carpet. But we'd suggest there's a good reason for wanting to smash things around.

In New York, for instance, cigaret taxes are being raised two more cents a pack and Mayor Wagner of New York City wants to add another city penny tax. The total, including Uncle Sam's seven-cent excise tax, would come to fourteen cents a pack. Because the companies



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ALL PREMIUMS COME FROM PHYSICIANS SURGEONS DENTISTS ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS
OMAHA 31, NEBRASKA
Since 1902



. . . and one to grow on

A tiny tablet of REDISOL to stimulate the appetite — to help in the intake of food for growth.

REDISOL is crystalline vitamin B_{12}, an essential vitamin for growth and the fundamental metabolic processes.

Ideal for the growing child, the REDISOL tablet dissolves instantly on contact in the mouth, on food or in liquids.

Packaged in bottles hermetically sealed to keep the moisture out and to retain vitamin potency in 25 and 50 mcg. strengths, bottles of 36 and 100 — in 100 mcg. strength, bottles of 36, and in 250 mcg. strength, vials of 12.

Also available as a pleasant-tasting cherry-flavored elixir (5 mcg. per 5-cc. teaspoonful) and as REDISOL injectable, cyanocobalamin injection USP (30 and 100 mcg. per cc., 10-cc. vials and 1000 mcg. per cc. in 1, 5 and 10-cc. vials).

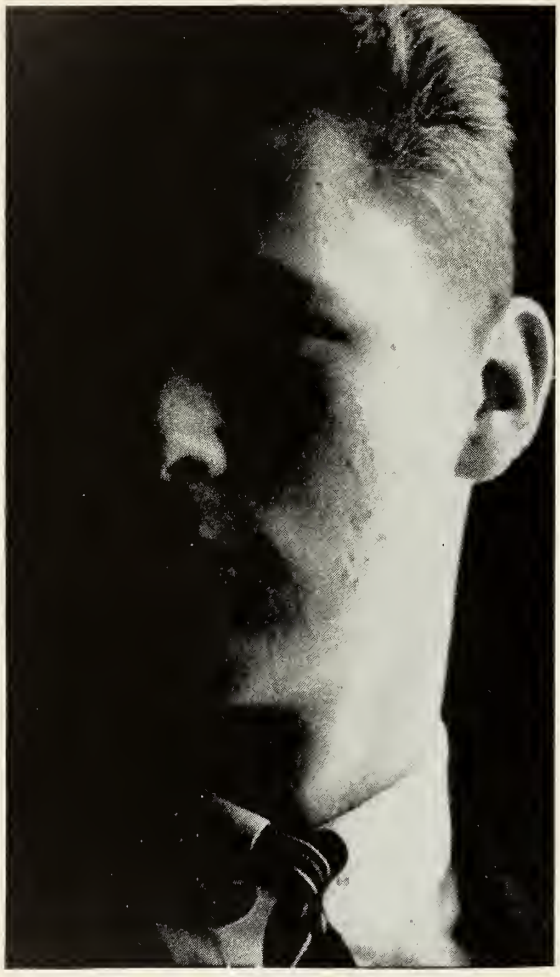
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Routine cleansing with pHisoHex augments standard acne therapy. "No patient failed to improve."[1] pHisoHex helps check the infection factor in acne. Used exclusively and frequently, it will keep the skin surface virtually sterile. Contains 3 per cent hexachlorophene.

pHisoHex®

(antibacterial detergent, nonalkaline, nonirritating, hypoallergenic)

tips the balance for superior results

Winthrop LABORATORIES
New York 18, N. Y.

1. Hodges, F.T.: GP 14:86, Nov., 1956.

Fourth Estate

Continued

making cigarets also pay income taxes which must be reflected in the prices, the smoker ends up paying as much or more for taxes than for tobacco.

It isn't any wonder Dr. Lilienfeld finds smokers somewhat nervous. It's enough to make a neurotic of any man to find out that tax collections have burned up half his pack before he's even opened it.

Wall Street Journal
Mar. 18, 1959

For Tougher Teeth

It seems elementary, but it needs to be emphasized every so often. Children need more brushing of teeth and less eating of sweet and sticky food. An expert on dentistry for children recently cautioned that these things are essential if young people are to have even moderately sound teeth by the time they become adults.

This expert noted that, of 40,000 teen-agers checked as they entered the Navy, only about 40 had teeth without cavities. The main hazards seem to be sugar and highly refined starches such as are found in white bread, crackers and ice cream. These cling to the teeth—often for hours.

Vegetables, whole grain bread and tough, chewy foods require more effort, but they are less destructive. The pioneer diet, apparently, had certain values which should not have been lost.

Kokomo Tribune
Feb. 13, 1959

In Russia you can say what you like about Krushchev —but Lord help you if you say what you don't like about him.—Walt Streightiff, *Quote.*

The man who is suddenly overpowered by temptation has probably been dreaming about it for a long time. —P. B. Sharpe, *Quote.*

The safest rule thru life, instead of reforming others, is to set about perfecting yourself.—*Tit-Bits,* London.

A secretary was applying for a new job. Under "office experience" on the application blank she wrote: "I'm familiar with all important phases of office procedure, including bowling, crossword puzzles, coffee breaks, personal letter-writing and collection-taking."—*Modern Office Procedures.*

■ Exhibits unusual analgesic properties, different from those of any other drug ■ Specific and superior in relief of SOMAtic pain ■ Modifies central perception of pain without abolishing natural defense reflexes ■ Relaxes abnormal tension of skeletal muscle

SOMA™

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

■ More specific than salicylates ■ Less drastic than steroids ■ More effective than muscle relaxants

SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with any previously used analgesic, sedative or relaxant drug.
SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

NOTABLY SAFE. Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy on high dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white sugar-coated 350 mg. tablets.
Literature and samples on request.

WALLACE LABORATORIES, NEW BRUNSWICK, N. J.

The Growth of Health Care Protection

This is the third article in a series prepared by Blue Cross-Blue Shield about the cost and methods of financing health care protection.

Prepayment and insurance as methods of financing health care costs are comparatively recent developments. In the 1920's, health care protection was not a significant factor. People who could pay their health care bills paid them. The remaining bills were paid by governmental agencies, charity—or charged off as uncollectable.

Blue Cross and Blue Shield were first in this field, and their phenomenal growth proved the urgent need for such protection. During the 1929-1939 period, 48 Blue Cross Plans were organized, with nearly 3,000,000 members. By 1945 there were 22 Blue Shield Plans, with 1,768,000 members.

Early in this period most commercial insurance companies took the position that health care was uninsurable. But after millions of people joined Blue Cross and Blue Shield, some companies became aware of the profit potential. Cautiously, and in such a way as to guarantee the insuring organization against loss, some of them began to write hospital-surgical-medical insurance.

These companies naturally place the interests of the insurance company first, management or unions second, providers of service third, and the insured individuals last.

Blue Cross-Blue Shield reverses this order. The member is first, provider of service second, management or unions third, and the Plans last.

Blue Cross-Blue Shield accepts the responsibility of guaranteeing payment to doctors and hospitals. In carrying out this responsibility, Blue Cross pays the hospitals direct, and Blue Shield makes all checks payable jointly to the doctor and patient.

The mounting public acceptance of health care protection is evident in the record growth of both Blue Cross-Blue Shield and commercial health insurance. The figures below indicate the combined membership growth nationally over the past 17 years.

End of Year	Hospital Coverage	Surgical Coverage	Medical Coverage
1940	12,312,000	5,350,000	3,000,000
1957	121,432,000	108,931,000	71,813,000

At the end of 1957 hospital expense protection covered more than 121 million persons—about 70 out of every 100 in the United States—and the majority of these also had protection against surgical and medical expense.

Most persons having health care expense protection in 1957 were covered by Blue Cross-Blue Shield or commercial insurance. The distribution by type of insuring organization is shown below:

Type of Insurer	Hospital Coverage	Surgical Coverage	Medical Coverage
Commercial Insurance	70,192,000	67,456,000	33,240,000
Blue Cross, Blue Shield & Medical Society Plans	54,923,000	45,383,000	36,926,000
All Other	4,947,000	5,597,000	6,019,000

These totals indicate that in 1957 commercial insurance covered more persons for hospital and surgical expense, but that in the medical expense area Blue Shield was doing more than all commercial insurance companies combined.

About one-third of the people of Indiana are Blue Cross-Blue Shield members. As of December 31, 1957, Blue Cross membership totaled 1,526,943. Of these, 1,396,368 had Blue Shield surgical protection, and 1,220,740 had Blue Shield medical protection.

Much has been accomplished during the past 30 years in developing and expanding voluntary health care protection. Much remains to be done, not only in terms of increasing the number of those covered—low income, aged, farmers, etc.—but also in increasing benefits to take care of rising costs, and broadening coverage in the medical, diagnostic and surgical areas. That is the trend, and Blue Cross-Blue Shield believes that a true solution to the problem of financing health care can be worked out on a completely private basis without the government being involved.

Warren Huddleston
Public Relations

Sources: Indiana Blue Cross-Blue Shield reports and Health Insurance Council Twelfth Annual Survey.

A SPOON LICKIN' GOOD SULFA!



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just 1 dose a day . . . achieves rapid therapeutic levels . . . sustained for 24 hours . . . extremely low incidence of sensitivity reactions and renal complications . . . convenient, highly economical . . .

ALWAYS ACCEPTABLE . . . WHENEVER SULFAS ARE INDICATED

Recommended dosage: first-day dose is 1 teaspoonful (250 mg.) for each 20 lbs. body weight up to 80 lbs. For each day thereafter, ½ teaspoonful for each 20 lbs. For 80 lbs. and over, use adult dosage of 4 teaspoonfuls (1.0 Gm.) initially, and 2 teaspoonfuls (0.5 Gm.) daily thereafter. Administer immediately after a meal.

Supplied: Each teaspoonful (5 cc.) contains 250 mg. of sulfamethoxypyridazine activity. Bottles of 4 and 16 fl. oz.

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Rural Communities Must Solve Own Problems

Indiana's Dr. F. S. Crockett Speaks At National Rural Health Conference

AMA News Release, WICHITA, KAN.— The need for individual communities to solve their own rural health problems—whether they be those of the aging population or the lack of physicians—was outlined by 2 dozen speakers at the recent (March 5-7) 14th National Conference on Rural Health, sponsored by the American Medical Association.

The current trend toward socialized health care cannot be reversed merely by preaching against it, according to Earl L. Butz, Ph.D., dean of agriculture at Purdue University, Lafayette, Ind.

"Aggressive community participation in positive action programs is the best answer to the philosophy held by some people that 'Washington will take care of my social security and welfare,'" he said.

Private enterprise and private initiative must be kept as the "senior partner" in local activities and government, Dr. Butz said, adding that if those services a community decides it must have are not provided by local people and local organizations, they will be provided by the government.

"We must be ever vigilant that our local communities assume the responsibilities put upon them by our private enterprise system," he concluded.

Examples of local enterprise were presented by J. D. Smerchek of the Kansas Farm Bureau, Manhattan, and Roy Battles, assistant to the master of the National Grange, Washington, D.C. Both groups have active rural health programs in which rural persons are—in the words of the AMA Council on Rural Health—helped to help themselves to better health.

One area in which communities can—and must—help themselves is that of meeting the problems of the aging population, according to Aubrey D. Gates, director of the AMA Division of Field Services. Each community has the resources, the courage and the determination to meet the problems of this group.

The first step in meeting the needs of the aging is an inventory of community assets in the form of its elder citizens—their number, their problems, and their experiences that can be used by the community. Then their needs must be measured and decisions made about how and what is necessary to meet them.

Gates pointed out that many steps are being taken to help communities meet the needs of their aged citizens. These include requests by the AMA that the Congress make available funds to help in the construction of community nursing homes; plans and suggestions offered for building and maintaining safer, more modern facilities; plans for visiting nurse service; suggestions for better home care, and plans for more adequate insurance for the aged.

He urged churches and other organized community groups to help in developing programs for the aged. State committees of doctors interested in rural health and aging may be contacted for help and advice.

Dr. Franklin D. Murphy, chancellor of the University of Kansas, Lawrence, decried the "great perversion of values" now occurring in the United States. This "deadly disease" must be fought through the conservation of human talent and its proper application, he said. We must do more to "avoid waste of human resources, both of mind and body."

As one example of this conservation and application, he believes that in rural America there must be better planning to provide area medical services. He suggested a large general hospital in one community with smaller satellite hospitals in the periphery, with patients flowing freely in both directions. In this way, costly duplication

of facilities can be avoided and maximum use can be made of limited personnel and talent.

Other speakers on the program and some highlights of their talks included:

Dr. F. S. Crockett, Lafayette, Ind., chairman of the AMA Council on Rural Health—A closer union of state medical committees on rural health with like committees in the Agricultural Extension Service, the Farm Bureau, the Grange and other groups is needed to provide better health care for rural communities. In fact, a "wholesale approach and a mass appeal" in health education is demanded.

Conrad M. Barnes, Seneca, Kan., general practitioner—"Today's family demands attention, compassion, and good medical care. Modern medicine, as practiced by modern family doctors, means better things for more people. The family doctor's patients are getting well more quickly and they are getting a tremendous bargain for their money."

Charles H. Coghlan, executive vice-president of Ohio Medical Indemnity, Inc., Columbus, Ohio—"The best buy in insurance" is determined by a number of factors, but most of all by "why you are buying the insurance coverage." Thus, what one person may consider as good coverage may be completely inappropriate for another person.

There is a growing demand for health insurance coverage for home and office calls, in addition to surgical and specific medical coverage. Ways will be found to meet this new demand.

John Pond, management consultant to the Larimore County Hospital, Boulder, Colo.—Hospital care is expensive and will probably continue to increase. The problem seems to be one of having the patient understand the necessity for the expenses. At least 80 cents of each hospital expense dollar should be allocated for hospital services, 12 cents for administration, and 8 cents for plant operation and maintenance.

Patient satisfaction is increased by those things that money cannot buy—kindness, sympathy, courtesy, thoughtfulness, a cheerful disposition, respect for the dignity of the individual.

Dr. Louis M. Orr, president-elect of AMA, Orlando, Fla.—Scientific, technological, educational and construction progress has helped to make the present-day rural practitioner a first-rate medical force in the community and throughout the nation. The efficiency of the rural practitioner continues to increase. In the last 15 years, his efficiency has risen 30%. He's seeing more patients and giving them better care.

Mrs. E. Arthur Underwood, D.D.S., Vancouver, Wash., president of the Auxiliary to the AMA and a practicing dentist—Most dental diseases can be prevented or controlled if a person follows rules of good health, good diet, and good tooth care. Teeth must be brushed adequately for three minutes twice a day. A three-minute hour glass in the bathroom will help measure the correct length of time.

Martin P. Hines, D.V.M., Raleigh, N. C.—Animal diseases that are transmissible to man (brucellosis, tuberculosis, and Q fever) are already being controlled through the cooperative efforts of veterinarians, physicians, rural and public health authorities. Rural persons do not have "to live with" many of these animal diseases that cause loss of life, physical suffering and chronic illness.

Dr. Alonzo P. Peeke, Volga, S. D.—Even such rural states as South Dakota are able to de-



MARY POGUE SCHOOL, INC.

Founded 1903. Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Varied group activities under competent direction on our spacious grounds of 28 acres. Selected movies.

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Total enrollment 90.

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To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U. S. PAT. OFF.—METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

The Upjohn Company, Kalamazoo, Michigan

Upjohn

Rural Communities

Continued

velop sound programs for the care of the mentally ill and mentally retarded. South Dakota through its state mental health association is providing better care for the mentally ill. Chapters of the association are organized in local communities. They work to raise the standards of treatment, to develop community treatment resources, and to educate the public.

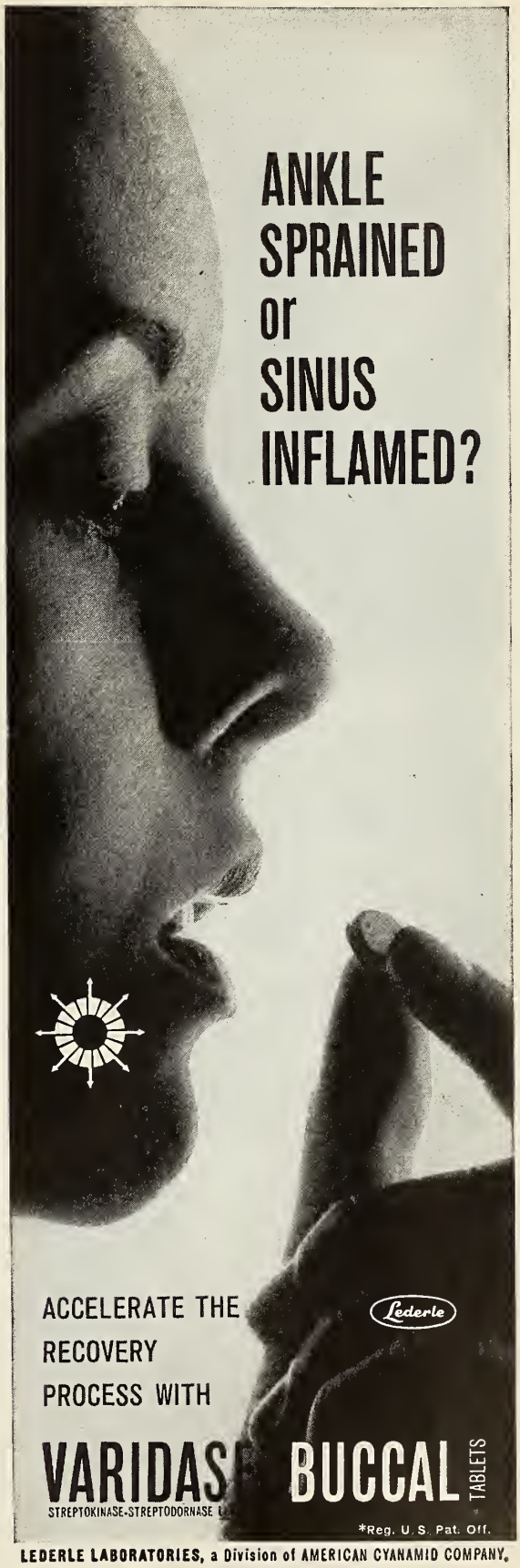
Dr. C. R. Brott, Beatrice, Neb.—His hospital has developed a modified "progressive care program" in which the seriously ill patient receives intensive care in a special unit. The less seriously ill patient is moved to another area where his care is less intensive and in turn less expensive. This area is called the "convalescent or geriatrics annex."

Dr. Prescott W. Thompson, director of outpatient service at Menninger Clinic, Topeka—There is hope on the horizon for the mentally ill. It can be realized by making all mental hospitals into hospitals which have shed any resemblance to asylums and "their gloomy exteriors and hopeless interiors . . . A mental hospital is visible evidence of what psychiatry is and what it offers."

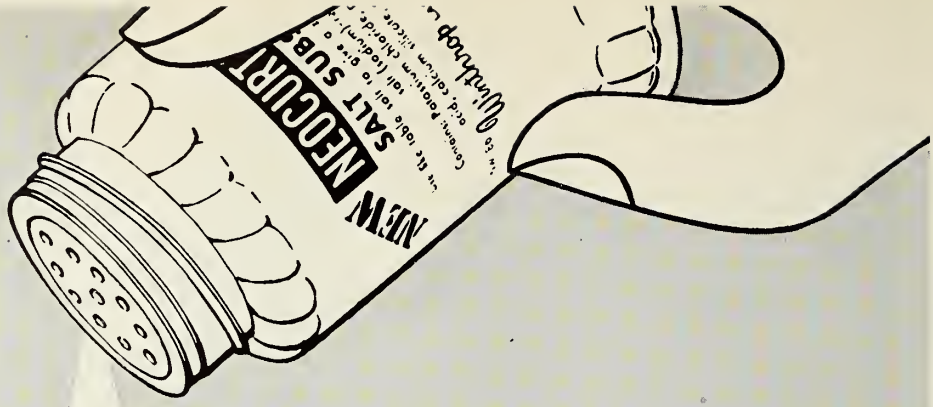
Dr. Julio Sanchez Vegas, Caracas, Venezuela, a special guest at the meeting—Better and cheaper drugs to treat intestinal parasitic diseases are badly needed, especially in Venezuela, where nearly half of the population is infested with parasites. Physicians, rural health technicians and pharmaceutical companies must work toward finding the necessary drugs to help not only Venezuela but also the millions of other persons who "are crippled by parasitic diseases."

Dr. T. P. Butcher, Emporia, Kan., president of the Kansas Medical Society—Science has proved the existence of 4 dimensions, but it could not have done so without the fifth dimension"—the human factor that is present in every calculation that man makes. It is his awareness of himself and everything else in time and space. Without this fifth dimension, man is alone—"a bitter victim of a grim and cosmic jest."

These days driving is like Russian roulette—you never know which driver is loaded.—Vesta M. Kelly, from *Quote.*



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



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NEW **Neocurtasal**® — available in convenient 2 oz. shakers and 8 oz. bottles.

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orange flavored, 2 oz. bottle, 125 mg. per teaspoonful (5 cc.)

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orange flavored, 10 cc. bottle (with calibrated dropper), 5 mg. per drop (100 mg. per cc.)

Note: Rapid and high initial antibiotic blood levels are an important factor in uneventful recoveries. Glucosamine potentiation provides the fastest, highest tetracycline levels available with oral therapy. Bibliography and professional information booklet available on request.

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Prepared by

Knox County Medical Society

Vincennes

The AMA has been criticized by some labor spokesmen for not having safeguards for a continuing preservation of high quality medical care rendered by individual practicing physicians in their offices. It is true that a formal mechanism has not been established, because the AMA has considered that the Joint Commission of Hospital Accreditation exerting its influence upon the quality of medical care in the hospitals would imply that the doctors would practice the same high quality care of patients in their offices as in their hospital practice. Unfortunately, these critics assume that the majority of these doctors have a Dr. Jekyl and Mr. Hyde personality and are making great effort to convince the public of this falsehood.

Continuing education of physicians has long been recognized by our profession as being necessary. Postgraduate programs, specialty boards, the conditions for membership in the Academy of General Practice and many other similar existing provisions all attest to this fact which preceded "Union" criticism of AMA.

To encourage physician participation in such activities to improve the patients' medical care has recently been under study to seek a feasible mechanism. There are at present 3 different suggestions to enable us to attain the desired goal and provide satisfactory evidence of individual performance.

First Suggested Method: AMA President Gundersen's Proposal for Periodic Retesting of Physicians by the State Medical Boards of Examination and Medical Licensure.

He suggested a 5-year interval; it is understood that Germany does this at 10-year intervals. Aside from the numerous different tests for each type of practice that would have to be given and the admitted difficulty involved in written and/or oral exams, the biggest objection is that physicians would be turning to a governmental agency appointed politically by the governors of the respective states.

Second Suggested Method: Pennsylvania Medical Association's 10th District proposes that a Central Registry be maintained for the doctors based upon what they are certified to perform by their hospital medical staffs. Any third party could thus make inquiry whenever an individual's competence was questioned. This is an improvement over the first suggestion in that physician staffs evaluate their peers, but it does not recognize that half the nation's hospital staffs are not organized under the Joint Commission of Hospital Accreditation, that in cities having more than one hospital there may be omissions from one or more such hospitals thereby resulting in a competent man appearing incompetent to the uninitiated inquirer.

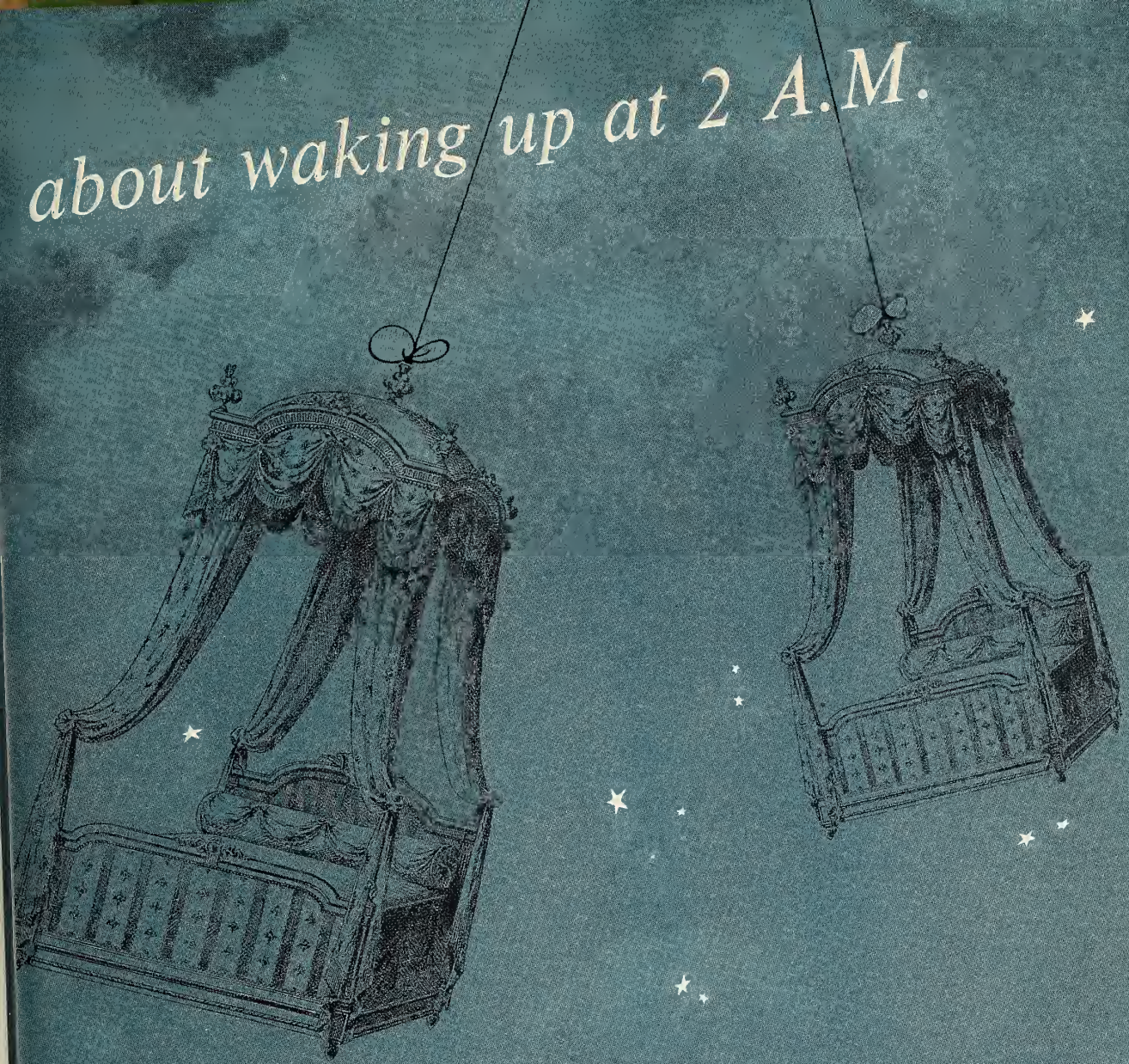
Third Suggested Method (and there will probably be others in time): Indiana "Perpetual Clinical Profiles" for County Medical Society Members. Purpose: To provide stimulus to member physicians to maintain their medical education in keeping with scientific progress thus enabling them to render the highest quality medical care to their patients. To provide a method of medical auditing for office as well as hospital practice. To provide a mechanism for any legitimate inquiry by authorized patient representative as to qualifications (professional) of a particular physician with the consent of said physician. To enable medical society defense of its members who might be unjustly discriminated against by any purchaser of medical care. This profile would contain pertinent information concerning his continuing medical training, accomplishments and evaluation by his peers.

Proper Group for this purpose:

The County Medical Society is the basic medical organization for ALL physicians. Although there are many special interest medical organizations and many of the concepts contained

Continued on page 660

about waking up at 2 A.M.



nebralin®

timed-release tablet

timed-release action for a full night's sleep

NEBRALIN is designed to duplicate the normal sleep pattern. It encourages muscular relaxation and induces sustained, relaxed sleep by the release of Dorsital and mephenesin in a timed-release tablet. Rapid-acting mephenesin quickly relaxes skeletal muscles to overcome "fatigue-tension" and conditions the body for sleep. Dorsital provides CNS sedation to induce sound, relaxed sleep. The initial and sustaining dosages are designed to keep the amount of barbiturate to be inactivated at any one time at a low level tapering toward morning. Evidence indicates that mephenesin is capable of producing sleep,[1] and when combined with a barbiturate enhances barbiturate action.[2, 3] Moreover, the integrated action of the two components permits smaller dosages of each,[4] assuring your patients refreshed awakenings without "morning hangover."

1 Schlesinger, E. B.: Tr. New York Acad. Sc. 2:6, (Nov.) 1948.
2 Richards, R. K., and Taylor, J. D.: Anesthesiology 17:414, 1956.
3 Shideman, F. E.: Postgrad. Med. 24:207, 1958.
4 Berger, F.: Pharmacol. Rev. 1:243, 1949.

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Clinical Profiles

Continued from page 656

herein were adopted from them, the county society is the only effective group, especially suited to such a broad, all inclusive project.

Voluntary Program:

The above goals are NOT to be achieved by coercion or expulsion from the local society. It is our belief that rehabilitation is more useful to the public good than is ostracism. This is then to be a voluntary program undertaken by interested physicians who appreciate its benefits to themselves and their patients . . . we are confident that in a few years all physicians will be participating.

Experimental Stage:

At the present time, many of the exact details of operating such a program have not been determined. The process of evolution and the expected adaptations to varying local conditions will produce a variety of different modifications which need not detract from the basic intent and usefulness of this accreditation program. It is conceived that an officer of the local society or a permanently designated registrar will be custodian of the individual doctor's file; however, the doctor could keep his file in his office producing it upon request of the registrar at anytime. His failure to do so would be evidence that he was not interested in presenting his case should question arise and would be obvious to all.

The following illustrates what is felt should be included as a minimum in the program. First, a record; second, a goal for study; third, a mechanism of office analysis.

Suggested Outline of Perpetual Clinical Profiles

1. Medical Training History—Premed and medical schools, internships, residencies—formal training programs . . . dates, places, etc.
2. Board Certification—If in process of taking boards, "passed Part I," etc.
3. Field of Practice—Speciality? Special interests or limited practice?
4. History of practice locations with dates; hospital appts; health officer? Solo, partnerships, or group? Part-time industrial appointments?
5. Military Service and clinical assignments.
6. Hospital medical staff offices and committee appointments. Accredited hospital? If a man was on Tissue Committee, he must have been respected by his collegues.
7. Medical society memberships, offices held, important committee memberships?
8. Special awards.
9. Community service record—School board member, Cancer Society advisor-chairman, etc.
10. Medical papers written, keep reprints—Medical lectures, keep copy of program in file.
11. Postgraduates study—Keep record of attendance, file program copy, Recommend minimum number of hours similar to Acad. G.P., urge adequate patient coverage during absence of colleague at P.G. courses cooperation and rotation.
12. Audit of office practice—Based upon self



analysis by doctor through medical writing. The papers may be published or presented and discussed before critical colleagues. To prepare such papers from the doctor's office cases require adequate clinical information in his records plus a coding system for locating the charts by medical terminology. Coding would also be helpful in locating patients for follow-up, for reminders of past due immunizations and yearly physicals, as well as statistical evaluation of quantity and quality of work performed. This is *not* an impossible job which can only be performed in ivory towers! The Clinical Analysis of Office Practice can be performed by individual physicians with the same amount of "control" as is found in a hospital or clinic study, for in the last analysis the man is *judged* by his *conclusions* drawn from the facts and methods which he used and presented to a critical, medically intelligent audience!

13. Membership in a scientific journal club? What Journals does he donate to his hospital library? What Journals does he take?

14. Adverse evidence might be included depending upon local decision; e.g. evidence of fee splitting, if antiques are desired. The Internal Revenue Service probably keeps more accurate records on this activity if anyone wishes to survey the problem.

Remember the purpose of an Accreditation Program is to improve patient care, not to be punitive regarding individual doctors.

Give

Generously

to

A.M.E.F.



Sanctarius on his steelyard chair in the act of weighing himself for a metabolism experiment

in obesity

bring the . . . **MOOD UP**

. . . **WEIGHT DOWN**

keep **BLOOD PRESSURE LEVEL**

with

QUADAMINE

GRANUCAP®

Quadamine GRANUCAPS® provide uniform and sustained therapeutic response. No excitation or sedation. Elevates the mood, protects against nutritional deficiencies, promotes activity and depresses the urge to eat.

Each GRANUCAP® (Sustained release) capsule contains:

Dextro Amphetamine Sulfate	15 mg.	Vitamin C	30.0 mg.
Amobarbital	45 mg.	Ferrous Sulfate	20.0 mg.
Vitamin A	6,600 Units	Cobalt Sulfate	0.49 mg.
Vitamin D	400 Units	Copper Sulfate	2.8 mg.
Vitamin B-1	1.6 mg.	Sodium Molybdate	0.45 mg.
Vitamin B-2	2.5 mg.	Zinc Sulfate	3.9 mg.
Niacinamide	15.5 mg.	Potassium Iodide	0.13 mg.

REFER TO PDR

PAGE 826

Samples and information on request. Write or ask your TUTAG representative

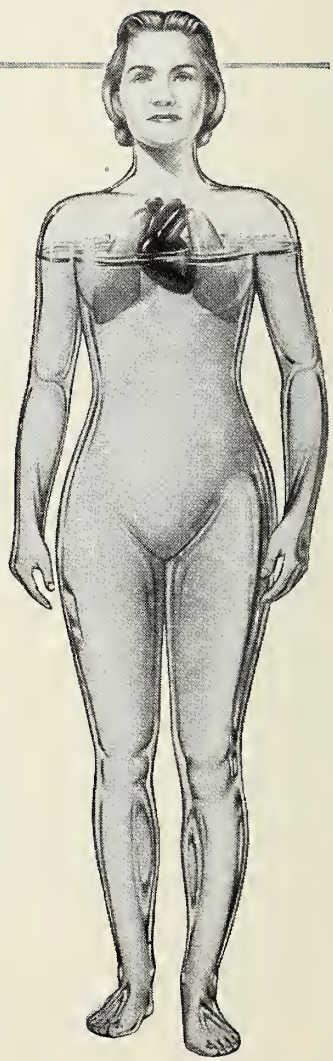
TUTAG

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DETROIT 34, MICHIGAN

From basic research—basic progress

A NEW MEASURE OF ACTIVITY



IN EDEMA:

- shows greater oral effectiveness than any other class of diuretic agent
- each 25 mg. HYDRODIURIL orally is equivalent to 1.6 cc. meralluride I.M.
- has been reported to be effective even in patients who do not respond satisfactorily to other diuretics
- has prompt onset of action with diuretic effectiveness maintained even on prolonged daily administration
- low toxicity—extremely well tolerated
- often achieves the benefits of a low salt diet without the unpleasant restriction

indications: Hypertension, congestive heart failure of all degrees of severity, premenstrual syndrome (edema), edema and toxemia of pregnancy, renal edema—nephrosis, nephritis; cirrhosis with ascites, drug-induced edema, and as adjunctive therapy in the management of obesity complicated by edema.

dosage: In edema—one or two 50 mg. tablets of HYDRODIURIL once or twice a day.

In hypertension—one or two 25 mg. tablets or one 50 mg. tablet HYDRODIURIL once or twice a day.

supplied: 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) in bottles of 100 and 1,000.

*HYDRODIURIL and DIURIL are trademarks of Merck & Co., INC.

Additional information on HYDRODIURIL is available to the physician on request.

bibliography: 1. Esch, A. F., Wilson, I. M. and Freis, E. D.: 3,4-Dihydrochlorothiazide: Clinical Evaluation of a New Saluretic Agent. Preliminary Report; M. Ann. District of Columbia **28**:9, (Jan.) 1959. 2. Ford, R. V.: The Clinical Pharmacology of Hydrochlorothiazide; Southern Med. J. **52**:40, (Jan.) 1959. 3. Fuchs, M., Bodi, T., Irie, S. and Moyer, J. H.: Preliminary Evaluation of Hydrochlorothiazide ('HYDRODIURIL'); M. Rec. & Ann. **51**:872, (Dec.) 1958. 4. Moyer, J. H., Fuchs, M., Irie, S. and Bodi, T.: Some Observations on the Pharmacology of Hydrochlorothiazide; Am. J. Cardiol. **3**:113, (Jan.) 1959.

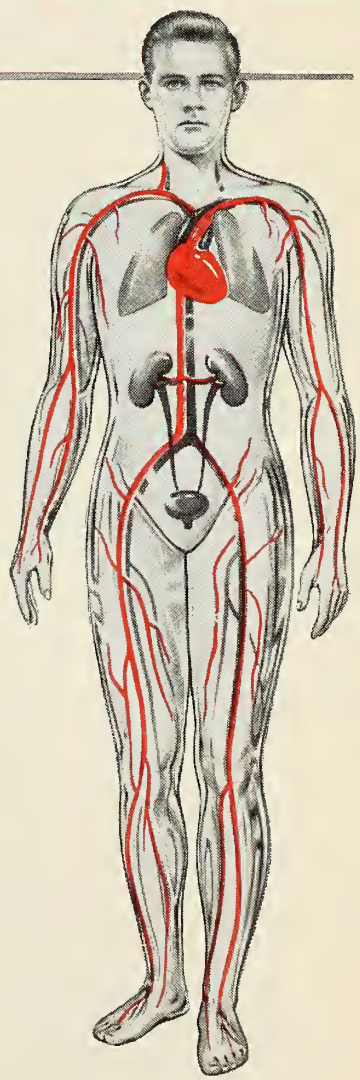
HYDRODIURIL (HYDROCHLOROTHIAZIDE)

- highly-active derivative of chlorothiazide
- qualitatively similar to DIURIL® but at least 10 to 12 times more potent by weight
- loss of potassium is clinically insignificant in the great majority of patients on normal diets

HYDRODIURIL*

NEW RELEASE

HYDROCHLOROTHIAZIDE



IN HYPERTENSION:

- effective by itself in some patients—markedly potentiates other antihypertensive agents
- provides background therapy to improve and simplify the management of all grades of hypertension
- has been reported by some investigators to have a greater antihypertensive effect in some patients than chlorothiazide at equivalent dosage
- does not lower blood pressure in normotensives
- reduces dosage requirements for other antihypertensive agents, often with concomitant reduction in their distressing side effects
- smooths out blood pressure fluctuations

precautions: It is important that the dosage be adjusted as frequently as the needs of the individual patient demand. When HYDRODIURIL is used with a ganglion blocking agent, it is mandatory to reduce the dose of the latter by at least 50 per cent, immediately upon adding HYDRODIURIL to the regimen.

HYDRODIURIL has shown no adverse effects on renal function; for this reason it may be used with excellent results even in patients for whom the organomercurials are contraindicated because of renal damage.

The excretion of potassium is much lower than that of sodium or chloride and, as is the case with DIURIL®, the loss of potassium is clinically insignificant in the great majority of patients on normal diets. If indicated, potassium loss may easily be replaced by including potassium-rich foods in the diet (orange juice, bananas, etc.).

MSD

MERCK SHARP & DOHME

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to the editor:

February 16, 1959

For the past several years the Subcommittee on Blood Dyscrasias of the Committee on Research has sponsored a pilot study of cases of blood dyscrasias in which the use of therapeutic agents was suspected as being the possible cause of the condition. Upon review of the work of the Registry on Blood Dyscrasias, the Subcommittee concluded that this information could serve as "an early warning system for the medical profession." They recommended that the Summaries be distributed semi-annually and more widely to a larger number of physicians. It is hoped through this means that physicians will become aware of the existence of the Registry and will report cases which come to their attention.

I am enclosing a Summary tabulation of the cases reported to the Registry for the period of July 1 to December 31, 1958. The cases in the present Summary have been derived from a number of sources, namely: reports from a selected group of collaborating physicians in the United States and Canada and cases reported in the literature. It should be pointed out that inclusion of a drug in the list does not mean necessarily that it is harmful or that it was the cause of the reported dyscrasia. The information contained in the Summary is not to be considered as having statistical significance since these are raw data and undoubtedly represent only a small segment of the total number of cases which probably occur. In order to make this material more useful it would be appreciated if this Summary were brought to the attention of any members of your Society to whom you feel it would be of interest.

Should the reader have cases of blood dyscrasias in which a drug or drugs are suspected as having been the possible etiologic agent, it would be appreciated if this fact were brought to our attention either by letter or report form which we will supply. Letters, inquiries, and requests for report forms should be directed to the Secretary, Committee on Research, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Norman De Nosaquo, M.D.
Secretary,
Committee on Research,
Council on Drugs.
American Medical Association

(Note: A copy of the Summary tabulation mentioned above is on file at the office of *The Journal,* where it may be inspected. It will be mailed to members on request.)

A woman arrived home in the U.S. after a long stay in the Orient. With her she had her little 6-month-old son. When she came to the customs inspection her heart sank as the official looked sternly at the large pile of luggage that was hers.

"What articles of value have you acquired abroad in the last 12 months?" he demanded.

"Well, there's the baby—" began the woman.

The customs official stared at the sleeping infant in the woman's arms. Then, waving the woman thru with all of her luggage, he smiled:

"Madam, original works of art are exempt from duty!"

The dangerous thing about about middle-of-the-roaders is that so many of them seem to drive.—Pep Mealiffe, *Quote.*



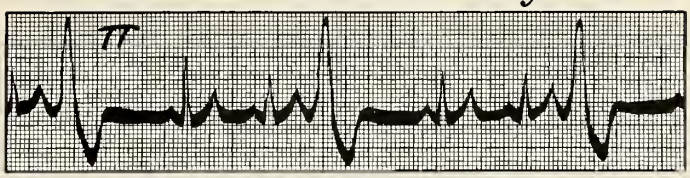
A pilot for the past four years

Charles Myers, an abave knee amputee, wore his first Hanger Limb aver eight years aga. "During that time I was in Central America, Mexica, and Canada. In Central America I warked an air route surveys under jungle conditions. I faund that my Hanger Limb stoad up well." The sturdiness and dependability af the Hanger Limb allows wearers ta return ta narmal life. Many, such as Mr. Myers, find they can cantinue their unusual occupations.

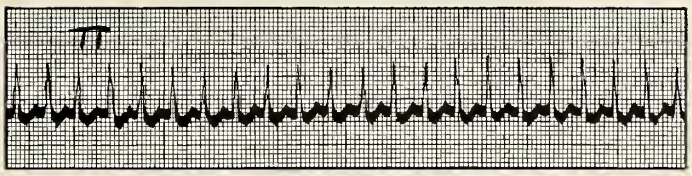
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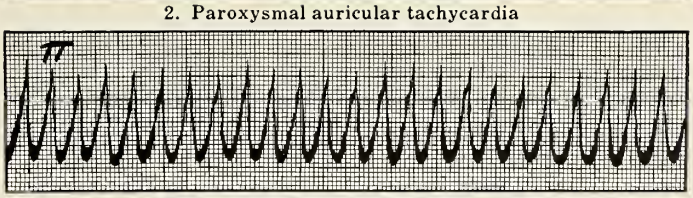
restore normal sinus rhythm



1. Premature ventricular contractions



2. Paroxysmal auricular tachycardia



3. Paroxysmal ventricular tachycardia

in arrhythmias

VISTARIL

hydroxyzine pamoate*

More than a tranquilizer

SPECIFIC ANTIARRHYTHMIC EFFECT

Vistaril is effective in ventricular extrasystoles and paroxysmal tachycardias (both auricular and ventricular).

plus

PSYCHOTHERAPEUTIC POTENCY

proven calming action indicated for arrhythmia patients.

and

THE OUTSTANDING SAFETY

of Vistaril as compared to other antiarrhythmic drugs in general use has been noted by investigators.

THE FOLLOWING DOSAGE REGIMEN IS RECOMMENDED

(individualized by the physician for maximum effectiveness):

PARENTERAL DOSAGE: 50-100 mg. (2-4 cc.) I.M. stat., and q. 4-6 h., p.r.n.; maintain with 25 mg. b.i.d. or t.i.d. In acute emergency, 50-75 mg. (2-3 cc.) I.V. stat.; maintain with 25-50 mg. (1-2 cc.) I.V. q. 4-6 h., p.r.n.

ORAL DOSAGE: Initially, 100 mg. daily in divided doses until arrhythmia disappears. For maintenance or prophylaxis, 50-75 mg. daily in divided doses.

SUPPLY: Vistaril Capsules, 25 mg., 50 mg. and 100 mg. Vistaril Parenteral Solution, 10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. (as the hydrochloride).

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References: 1. Burrell, Z. I., et al.: Am. J. Cardiol., 1:624 (May) 1958. 2. Hutcheon, D. E., et al.: J. Pharmacol. & Exper. Therap., 118:451 (Dec.) 1956.

Medical Researchers to Hold Conference Relating to Medical Research Laws

Nat'l Society for Medical Research, Chicago—The hodge-podge of laws and regulations now governing medical research obstructs and imperils progress in the life sciences, according to Dr. Lester R. Dragstedt, president of the National Society for Medical Research and professor of surgery at the University of Chicago School of Medicine. To bring order into this chaotic situation, the society, in conjunction with the University of Chicago has called the first National Conference on the Legal Environment of Medical Science. The meeting will be held May 27-28 on the University of Chicago campus.

Because in 39 states you can will your automobile, your house or your bank account, but cannot bequeath your cornea to an eye bank, or your own body to a medical school for research, scientists are facing a critical lack of materials for research in anatomy, pathology and organ transplants. "In an era when physical science knows no limits," Dr. Dragstedt stated, "biology and medical advances are thwarted by jerry-built laws which were mainly enacted before the new medical possibilities appeared on the horizon."

Physicians, scientists, and lawyers also are confused over legal rights and responsibilities toward human beings serving in trials of new medical treatments. Practical problems such as access to cadavers and obtaining animals for humane use in laboratories, according to Dr. Dragstedt, has stimulated the society, whose membership includes all the accredited medical schools and most medical research associations, to issue a call for clarification of standards.

Participants will include scientists, legal scholars, religious leaders and representatives of various groups affected by differing practice, decisions and laws, which Dr. Dragstedt says have "just growed like Topsy" over the years.

The conference will focus on 3 major fields:

1. Medical experiments on human subjects.
2. Medical studies involving the use of dead human bodies.
3. Medical experiments on animal subjects.

The conference is an outgrowth of an NSMR standing committee under Dr. Oliver P. Jones, head of the Anatomy Department of the University of Buffalo Medical School. The Committee was established originally to investigate shortages of cadavers for anatomical studies.

The conference will attempt to reach agreements on ethical standards for the experimental use of human volunteers, cadavers and laboratory animals. The conferees will also seek to develop principles for a model legal code to govern research in medicine.

Rev. Thomas J. O'Donnell, S.J., Regent, Georgetown University School of Medicine, will be chairman of the section on human experimentation.

Dr. Russell T. Woodburne, Professor of Anatomy, University of Michigan School of Medicine, will chairman the section on the use of cadavers.

Dr. William T. S. Thorp, Dean of the College of Veterinary Medicine, University of Minnesota, will be the chairman of the section on animal experimentation.

Dr. Irvin Ladimer will serve as conference secretary. He is an authority on the legal and ethical aspects of medical research on human beings. Formerly associated with the National Institutes of Health where he developed a medical malpractice insurance plan for use of normal volunteers and served as secretary of the Clinical Research Committee.

Inquiries relating to the conference should be addressed to the National Society for Medical Research, 920 South Michigan Avenue, Chicago 5.

RESEARCH:

key to Kent's popularity

In 1958, Kent made the greatest gain in popularity ever recorded by any filter cigarette in any year—a sales increase of 20-billion cigarettes.

Behind this popularity is a story of months and years of research, perfecting the remarkable combination of filter action and flavor found in today's Kent cigarette. In developing Kent, Lorillard research scientists recognized that smokers wanted, on the one hand, a really satisfying taste; on the other, reduced tars and nicotine. In addition, smokers demanded a free and easy draw.

These, then, were the objectives. The first scientific breakthrough in the project was the development of the exclusive Micronite filter, patented by Lorillard. This filter was created because of newly-discovered principles in the field of filtration, which have been previously described in these pages.

Though this filter satisfied everyone on its ability to reduce tars and nicotine to the lowest level among the largest selling brands, there was still work to be done in the areas of taste and draw. After additional months of research, a new tobacco blend was developed which delivered rich taste *after* the smoke had passed through the filter. Next in the series of laboratory triumphs was a method of improving the draw to compare with the most free-drawing of all filter brands.



The rest of the Kent story is a legend in the tobacco industry. Outside, independent research studies confirmed the fact that Kent had achieved its objectives. Smokers responded. In fact, during the past year, more smokers changed to Kent than to any other cigarette in America.

A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!

Wanted: LOCATIONS

Following is a list of physicians who have made inquiry at the ISMA office during February and March, 1959, concerning openings in our state for general practice:

Physicians Seeking Locations

William R. Stewart, M.D., 482 Clearview Dr., Euclid 23, Ohio.

E. James Potchen, M.D., 806 Kalamazoo Ave., S. E., Grand Rapids 7, Mich.

Arnold J. Funckes, M.D., 2240 Cordova, Youngstown, Ohio.

Robert L. Woodall, M.D., Methodist Hospital, 1600 W. 6th Ave., Gary, Ind.

William R. Wells, M.D., 11 Blanchard St., Bangor, Maine.

Kenneth W. Eskew, M.D., 23 Marlin Drive, Brookside Park, Newark, Del.

Don G. Warren, M.D., 140 Perimeter, S.E., Albuquerque, N. M.

James A. Danford, M.D., 217 Lee Dr., Ellsworth AFB, So. Dak.

Victor E. Schlossberg, Jr., M.D., U. S. Naval Air Station, Grosse Ile, Mich.

Henry H. Cohan, M.D., 20th Station Hospital, APO 696, New York, N. Y.

Specialists

Richard E. Hosbach, M.D., 523 E. 82nd Street, New York 28, N. Y. **OB-GYN.**

O. O. Wiswell, M.D., 6223 Forest Avenue, Des Moines, Iowa.

Carl E. Solomonson, M.D., 8700 W. Wisconsin Avenue, Milwaukee, Wisconsin. **Internal Medicine.**

Thomas E. Von der Haar, M.D., 1879 Ackley, Wayne, Michigan. **Internal Medicine—solo or small group.**

R. S. Logan, M.D., 1525 State Street, Santa Barbara, California. **Dermatology.**

James Poon, M.D., 6102 E. Marily Road, Indianapolis, Indiana. **Ophthalmology.**

Floyd D. Travis, M.D., 1123 Grafton Street, Dayton, Ohio. **General surgery—solo or group.**

Roger C. Murray, M.D., 2101 Fox Avenue, Madison 5, Wisconsin. **General surgery.**

Frank L. Lanuti, M.D., 215 S. Randall Avenue, Madison 5, Wisconsin. **General surgery.**

Raymond Vespa, M.D., 959 21st Street, Des Moines 11, Iowa. **General surgery.**

George Nishioka, M.D., 1827 Pelham Avenue, West Los Angeles 25, California. **General surgery.**



IT ALL ADDS UP!

+ Friendly and well trained personnel

+ 33 Modern Laboratories

+ Blue Ribbon ℞ Service

+ Finest optical supplies

+ Guaranteed satisfaction

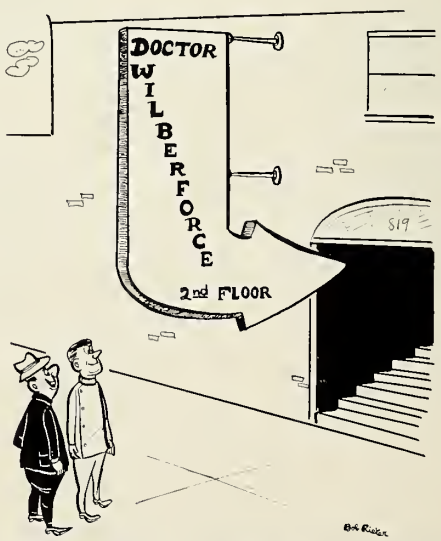
It's easy to do business with White-Haines

The WHITE-HAINES OPTICAL COMPANY

Blue Ribbon Rx Quality for Over Half a Century

INDIANAPOLIS, SOUTH BEND and TERRE HAUTE

GENERAL OFFICES: COLUMBUS 16, OHIO



"Finally hung up your 'shingle' eh, Wilberforce?"

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 52 — May 1959 — Number 5

Narcotics and the Practicing Physician

A PHYSICIAN who compounds, sells, deals in, dispenses or gives away narcotic drugs must first register with the District Director of Internal Revenue in the district in which he plans to establish his practice. This is accomplished by writing a letter to the district director. Once registered, the physician is given a narcotic registration number and is issued a Special Tax Stamp.

The stamp must be renewed each year. A one-dollar fee is charged annually for this service. With each renewal the physician must declare all narcotics on hand. This inventory is prepared on the reverse side of Form 678, the Application for Registry, which is mailed to him by the director. The duplicates of the inventory must be kept on file for spot inspection over a period of 2 years. Penalties may be assessed for failure to return renewal application and inventory on time.

This article is composed of excerpts from publications of the Bureau of Narcotics, including Regulations No. 5 and Pamphlet No. 56. Published with the consent and approval of the Supervisor, District No. 9, Bureau of Narcotics.

Each year the old stamp is replaced by the new stamp, and the new stamp must be posted in a conspicuous place at the location of the practice. Penalties may be imposed for failure to do so.

Should the physician relocate his practice in a new district, he must re-apply for a new registration number, for the one he used in the previous district is now invalid. This may be accomplished by writing the director of the original district.

If the physician discontinues practice on any date other than June 30 he shall return the Special Tax Stamp to the district director. The stamp will be cancelled and returned to the physician, who should retain it for at least 2 years. All narcotics on hand should be disposed of in accordance with instructions of the director.

If the physician relocates his office in the same district, or if he changes his name, he should execute a new Form 678, marking it revised registry and forward the same, together with his Special Tax Stamp, to the district director who issued the stamp for recording the change.

Loss or destruction of the stamp must be reported immediately to the district director.

Physicians who store or dispense narcotics in more than one office must have proper registration and pay the special tax for each office. He must keep separate records for each office, and at the time of reregistration he must file separate inventories on his Forms 678.

After the physician is registered and has a Special Tax Stamp, he is entitled to issue prescriptions for narcotic drugs and he may order narcotic drugs for dispensing purposes pursuant to official order forms. Official order forms may be obtained in booklets from the district director for 10 cents per booklet.

Purchase of Narcotics for Dispensing

The official order forms bear the physician's name, address and registry number and also a serial number which is recorded by the director. The physician may order supplies of narcotics by filling out order forms and directing the original and triplicate copies to a dealer. The duplicate copy must be maintained by the physician for a period of 2 years. The dealer will complete the physician's order and fill out the proper spaces, retain the original copy of the order form and forward the triplicate copy to the District Supervisor, Federal Bureau of Narcotics.

All official order form blanks must be kept in a safe place, particularly out of reach and sight of visitors to the office. Any loss of unused or used order forms must be reported to the Commissioner of Narcotics, Washington, D. C., as soon as the loss is noted, with notation of the serial number of each form. If an entire book of order forms is lost or stolen, and the registrant is unable to state the serial numbers of the order forms contained therein, he shall report, in lieu of the numbers of the forms, the date or approximate date of purchase.

If any forms thus reported are subsequently recovered, this fact must be reported to the commissioner of narcotics.

The attachment of extra sheets to order forms is not permitted. If one order form is not sufficient to include all the items of an order, an additional form or forms shall be used. The forms shall not in any case be used as prescriptions.

Order forms must be prepared by use of typewriter, ink or indelible pencil. The purchaser must enter in the space provided at the bottom of the form the number of items ordered.

The physician must sign his name as it appears on his application for registration—in ink or indelible pencil.

No alterations, erasure, or change of any description may be made in any order, or in the endorsement thereon, by any person.

Any order form returned because of improper preparation must be retained on file with the duplicate thereof and a new form prepared if the articles are still desired.

When a physician discontinues practice or transfers to a different location in the same or different district, he shall return for cancellation all unused order forms to the district director from whom obtained.

The presence of order blanks, along with the small amount of narcotics the physician carries in his bag, presents a strong argument against the use of any device which indicates an automobile to be that of a physician. Certainly, no physician with any sense of responsibility will leave his bag inside his car so it is visible to a passer-by. The trunk is more difficult to enter and, for that reason, is the place of choice for storage when the bag is not in use.

Another safety feature regarding stocking and safeguarding narcotics is that the physician should order only a small working supply of narcotics to be kept on hand. He should obtain an office safe approved by Underwriters Laboratories to store narcotics for office use.

Prescribing Narcotics

The prescribing of narcotics is usually done through the medium of prescription blanks. The use of prescription blanks for prescribing narcotics has been carefully outlined to avoid alteration or misuse. First, and quite important, they must never be used to stock one's office supplies. True, it is a simple matter to write a prescription for 20 morphine sulphates, ¼ grain, give the patient one, and utilize the remainder for 19 other patients. This method is convenient, quick, economical and obviates the necessity of keeping records. It has one drawback; it is about as safe as sleeping with a hungry boa constrictor. The Bureau, of necessity, views this practice with extreme disfavor.

All narcotic prescriptions shall be dated as of and signed on the day when issued and shall

bear the full name and address of the patient and the name, address and registry number of the practitioner. Prescriptions should be written with ink or indelible pencil or typewritten; if typewritten, they shall be signed by the practitioner.

An order purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment but for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of the act; and the person filling such an order, as well as the person issuing it, may be charged with violation of the law.

The refilling of a prescription for narcotics is prohibited.

Except as noted in the second paragraph below, the furnishing of narcotics pursuant to telephone advice of practitioners is prohibited, whether prescriptions covering such orders are subsequently received or not, except that in an emergency a druggist may deliver narcotics through his employe or responsible agent pursuant to a telephone order, provided the employe or agent is supplied with a properly prepared prescription before the delivery is made, which prescription shall be turned over to the druggist and filed by him as required by law.

A physician's telephone request for furnishing of narcotics without a written prescription places the pharmacist in an unfortunate situation because of his desire to please and keep the physician's customers. If he yields, both he and the doctor may be indicted for the violation.

The 1954 Oral Prescription Law permits physicians to prescribe by telephone certain narcotic drugs and preparations of narcotic drugs. These preparations are designated by the letter "B." One example of a "B" narcotic preparation is a tablet containing a mixture of aspirin and codeine.

Pursuant to the regulations, a physician may dispense narcotic drugs to bona fide patients pursuant to the legitimate practice of his profession without prescriptions or order forms. Institutions, such as hospitals, shall keep a daily record showing the kind and quantity of narcotics dispensed or administered, the name and address of each person to whom dispensed or administered, the name and address of the person upon whose authority and the purpose for which dispensed or administered.

A physician dispensing exempt preparations (such as paregoric) shall record all sales, exchanges, gifts or other dispositions, the entries to be made at the time of delivery.

Physicians are not forbidden by regulation to write narcotic prescriptions for members of their own families. However, the experience of the Bureau of Narcotics indicates that such a practice is apt to lead to misunderstandings. The Ethical Practices Committee of the American Medical Association discourages physicians from treating any member of their immediate family with narcotic drugs.

A practitioner maintaining an office where he is duly registered with the collector of the district in which the office is located, and where his complete stock of narcotic drugs and all narcotic records are kept, may distribute, dispense, give away, administer or prescribe narcotic drugs in other collection districts in which he may be lawfully engaged in the practice of his profession, within the United States, in the course of the professional practice only, without incurring additional tax liability.

Prescription blanks should be carefully safeguarded to prevent acquisition by unauthorized persons and to prevent possible forging of narcotic prescriptions.

Narcotic drugs and preparations shall at all times be properly safeguarded and securely kept where they will be available for inspection by authorized officers. Loss or destruction of narcotics shall be reported to the district supervisor.

Treatment of Addiction or Incurable Disease

The following outline of procedure to be observed in prescribing and dispensing narcotic drugs is issued for the guidance of registrants under the Harrison Narcotic Law.

It is impossible to state an inflexible rule which will cover all cases, and this outline must, therefore, be general in nature and subject to modification through further interpretation of the law by the courts. The Bureau is not charged with the duty of laying down any fixed rule as to the furnishing of drugs or the frequency of the prescriptions in any particular case. The responsibility for the proper prescribing and dispensing of narcotic drugs, under the Harrison

Narcotic Law, rests upon the physician in charge of any given case.

While the primary responsibility for the proper prescribing and dispensing of narcotic drugs rests upon the physician in each case, a corresponding responsibility rests upon the druggist who fills a prescription to determine, in good faith, that the prescription was issued in the course of professional practice, and not for the purpose of gratifying addiction. Caution should be exercised to avoid being imposed upon by unscrupulous persons. Prescriptions for narcotics should be scrutinized carefully in an effort to detect possible alterations or forgery.

The good faith of the physician and the bona fides of his treatment in a given case will be established by the facts and circumstances of the case and the consensus of medical opinion with regard thereto, based on the experience of the medical profession in cases of similar nature. Physicians will be expected to exercise such care in every case where narcotic dosage is indicated, that the patient under treatment shall receive no quantity of narcotic drug greater than that sufficient for bona fide medical needs, in order that there may be no surplus available for possible diversion by the patient to illicit use.

Without reference to the question of addiction, a physician acting in accordance with proper medical practice may prescribe narcotics for the relief of acute pain or for any acute condition, such as influenza, pneumonia, renal calculi, broken limbs, etc.

A reputable physician directly in charge of bona fide patients suffering from diseases known to be incurable, such as cancer, advanced tuberculosis and other diseases well recognized as coming within this class, may in the course of his professional practice, and strictly for legitimate medical purposes, dispense or prescribe narcotic drugs for such diseases, provided the patients are personally attended by the physician who regulates the dosage, and the physician prescribes no quantity greater than that ordinarily recognized by members of his profession to be sufficient for the proper treatment of the given case.

As previously indicated, physicians should recognize the danger of supplying persons suffering from incurable diseases with excessive quantities of narcotics, because such persons may use the narcotics wrongfully, either by taking excessive quantities or by disposing of a portion of the drugs in their possession to other addicts or persons not lawfully entitled thereto.

Mere addiction alone is not recognized as an incurable disease. It is well established that the ordinary case of addiction yields to proper treatment, and that addicts remain permanently cured when drug taking is stopped and they are otherwise physically restored to health and strengthened in will power.

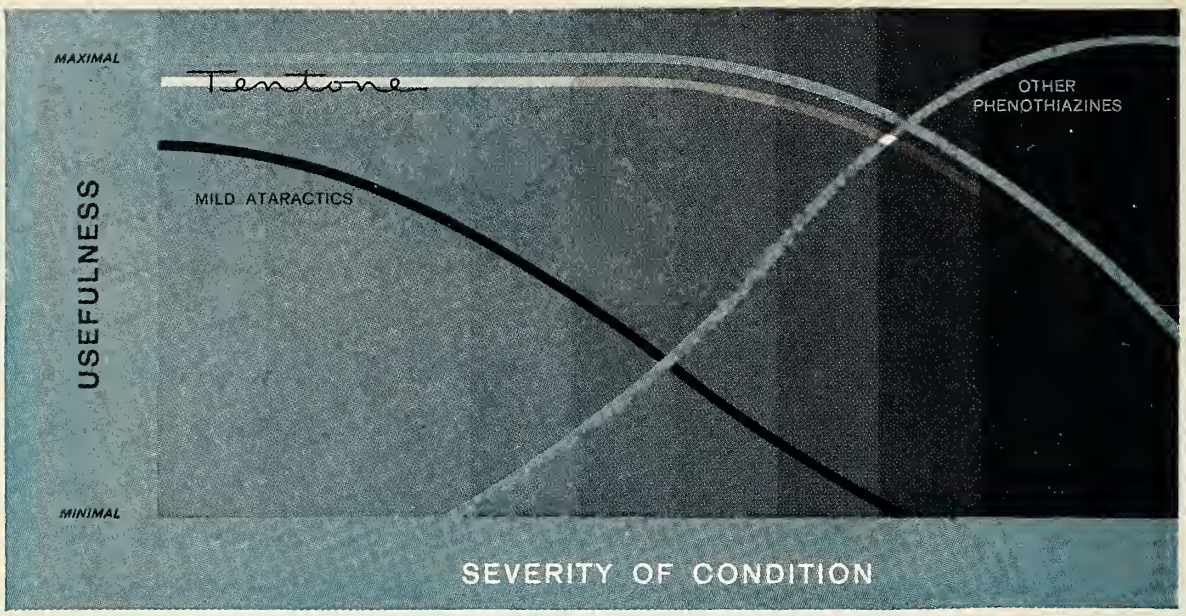
An exception may be noted in the case of an aged and infirm person, with drug addiction of long standing, whose collapse and death might result from withdrawal of the drug. Here, again, there is the necessity of controlling dosage to prevent the patient from obtaining excessive quantities of the drug. This Bureau has never sanctioned or approved of the so-called reductive ambulatory treatment of addiction for the reason that where the addict controls the dosage he will not be benefited or cured.

Medical authorities agree that the treatment of addiction, with a view to effecting a cure, which makes no provision for confinement while the drug is being withdrawn, is a failure, except in a relatively small number of cases where the addict is possessed of a much greater degree of will power than that of the ordinary addict.

ANNOUNCING



A HIGHLY EFFECTIVE TRANQUILIZER FOR EXTENDED OFFICE PRACTICE USE



POSITIVE CALMING ACTION ADAPTED FOR LOWER RANGE OF EMOTIONAL DISORDERS

The development of TENTONE® Methoxypromazine Maleate *Lederle* does not duplicate primary function of existing tranquilizers. TENTONE fills the need for a practical, potent agent for extended use in everyday practice (as illustrated above).

Action of TENTONE Methoxypromazine Maleate approaches that of the strong phenothiazines without their drawbacks. Calming response is positive and rapidly apparent to both patient and physician. However, as a basic phenothiazine modification, TENTONE allows full therapeutic application in the mild and moderate range of anxiety-tension and somapsychic disorders most usually seen in general practice.

EXCELLENT TOLERATION— MARKED REDUCTION IN COMPLICATIONS

Incidence of untoward reactions is exceptionally low and approximates the mild ataractic drugs. Reduction in sensitivity reaction, intestinal distress, blood, brain or liver toxicity is striking, particularly in the low dosage range. TENTONE exhibits greater freedom from depression and drug habituation. Physical and psychic orientation is usually preserved. Occasional drowsiness may be encountered, particularly in higher dosages. In moderate to more severe cases, this sedative effect may be desired.

TENTONE has thus been described as one of the easiest tranquilizers to handle in office practice. In indicated cases, the physician may be relieved of the patient's unnecessary concern over his own illness. In contrast to the previous types of drugs, complaints over induced distress or inadequate benefit are rare.

WHEN MORE THAN MILD SEDATIVE EFFECT IS DESIRED

Consequently, TENTONE is more useful than other ataractic drugs in two areas: (1) mild to moderate conditions—when more than mild sedative effect is sought, (2) middle range of moderate to severe cases—when less than psychopathology is involved.

Indications include ■ common anxiety-tension states ■ obsessive-compulsive behavior ■ neurosis ■ depression ■ situational anxiety and hysteria

And the emotional components of: ■ agitation ■ restlessness ■ tremors ■ insomnia ■ alcohol- and drug-withdrawal syndrome ■ hyperkinesis ■ prenatal anxiety ■ rheumatic disorders ■ dermatoses ■ menopausal syndrome ■ premenstrual tension ■ peptic ulcer, other g.i. disorders ■ asthma, other allergy ■ multiple sclerosis, arteriosclerosis ■ malignancy, other progressive diseases

POSSIBLE POTENTIATION OF ANALGESICS AND NARCOTICS

Since tranquilizing drugs may potentiate the action of pain-relievers, sedatives, and barbiturates, they should be used with caution in conjunction with them, or to achieve a greater response to these drugs in various conditions when desired. They may also be useful in reduction of effective dosage to better tolerated, or non-habituating levels.

ADAPTABLE LOWER DOSAGE RANGES

Dosage must be individualized to severity of condition and response desired.

In mild to moderate cases: varies from 30 to 100 mg. daily.

In moderate to severe cases: from 75 to 500 mg. daily.

In psychotic or institutionalized patients, TENTONE may be useful as a substitute when toxicity precludes effective dosage of other phenothiazines, or as maintenance after hospitalization. Dosage may range from 100 to 1500 mg. daily in divided doses.

Supplied: 10 mg., 25 mg. and 50 mg. tablets



Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

New Indiana State Laws Affecting the Medical Profession

The following acts as passed by the last legislature are printed for the benefit of ISMA members in that they directly affect those who practice medicine.

SENATE ENROLLED ACT No. 210

AN ACT to determine the persons who may consent to the autopsy of the body of a deceased person and declaring an emergency.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. For the purpose of this act, "autopsy" is defined as the dissection of a dead body for the purpose of ascertaining the cause, seat and nature of a disease or for the purpose of inquiring into the cause of death.

SEC. 2. For the purpose of this act the consent to an autopsy shall be by written instrument which shall specify the purpose of and extent of the dissection so authorized. When the consenting person is not available in the county of death, the consent may be made by telegram or by witnessed telephone conversation.

SEC. 3. For the purpose of this act "licensed physician" is defined as any person who holds an unlimited license to practice medicine and surgery in the State of Indiana and whose license is current in all respects.

SEC. 4. For the purpose of this act consent for a licensed physician to conduct an autopsy of the body of a deceased person is sufficient when given by the following persons if they survive the deceased:

(a) By the surviving spouse, unless the deceased and the surviving spouse were legally separated at the date of death, in which event, for the purpose of this act, such survivor shall not be considered a surviving spouse;

(b) If there be no surviving spouse, then by any one adult child of the deceased;

(c) If there be no surviving spouse or adult child of the deceased, then by one parent of the deceased;

(d) If there be no surviving spouse, adult child or parent and there be an adult person who is next of kin of the deceased, residing in the County in which the deceased died a resident, then by any one such next of kin;

(e) And if there be no surviving spouse, adult child, parent or such next of kin, then by any person assuming custody of and financial responsibility for the burial of the body; provided, however, if there be more than one such person, then consent of one of them is sufficient.

SEC. 5. Consent to an autopsy in accordance with this act is conclusive as to any rights in the body of a deceased person as against any claim by any other person or persons, but only for the purpose of performing such autopsy.

SEC. 6. Nothing contained in this act shall be construed to repeal, modify or amend any other laws or parts of laws concerning autopsies but shall be construed as supplemental thereto nor shall anything in this act be so construed as to require consent for a coroner to perform an autopsy in the discharge of his duties.

SEC. 7. Whereas an emergency exists for the immediate taking effect of this act the same shall be in force and effect from and after its passage.

February 21, 1959.

DIGEST

An act providing for the use of a tuberculin skin test for teachers, bus drivers, janitors and food handlers and requiring diagnostic X-ray for reactors and providing procedures in the event tests are positive.

ENGROSSED SENATE BILL No. 8

AN ACT to amend sections 810, 811, 812 and 813 of an act entitled "An Act concerning public health, providing for state and local health officials and personnel, prescribing their powers and duties, establishing a public health code and providing for the administration of public health laws, prescribing penalties, repealing certain laws, and declaring an emergency," approved March 8, 1949.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. Section 810 of the above entitled act is amended to read as follows: Sec. 810. It shall be unlawful for school authorities to employ teachers, janitors, bus drivers or food handlers who are addicted to drugs, or who are intemperate, or who have tuberculosis or syphilis in an infectious stage. Every board of education and school trustee shall require a physical examination for tuberculosis, including adequate laboratory tests and x-rays, of all such employees of the board or school trustee at least once in three years; and shall cause the physical examination to be made within one year from the date this code becomes

operative, unless the employee can produce evidence of a satisfactory examination made within the preceding three-year period Such examinations, tests, and x-rays shall be made only by physicans holding an unlimited license to practice medicine. The physician may elect to submit a report indicating negative reaction to an intradermal skin test for tuberculosis in lieu of the above stated x-ray report. If this election is made by the physician the test used shall be a Mantoux intradermal skin test. If an employee so tested shall have a negative reaction then the intradermal skin test shall be repeated each year so long as the employee remains negative. If an employee so tested shall have a positive reaction to such test, then a diagnostic x-ray and laboratory test shall be taken to determine whether or not the disease is in an infectious state. If the disease is not in an infectious state, the employee shall be eligible for service but such employee shall then annually thereafter submit to a diagnostic x-ray and laboratory test to determine his continued eligibility for such employment. The cost of such examinations, laboratory tests, x-rays, and the providing of a diagnostic data shall be borne by the board of education.

SEC. 2. Section 811 of the above entitled act is amended to read as follows: Sec. 811. The x-ray film shall be retained by the person taking * * * * * it for a period of three years, and at any time within such period, upon order of the state board, such film shall be delivered to the state board at such place as it may designate, * * * * * and if the state board or its designated agent, upon viewing such film, finds that due to the condition of the same a proper diagnosis cannot be made from such film, a new one, conforming to the uniform rules as shall be prescribed by the state board, shall be taken within ten days and submitted in like manner.

SEC. 3. Section 812 of the above entitled act is amended to read as follows: Sec. 812. In lieu of the test directed by such authority, with payment for the same by the board of education, an employee may be tested at his own expense by any other duly licensed doctor of medicine of his own choosing.

SEC. 4. Section 813 of the above entitled act is amended to read as follows: Sec. 813. If the result of the test indicates the presence of tuberculosis in an infectious state, the employee shall be ineligible for further service until satisfactory proof of recovery is furnished. If such employee is under contract or tenure protection, he may be granted any sick leave compensation provided by the board of education or trustee for other employees and shall, upon satisfactory recovery, be permitted to complete the term of his contract, or, if under tenure, shall be reinstated with the same tenure status as he possessed at the time his services were discontinued, provided the absence does not exceed a period of three years.

(Amends Acts 1949, p. 416; Burns 35-1111—35-1114)

February 6, 1959.

HOUSE BILL DIGEST

An Act providing for subpoena to require expert witnesses to appear in the county of their residence or adjoining counties.

HOUSE BILL No. 292

AN ACT to amend section 282 of an act entitled "An Act concerning proceedings in civil cases," approved April 7, 1881.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. Section 282 of the above entitled act is amended to read as follows: Sec. 282. A witness who is an expert in any art, science, trade, profession or mystery may be compelled to appear and testify in any court in the county of the residence of the witness or any court in the adjoining county to an opinion, as such expert, in relation to any matter, whenever such opinion is material evidence relevant to an issue on trial before a court or jury, without payment or tender of compensation other than the per diem and mileage allowed by law to witnesses, under the same rules and regulations by which he can be compelled to appear and testify to his knowledge of facts relevant to the same issue.

SEC. 2. Whereas an emergency exists for the immediate taking effect of this act, the same shall be in full force and effect from and after its passage.

(Amends Acts 1881 (SS) p. 240; Burns 2-1722.)

February 16, 1959.

DIGEST

This Act provides for the issuance of a Temporary Medical Educational Permit by the Board of Medical Registration and Examination of Indiana to foreign medical graduates desiring to secure post-graduate medical training in any medical educational institution or hospital located in Indiana. It provides standards and fees for the issuance of such permits and limitations as to the renewal thereof; provides penalties for failure to secure such permits and declares an emergency.

SENATE BILL No. 236

AN ACT concerning Temporary Medical Educational Permits for foreign medical graduates, prescribing penalties for a violation thereof; and declaring an emergency.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. Any graduate of a medical school located outside the United States and its possessions, except the Dominion of Canada, desiring to obtain graduate medical education and training in any medical educational institution or hospital located in the State of Indiana is hereby required to obtain a Temporary Medical Educational Permit in accordance with the provisions of this Act before entering upon or continuing such graduate educational training.

SEC. 2. A graduate of a medical school located outside the United States and its possessions, except the Dominion of Canada, who makes application to the Board of Medical Registration and Examination of Indiana for a "Temporary Medical Educational Permit" shall submit with such application the medical diploma, or other documentary evidence of credentials acceptable to the Board of Medical Registration and Examination of Indiana;

also, documentary evidence, satisfactory to said Board, of having passed the examination of, and having been granted a certificate thereof by the Educational Council for Foreign Medical Graduates, or some other nationally recognized similar organization having comparable standards therefor as approved by said Board, may be considered and used by the said Board in its determination of the qualifications of said applicant; and, official verification of such applicant's appointment for training by a Teaching Institution or Hospital located in the State of Indiana which is approved by the Council on Medical Education and Hospitals of the American Medical Association, for the purpose of graduate medical education and training, or any other nationally recognized similar organization having comparable standards as approved by said Board, may be considered and used by said Board in its determination of the qualifications of such applicant for such Temporary Medical Educational Permit.

SEC. 3. A graduate so qualified and approved by the Board of Medical Registration and Examination of Indiana, may be granted a "Temporary Medical Educational Permit" for a period of one year. Upon expiration of such permit, it shall be surrendered to the said Board, at which time such permit may be renewed for one year from date of expiration, provided, such applicant presents to the Board of Medical Registration and Examination of Indiana an official written report from the institution to which he or she is serving, certifying to said applicant's satisfactory service, whether such service has been terminated, or for what period of time appointment has been extended. One permit shall be issued and each renewal shall be recorded on the original permit. No more than four such renewals may be granted. Upon expiration of permit, or termination of training, under the provisions of this Act, said permit shall be surrendered to the Board of Medical Registration and Examination of Indiana. Any such original application for such permit shall be accompanied by a fee of ten ($10.00) dollars for processing such application. On issuance of such original application, the applicant shall pay to said Board an additional sum of forty ($40.00) dollars. For any renewal thereof such applicant shall pay to said Board the sum of ten ($10.00) dollars for each such renewal.

SEC. 4. Any person who shall violate any of the provisions of Sections 1, 2 or 3 of this Act by entering upon or continuing any such graduate medical educational training in any such medical educational institution or hospital located in the state of Indiana, without first having secured such Temporary Medical Educational Permit, or who shall fail to surrender any such Temporary Medical Educational Permit to said Board on its expiration, shall be deemed guilty of a misdemeanor, and, on conviction thereof shall be find not less than twenty-five ($25.00) dollars nor more than two hundred ($200.00) dollars.

SEC. 5. The possessor of a "Temporary Medical Educational Permit" who makes application to the Board of Medical Registration and Examination of Indiana for a license to practice medicine, shall conform to the requirements of said Board for graduates of schools located outside the United States and its possessions, as specified in the applicable Rules therefor then in effect and as adopted by said Board in accordance with the statutes in such cases made and provided. It is hereby declared that it is not the intent or purpose of this Act to amend, qualify or supersede any of the provisions of the Medical Practice Act, being Acts 1897, Chapter 169, as amended.

SEC. 6. Whereas an emergency exists for the more immediate taking effect of this Act, the same shall be in full force and effect on and after July 1, 1959.

March 2, 1959

DIGEST

An Act providing that County Commissioners may authorize the furnishing of financial assistance to community psychiatric clinics and upon request, County Councils shall appropriate funds for such purposes but the levy shall not exceed five cents on each $100.00 valuation.

ENGROSSED SENATE BILL No. 206

AN ACT authorizing counties to furnish financial assistance to community psychiatric clinics.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. As used in this act, the term "community psychiatric clinic" shall mean any psychiatric clinic incorporated under the provisions of "The Indiana General Not for Profit Corporation Act," the same being Chapter 157 of the Acts of the Indiana General Assembly of 1935, which clinic is organized and operated solely for the purpose of providing psychiatric services to residents of any specific county.

SEC. 2. The board of county commissioners of a county may authorize the furnishing of financial assistance to any community psychiatric clinic located, or which may hereafter be located, in the county; and the county council of the county, upon the request of the board of county commissioners, may appropriate annually, from the general fund of the county, funds to provide such financial assistance in an amount of not to exceed the amount which could be collected from the annual levey of a five cent tax on each one hundred dollars valuation of taxable property.

SEC. 3. If there is no community psychiatric clinic located in any specific county, the board of county commissioners of such county may authorize the furnishing of financial assistance to any community psychiatric clinic which is located, or which may hereafter be located, in any other county; and the county council of such county, upon the request of the board of county commissioners, may appropriate annually, from the general fund of the county, funds to provide such financial assistance in an amount of not to exceed the amount which could be collected from the annual levy of a five cent tax on each one hundred dollars valuation of taxable property.

SEC. 4. Whereas an emergency exists for the more immediate taking effect of this act, the same shall be in full force and effect from and after July 1, 1959.

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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THE COST OF LIVING

THE CONSUMER price index is a number, based on the prices of a selected list of essential goods and services, expressing as a percentage figure the relation of those goods and services in present prices to the prices of the same things during a base period in the past.

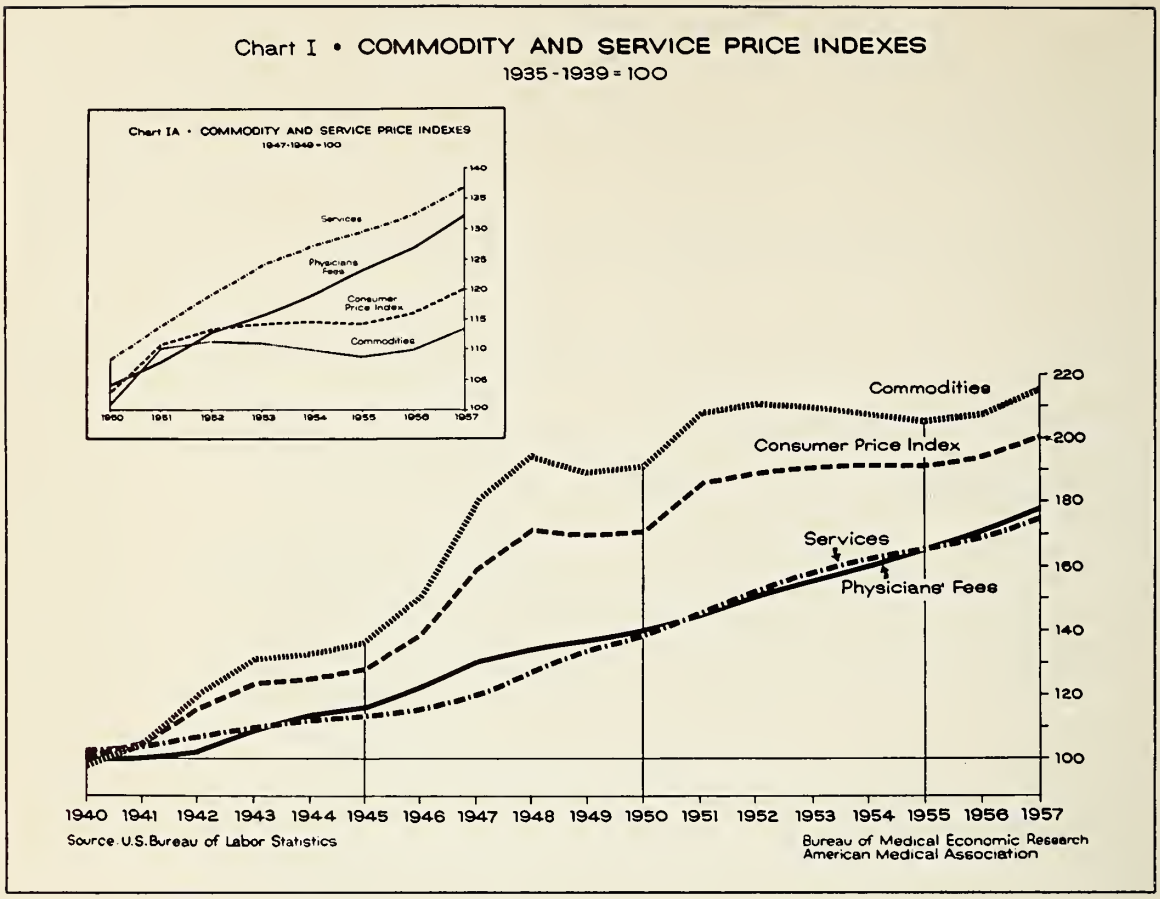
From 1940 to 1950 the base period for determining the consumer price index was 1935-39. Average prices between 1935 and 1939 were given a composite value of 100. In 1950 the consumer price index had risen to 172. The index for commodities was up to 192, that for services was up to 142. The index for physicians' fees was up to 142.

In 1950 the government changed the base period to 1947-49. Composite prices for 1947-49 were assigned a value of 100. In 1957 the consumer price index was up to 120 on this new scale. Commodities were up to only 113, services in general were up to 137 and physicians' fees up to 132. (Chart IA)

The change in the base period has produced an apparently galloping increase in the prices of services, physicians' fees and medical care in general.

This is because the price increase in commodities was fast between 1945 and 1948. Actually the index for physicians' fees and medical care has risen slowly and gradually and has never risen above the consumer price index or the index for commodities.

If the prices for 1957 are charted against the



base period of 1935-39 the consumer price index is 200. (Chart I) The index for medical care on this basis is 190 and the index for physicians' fees is 179, both well below the all inclusive consumer price index. In fact during the entire time since 1940 the latter two indexes have been that much below or even lower in proportion.

The change in the base period has made it appear that medical costs have been increasing since 1950 out of proportion to other costs. As a matter of fact medical care costs have increased slightly, but have been maintaining a gradual increase proportional to the consumer price index but significantly below it.

In an inflationary economy the best way to evaluate prices is to determine what part of an average week's wage is required to purchase something which was priced at one week's wage during the base period.

In Chart III, which is reproduced from AMA Publication M-116, the 1957 prices are represented in this way in relation to the 1935-39 base period. Most of the medical items are below the costs for food and clothing and are also below the price for all goods and services.

Hospital rates are the highest. This can be understood when it is remembered that many of the commodities which a hospital uses today are naturally expensive. Many of them were not obtainable in 1939 and therefore did not appear on the hospital expense sheet.

However, while many of the drugs and new items of equipment are expensive, they are much more effective than comparable items were in 1939. If the shortened patient stay could be applied to the hospital cost index it would be considerably reduced. If the increased income, which results from the fact that the patient is back to work much sooner, could be applied to the hospital index it would be reduced still further.

A few years ago it was determined that, if all

IF in 1937
11 colls to o physicion's office cost the production worker one full week's woges
THEN in 1957
the some amount of physicians' services cost 49% of o week's woges

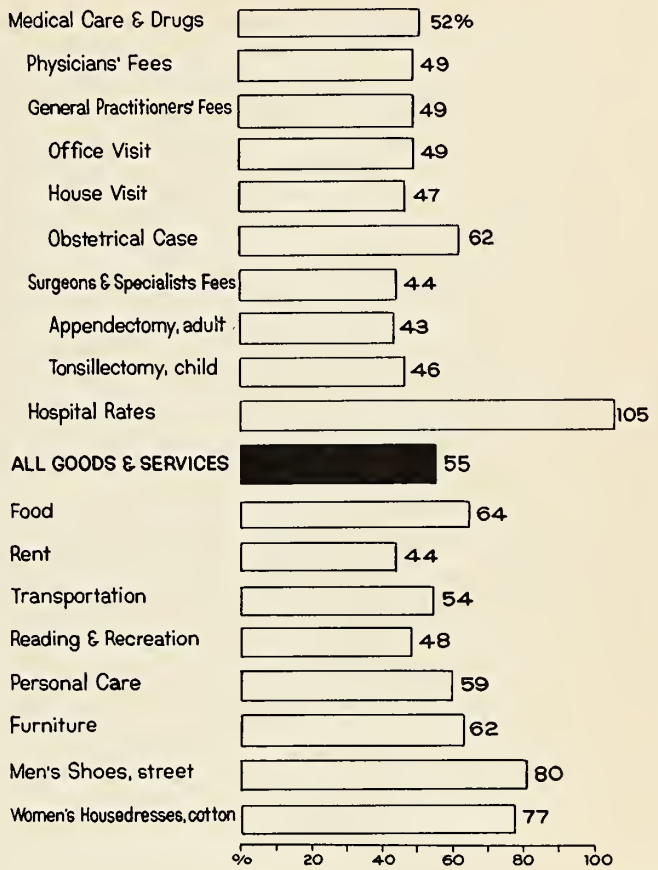
IF in 1937
5 doys in o hospital room cost the production worker one full week's woges
THEN in 1957
this some omount of hospitol service cost 105% of o week's woges

IF in 1937
4 poirs of men's street shoes cost the production worker one full week's woges
THEN in 1957
4 pairs cost 80% of o week's woges

Chart III

PERCENTAGE OF ONE WEEK'S WAGES REQUIRED IN 1957

to purchase the same amount of medical care and other items which could be purchased with ONE WEEK'S WAGES IN 1935-1939



Source: U.S. Bureau of Labor Statistics

Bureau of Medical Economic Research
American Medical Association

effects of inflation were ignored, the average hospital admission cost would be only about 20% more expensive than it would have been in 1935. The fact that each admission is shorter would make it worth more.

Certainly medical care today with its shortened period of convalescence, earlier return to work and generally improved efficiency is the best bargain of all the goods and services represented in the consumer index.

President's Page

Your officers, Executive Committee and Council hired a firm of management consultants to survey and make recommendations covering the organization, operations and personnel of the Indiana State Medical Association. This project has been discussed from many angles for many months before the idea was presented for approval by the Council. An adequate representative number of firms were asked to present their plans and approximate cost for this survey and recommendations. Wolf Management Engineering Company of Chicago was chosen for the job, for it appeared that this firm would give us the most information for the least amount of money.

The survey has been completed and the recommendations approved by the Executive Committee and Council. I believe this project is one of the most significant progressive steps the Indiana State Medical Association has made in a long while. Our accounting methods have been brought up to date.

There has been reassignment of many duties and two new positions have been created. There have been important suggestions made to improve our medical journal and other means of communication between the State Association and its members. The housing of our headquarters office was given considerable study and as a result it was recommended our present offices be expanded and remodeled, which will permit us more efficiently arranged space, pending the final decision on our future plans. It is the belief of this consulting firm and your officers that plans should go ahead to arrange to have our own building in about 3 to 5 years at a place readily available to all doctors, especially those from out of town.

I believe the money spent for the survey and recommendations has been well spent. We will have more accurate, fireproof files of members and records. The State Association will be able to give better and more encompassing service to all its members and other groups and the public, which should improve our public relations and our worth to the public. As a result of the recommendations of the House of Delegates and Wolf Management Engineering Company, the Building Committee of the House of Delegates soon will institute a program of information to the members of the Association concerning the need of a headquarters building.

Kenneth L. Olson M.D.

ROSTER OF MEMBERS



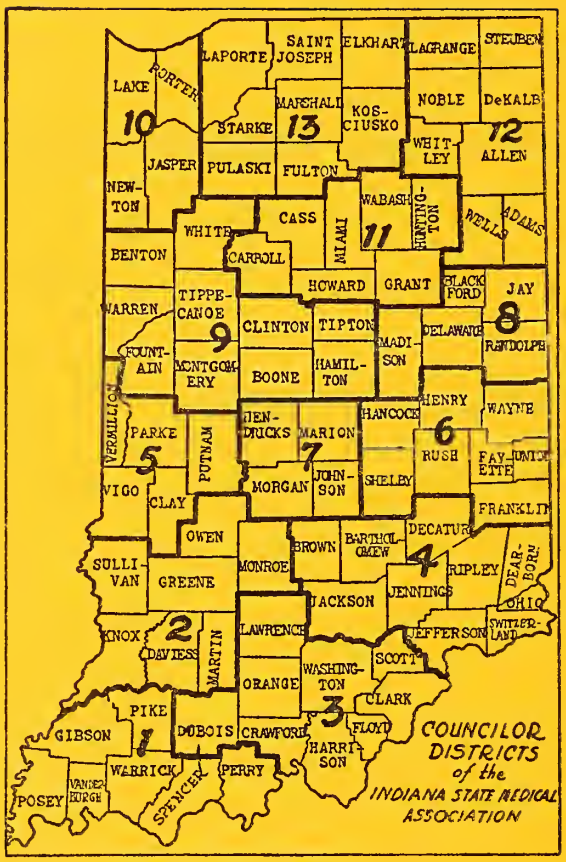
Indiana State Medical Association

Woman's Auxiliary

May 1959

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VANDER-BURGH
POSEY
COUNCILOR DISTRICTS of the INDIANA STATE MEDICAL ASSOCIATION

Membership Roster

INDIANA STATE MEDICAL ASSOCIATION

Following is a list of paid-up members of the Indiana State Medical Association as of May 1, 1959.

The letter (S) following a name indicates that the physician is a senior member of his local society and of the Indiana State Medical Association. The letter (H) following a name indicates that the physician is an honorary member of his local society and the Indiana State Medical Association.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 1019 Hume Mansur Building, Indianapolis 4, Indiana. The cooperation of members is urgently requested.

ALPHABETICAL LIST OF MEMBERS

Name	City	County
	A	
Aagesen, Walter J.	Anderson	Madison
Abel, Robert	Wakarusa	Elkhart
Abell, Charles F.	Marion	Grant
Abramson, Allan L.	Gary	Lake
Abreu, Benedict E.	Indianapolis	Marion
Acher, Robert P.	Greensburg	Decatur
Acker, Robert B. (S)	South Bend	St. Joseph
Acre, Robert R.	Evansville	Vanderburgh
Adair, Samuel	Jeffersonville	Clark
Adair, William K. (S)	Crothersville	Jackson
Adams, Daniel S. (S)	Indianapolis	Marion
Adams, Julia L.	Muncie	Delaware-Blackford
Adams, E. Wade	Fort Wayne	Allen
Adams, Max R.	Flora	Carroll
Adams, William B.	Muncie	Delaware-Blackford
Adamski, Michael S.	Logansport	Cass
Addleman, Robert H.	Indianapolis	Marion
Ade, Charles H.	Lafayette	Tippecanoe
Ade, Mary Keller	Lafayette	Tippecanoe
Adkins, Harold C.	Indianapolis	Marion
Adler, David L.	Columbus	Bartholomew-Brown
Adler, Raymond N.	Evansville	Vanderburgh
Adney, Frank B.	Richmond	Wayne-Union
Advincula, Luis	Terre Haute	Vigo
Adye, Wallace M.	Evansville	Vanderburgh
Agana, Adriano	Gary	Lake
Aiken, Arthur F.	Fort Wayne	Allen
Aiken, Milo M.	Plainfield	Hendricks
Aiken, Nevin E.	Fort Wayne	Allen
Ake, Loren	Richmond	Wayne-Union
Albert, Harold F.	Rey Key	Jay
Albertson, Frank P.	Indianapolis	Marion
Albrecht, Willard H.	Indianapolis	Marion
Alcorn, Merritt O.	Madison	Jefferson-Switzerland
Alden, John O.	Shelbyville	Shelby
Alderfer, Henry	Marion	Grant
Aldred, Allen W.	Lawrenceburg	Dearborn-Ohio
Aldrich, Harry D.	Indianapolis	Marion
Aldrich, Howard	Indianapolis	Marion
Alexander, Ezra D.	Indianapolis	Marion
Alexander, John E.	Evansville	Vanderburgh
Alexander, Stephen J.	Crawfordsville	Montgomery
Alfano, Paul A.	Gary	Lake
Alford, James A.	Hamilton	Steuben
Allegretti, Michael L.	Hammond	Lake
Allen, Hubert E. (S)	Richmond	Wayne-Union
Allen, L. Howard	Bedford	Lawrence
Allen, Orris T. (S)	Terre Haute	Vigo
Allen, Robert K.	Indianapolis	Marion
Allen, Robert T.	Richmond	Wayne-Union
Almquist, Carl O.	Gary	Lake
Altier, William H.	Fowler	Benton
Alvey, Charles R.	Muncie	Delaware-Blackford
Alvis, Edmond O.	Indianapolis	Marion
Alward, John H.	Kokomo	Howard
Ambrose, Jesse C.	Noblesville	Hamilton
Ambrose, Kenneth E.	Monmount, Ill.	Spencer
Amico, Pasquale J.	Crown Point	Lake
Amini, Sohrab	Huntingburg	Dubois
Amos, Robert L.	New Castle	Henry
Amstutz, Henry C.	Goshen	Elkhart
Amy, William E. (S)	Corydon	Harrison-Crawford
Anderson, James W.	Indianapolis	Marion
Anderson, John B.	Vincennes	Knox
Anderson, John T.	Indianapolis	Marion
Anderson, Milton H.	Evansville	Vanderburgh
Anderson, Richard M.	Vincennes	Knox
Anderson, Walter C.	Terre Haute	Vigo
Anderson, Wendell C.	Indianapolis	Marion
Andrews, Hugh K.	Franklin	Johnson
Angel, Virgil E.	East Chicago	Lake
Angeles, Uldarico A.	Gary	Lake
Ansbacher, Stefan (H)	Marion	Grant
Antes, Earl H.	Evansville	Vanderburgh
Antonetti, John A.	Evansville	Vanderburgh
Appel, Richard H.	Indianapolis	Marion
Apple, Eddie R.	Salem	Washington
Applegate, Albert E.	Frankfort	Clinton
Arata, Justin E.	Fort Wayne	Allen
Arbeiter, Herbert I.	Hammond	Lake
Arbogast, John L.	Indianapolis	Marion
Arbogast, Paul B.	Vincennes	Knox
Arbuckle, William E. (S)	Indianapolis	Marion
Arendell, Robert E.	Evansville	Vanderburgh
Arford, John E.	Warsaw	Kosciusko
Arford, Roxford D. (S)	Middletown	Henry
Arisman, Ralph K.	South Bend	St. Joseph
Arlook, Theodore D.	Elkhart	Elkhart
Armalavage, Leon J.	Gary	Lake
Armer, Robert M.	Indianapolis	Marion
Armington, Charles L.	Anderson	Madison
Armington, Robert L.	Anderson	Madison
Armstrong, Thomas D.	Michigan City	La Porte
Arney, Amos	Michigan City	La Porte
Arnold, Aaron L.	Indianapolis	Marion
Arnold, Robert D.	Indianapolis	Marion
Aronson, Sidney S.	Indianapolis	Marion
Arrowsmith, James L.	Hammond	Lake
Arthur, Nora M. (S)	Washington	Daviess-Martin

Name	City	County
Artis, Myrle E.	Kokomo	Howard
Artz, Richard W.	Angola	Steuben
Ash, Harold H.	W. Lafayette	Tippecanoe
Asher, Ernest O. (S)	New Augusta	Marion
Asher, James W.	New Augusta	Marion
Ashmore, Herbert C.	Chesterton	Porter
Atchison, Kenneth C. (S)	Rockport	Spencer
Atienza, Rizalino T.	Gary	Lake
Atkins, Clarence C.	Rushville	Rush
Ault, Carl H.	Kokomo	Howard
Ault, Roy	Terre Haute	Vigo
Aust, Charles H.	Indianapolis	Marion
Austin, Charles E.	Anderson	Madison
Austin, Eugene W.	Evansville	Vanderburgh
Austin, Maynard A. (S)	Evansville	Vanderburgh
Austin, Richard P.	Bedford	Lawrence
Avery, George O.	Indianapolis	Marion
Ayres, Kenneth D.	Anderson	Madison
Ayres, Wendell W.	Marion	Grant

B

Babb, Forrest J.	Stockwell	Tippecanoe
Bacastow, Merle S.	Indianapolis	Marion
Bacevich, Andrew J.	East Chicago	Lake
Bachmann, Arnold J.	Indianapolis	Marion
Backer, George P.	LaPorte	LaPorte
Backer, Henry G.	Ferdinand	Dubois
Backs, Alton J.	South Bend	St. Joseph
Backs, Mark F.	Willow Grove, Pa.	St. Joseph
Badders, Ara C.	Portland	Jay
Bahler, Dean R.	Leesburg	Kosciusko
Bahr, Robert E.	Fort Wayne	Allen
Bailey, Douglas A.	Marion	Grant
Bailey, Earl W.	Logansport	Cass
Bailey, Edwin B.	Linton	Greene
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Bailey, Orville T.	Indianapolis	Marion
Bailey, Paul P.	Fort Wayne	Allen
Baird, Melvin S.	Indianapolis	Marion
Baitinger, Herbert M.	Gary	Lake
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Bakemeier, Robert E.	Indianapolis	Marion
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Baker, John R.	Lafayette	Tippecanoe
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Balcom, Francis H.	Indianapolis	Marion
Baldridge, William O.	Terre Haute	Vigo
Balingit, Bienvenido L.	East Chicago	Lake
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Ball, Phillip	Muncie	Delaware-Blackford
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Ballenger, William E.	Richmond	Wayne-Union
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Banks, Horace M.	Indianapolis	Marion
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Baptisti, Arthur, Jr.	Indianapolis	Marion
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Barnett, Ralph E.	Peru	Miami
Barnhart, Willard T.	Evansville	Vanderburgh
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Barrett, Thomas L.	Vincennes	Knox
Barron, Elmer A.	East Chicago	Lake
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Barry, Maurice J. (S)	Indianapolis	Marion
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Bartle, James Leo	Indianapolis	Marion
Bartlett, Donald T.	Vincennes	Knox
Bartley, Max D.	Indianapolis	Marion
Barton, Reginald R.	Gary	Lake
Barton, Robert	Angola	Steuben
Barton, Willoughby M.	Centerville	Wayne-Union
Bartsch, Harvey L.	South Bend	St. Joseph
Bash, Wallace E.	Fort Wayne	Allen
Baskett, Russell J.	Jonesboro	Grant
Bassett, Clancy (S)	Thorntown	Boone
Bassett, Margaret	Thorntown	Boone
Bassler, Carl R. (S)	Mishawaka	St. Joseph
Bastnagel, William F.	Indianapoils	Marion
Batman, Gordon W.	Indianapolis	Marion
Battersby, J. Stanley	Indianapolis	Marion
Batties, Paul A.	Indianapolis	Marion
Bauer, Thomas B.	Indianapolis	Marion
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Baumeister, Herbert E.	Indianapolis	Marion
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Baxter, Harry R.	Seymour	Jackson
Baxter, John P.	Indianapolis	Marion
Baxter, Neal E.	Bloomington	Owen-Monroe
Baxter, Samuel M.	New Albany	Floyd
Bayley, William E.	Lafayette	Tippecanoe
Baylor, Edward M.	Evansville	Vanderburgh
Baynes, Frank L.	Wolcott	White
Beach, Robert R.	Indianapolis	Marion
Beam, Vernon B.	East Chicago	Lake
Beamer, Parker R.	Indianapolis	Marion
Beams, Ralph H.	Fort Wayne	Allen
Bean, Joseph S.	Logansport	Cass
Bear, Lowery H. (S)	Vevay	Jefferson-Switzerland
Beardsley, Frank A.	Frankfort	Clinton
Beaven, John B.	Jasper	Dubois
Beaver, Ernest R.	Rensselaer	Jasper-Newton
Beaver, Howard W.	Indianapolis	Marion
Beaver, Norman E.	Berne	Adams
Bechtold, Samuel E.	South Bend	St. Joseph
Beck, David C.	Monticello	White
Beck, Evart M.	Indianapolis	Marion
Beck, Herma A. (S)	Lebanon	Boone
Beck, Robert E.	Evansville	Vanderburgh
Beck, Thomas A.	Swayzee	Grant
Becker, Harry G.	Indianapolis	Marion
Becker, Philip H.	Crown Point	Lake
Becker, Samuel W.	Whiting	Lake
Beckes, Ellsworth W.	Vincennes	Knox
Beconovich, Robert	Hammond	Lake
Becquet, Norbert J.	Indianapolis	Marion
Bedwell, Marion H.	Sullivan	Sullivan
Beeler, Franklin K.	Anderson	Madison
Beeler, John W.	Indianapolis	Marion
Beeler, Raymond C. (S)	Indianapolis	Marion
Beeson, Wilbur	Greenfield	Hancock
Beetem, Luther F.	Madison	Jefferson-Switzerland
Begley, Joseph W., Jr.	Evansville	Vanderburgh

Name	City	County
Beggs, Lowell F.	Columbus	Bartholomew-Brown
Behn, Walter M., Jr.	Kokomo	Howard
Behn, Walter M.	Gary	Lake
Behnke, Roy H.	Indianapolis	Marion
Beierlein, Karl M.	Fort Wayne	Allen
Beilke, Clifford A.	East Chicago	Lake
Belding, Ray T.	Kempton	Tipton
Bell, Horace D.	South Bend	St. Joseph
Belshaw, George	Indianapolis	Marion
Belt, James H.	Indianapolis	Marion
Benchik, Frank A.	East Chicago	Lake
Bender, Cecil K.	Goshen	Elkhart
Bender, Martin J.	Evansville	Vanderburgh
Bender, Robert L.	Elkhart	Elkhart
Bendler, Carl H.	Gary	Lake
Benedict, Charles D.	LaGrange	LaGrange
Benedict, Paul F.	Indianapolis	Marion
Benham, Lawrence E.	Bedford	Lawrence
Benken, Lawrence D.	Muncie	Delaware-Blackford
Bennett, Abner P.	Evansville	Vanderburgh
Bennett, Ivan F.	Indianapolis	Marion
Bennett, J. B.	Warren	Huntington
Bennett, Jene R.	South Bend	St. Joseph
Benninghoff, Daniel R. (S)	Fort Wayne	Allen
Benoit, Merrill P.	Anderson	Madison
Benson, James E.	Elkhart	Elkhart
Benz, Jesse (S)	Marengo	Harrison-Crawford
Benz, Owen F.	Wanatah	La Porte
Bergal, Milton B.	Gary	Lake
Bergan, Joseph A.	Michigan City	La Porte
Bergendahl, Emil H.	Fort Wayne	Allen
Berger, Morley	Beech Grove	Marion
Berghoff, James R.	Fort Wayne	Allen
Berghoff, Raymond J.	Fort Wayne	Allen
Bergwall, Warren L.	Muncie	Delaware-Blackford
Berke, Robert D.	South Bend	St. Joseph
Berkshire, Shaffer B.	North Vernon	Jennings
Berkson, Myron E.	Michigan City	La Porte
Berman, Edward J.	Indianapolis	Marion
Berman, Jacob K.	Indianapolis	Marion
Bernard, Marvin R.	Gary	Lake
Bernoske, Daniel G.	Crown Point	Lake
Best, Robert C.	Whiting	Lake
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Bethea, Robert O.	Farmersburg	Sullivan
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Bibler, Lester D.	Indianapolis	Marion
Bibler, Richard H.	Warsaw	Kosciusko
Bichacoff, Billie D.	Webster Springs, W.Va.	Allen
Bickel, David A.	South Bend	St. Joseph
Bidney, Evelyn B.	Bloomington	Owen-Monroe
Bigler, Frederick W.	Goshen	Elkhart
Bill, Robert O.	Indianapolis	Marion
Billings, Elmer R.	Elkhart	Elkhart
Bills, Robert N.	Gary	Lake
Bird, Charles R. (S)	Indianapolis	Marion
Birdzell, John P.	Crown Point	Lake
Birmingham, Peter J. (S)	South Bend	St. Joseph
Bisgyer, Jay L.	Gary	Lake
Bishop, Charles A.	South Bend	St. Joseph
Bishop, Harry A.	Frankton	Madison
Bishop, Robert E.	Bluffton	Wells
Bissonnette, Roger P.	Evansville	Vanderburgh
Bivin, James H.	Mooresville	Morgan
Bixler, Donald P.	Anderson	Madison
Bixler, Louis C.	South Bend	St. Joseph
Bjorklund, C. Ray	Hobart	Lake
Black, Boyd K.	Vincennes	Knox
Black, Charles E.	Gary	Lake
Black, Henry R.	Indianapolis	Marion
Black, Joe M.	Seymour	Jackson
Blackburn, Erwin	South Bend	St. Joseph
Blackford, Florence	Indianapolis	Marion
Blackford, Ralph E.	Indianapolis	Marion
Blackwell, Donald S.	Indianapolis	Marion
Blake, Albert L.	Indianapolis	Marion
Blassaras, Chris	Anderson	Madison
Blatt, A. Ebner	Indianapolis	Marion
Blazey, Arthur G.	Washington	Daviess-Martin
Bledsoe, James G.	New Castle	Harrison-Crawford
Blessinger, Louis H.	Corydon	Henry
Blessinger, Paul J.	Jasper	Dubois
Blichert, Peter A.	Fort Wayne	Allen
Blix, Fred M.	Ladoga	Montgomery
Bloemker, Edward F.	Indianapolis	Marion
Bloom, Asa W.	Marion	Grant
Bloom, George R.	Elkhart	Elkhart
Bloomer, Richard S.	Rockville	Parke-Vermillion
Blosser, Blaine A. (S)	Fremont	Steuben
Blosser, Howard V. (S)	Fort Wayne	Allen
Blossom, Paul W.	Richmond	Wayne-Union
Blum, Leon L.	Terre Haute	Vigo
Boardman, Carl (S)	Gary	Lake
Bobb, Kenneth E.	Seymour	Jackson
Bobowski, Stan J.	Indianapolis	Marion
Bodnar, Leslie M.	South Bend	St. Joseph
Bogardus, Carl R.	Austin	Scott
Boggs, Eugene F.	Indianapolis	Marion
Bogmenko, Leon T.	Pendleton	Madison
Bohner, Caryle B.	Hidalgo, Mexico	Marion
Bolin, John T. (S)	Mountain Home, Arkansas	Lake
Bolin, Robert C.	Lafayette	Tippecanoe
Boling, Grover C., Jr.	Indianapolis	Marion
Bolman, Ralph M.	Fort Wayne	Allen
Bombar, Leslie E.	Hammond	Lake
Bonaventura, Angelo P.	East Chicago	Lake
Bond, George S. (S)	Indianapolis	Marion
Bond, Virginia	Indianapolis	Marion
Bond, Walter C.	Clay City	Clay
Bond, William H.	Indianapolis	Marion
Bonsett, Charles A.	Indianapolis	Marion
Booher, Norman R.	Indianapolis	Marion
Booher, Olga Bonke	Indianapolis	Marion
Booker, Harold E.	Indianapolis	Marion
Boone, Max L.	Peru	Miami
Boone, Robert D.	Indianapolis	Marion
Boonstra, Charles E.	Bluffton	Wells
Booth, Boynton H.	Indianapolis	Marion
Booth, Franklin M.	South Bend	St. Joseph
Booze, James	A.P.O. 117, New York, N. Y.	Marion
Bopp, Henry, Jr.	Terre Haute	Vigo
Bopp, James	Terre Haute	Vigo
Borak, Walter J.	Gary	Lake
Borders, Theodore R.	Fort Wayne	Allen
Boren, Paul	Poseyville	Posey
Boren, Samuel W. (S)	Poseyville	Posey
Borenstein, Herschel	Gary	Lake
Borland, Raymond M.	Bloomington	Owen-Monroe
Borough, Lester D.	South Bend	St. Joseph
Bosch, Ralph	Seymour	Jackson

Name	City	County
Bosler, Howard A.	Waterford Mills, mail Goshen	Elkhart
Bossard, John W.	Fort Wayne	Allen
Boswell, Robert W. C.	Evansville	Vanderburgh
Botkin, Charles (S)	Muncie	Delaware-Blackford
Botkin, Clyde G.	Muncie	Delaware-Blackford
Botkin, Thomas	Muncie	Delaware-Blackford
Boughman, Joseph D.	Kokomo	Howard
Bowdoin, George E.	Elkhart	Elkhart
Bowen, Otis R.	Bremen	Marshall
Bowers, Charles R.	Anderson	Madison
Bowers, Copeland C.	Kokomo	Howard
Bowers, Gah T.	Fort Wayne	Allen
Bowers, Garvey B.	Kokomo	Howard
Bowers, George W.	Indianapolis	Marion
Bowers, John A.	Kokomo	Howard
Bowers, Jesse W. (S)	Fort Wayne	Allen
Bowman, Charles M.	Albion	Noble
Bowman, George W.	Indianapolis	Marion
Bowser, Philip G.	Goshen	Elkhart
Boyd, Charles S.	East Chicago	Lake
Boyd, H. Clark	Terre Haute	Vigo
Boyd, Stella N.	Evansville	Vanderburgh
Boyer, Floyd A.	Indianapolis	Marion
Boyer, Grace B.	Marion	Grant
Boyer, Philip A.	Indianapolis	Marion
Boyle, Carroll	Poseyville	Posey
Boys, Frank F.	East Chicago	Lake
Boze, Robert L.	Berne	Adams
Bradley, Charles F.	Hobart	Lake
Bradley, Louis F.	Chicago, Ill.	Marion
Bradley, Stephen C. (S)	Terre Haute	Vigo
Brady, Kingdon	Morocco	Jasper-Newton
Brady, Samuel G.	Gary	Lake
Brady, Thomas A.	Indianapolis	Marion
Brakel, Frank J.	Evansville	Vanderburgh
Brandman, Harry	Gary	Lake
Brandt, William E.	Columbia City	Whitley
Brauchla, Carl H. (S)	Anderson	Madison
Brauer, Abraham A.	Gary	Lake
Braun, Benjamin D.	Chicago, Ill.	Lake
Braunlin, Robert F.	Marion	Grant
Braunlin, William H. (S)	Marion	Grant
Brayton, John R., Jr.	Pensacola, Fla.	Marion
Brayton, John R.	Indianapolis	Marion
Brayton, Lee	Indianapolis	Marion
Brazelton, Osborne T. (S)	Princeton	Gibson
Brechtl, Harvey J.	South Bend	St. Joseph
Breedlove, Dane	Toledo, Ohio	Grant
Breneman, William L.	Indianapolis	Marion
Brenner, Andrew M.	Winchester	Randolph
Brenton, Harold L.	Columbia City	Whitley
Bretz, John M.	Huntingburg	Dubois
Brewer, Robert A.	A.P.O. 114, New York, N. Y.	Wells
Brickley, Harry D. (S)	Bluffton	Wells
Brickley, Richard A.	Indianapolis	Marion
Bridges, Alvin	Anderson	Madison
Bridges, William L.	Fort Wayne	Allen
Bridwell, Edgar	Bedford	Lawrence
Briggs, Robert W.	Indianapolis	Marion
Brillhart, James R.	Indianapolis	Marion
Brincko, John	Gary	Lake
Bringas, Irineo B.	Gary	Lake
Brink, Calvin C. (S)	Gary	Lake
Briscoe, Clarence E. (S)	New Albany	Floyd
Bristol, Henry M. S.	Terre Haute	Vigo
Britt, Robert	Evansville	Vanderburgh
Britton, Welbon D.	Montezuma	Parke-Vermillion
Brock, Earl E. (S)	Anderson	Madison
Brockman, Wilfred	Corydon	Harrison-Crawford
Brockmole, Arnold W.	Oraville, Calif.	Vanderburgh
Brodie, Donald W.	Indianapolis	Marion
Bromley, Luman W.	Fort Wayne	Allen
Bronson, Paul J.	Terre Haute	Vigo
Brooks, G. Tanner	Richmond	Wayne-Union
Brooks, Harry L.	Michigan City	La Porte
Broomes, Edward L. C.	East Chicago	Lake
Broshears, Kenneth P.	Linton	Greene
Brosius, Robert H. W.	Fort Wayne	Allen
Brown, Archie E.	Indianapolis	Marion
Brown, David B.	Gary	Lake
Brown, David E.	Indianapolis	Marion
Brown, Dewitt W.	Indianapolis	Marion
Brown, Earl R. Jr.	Indianapolis	Marion
Brown, Frances T.	Indianapolis	Marion
Brown, Frank M.	Indianapolis	Marion
Brown, Frederic W.	Fort Wayne	Allen
Brown, George E.	Greenwood	Johnson
Brown, George W.	Evansville	Vanderburgh
Brown, Gordon T.	Indianapolis	Marion
Brown, James C.	Valparaiso	Porter
Brown, James M.	Anderson	Madison
Brown, Jesse F.	Gary	Lake
Brown, John S.	Carlisle	Sullivan
Brown, Kenneth H.	New Albany	Floyd
Brown, Leland G.	Muncie	Delaware-Blackford
Brown, Leo R.	Gary	Lake
Brown, Marcel S.	Spencer	Owen-Monroe
Brown, Richard J.	Richmond	Wayne-Union
Brown, Robert M.	Marion	Grant
Brown, Robert R.	Terre Haute	Vigo
Brown, Stewart D.	Albany	Delaware-Blackford
Brown, Thomas C.	Indianapolis	Marion
Brown, Thomas M.	Muncie	Delaware-Blackford
Brown, Wendell E.	Indianapolis	Marion
Browning, James S.	Indianapolis	Marion
Browning, William M.	Indianapolis	Marion
Brownley, Emma J.	Indianapolis	Marion
Brubaker, Harold S.	Huntington	Huntington
Brubaker, Ora G. (S)	North Manchester	Wabash
Brubeck, Robert E.	Martinsville	Morgan
Bruce, Reginald A.	Indianapolis	Marion
Brueckman, F. Robert	Indianapolis	Marion
Bruegge, Theodore J.	Kokomo	Howard
Bruetsch, Walter L.	Indianapolis	Marion
Bruner, Ralph W.	Jeffersonville	Clark
Bryan, Franklin A.	Fort Wayne	Allen
Bryan, Robert E.	Kendallville	Noble
Bryan, Robert J.	South Bend	St. Joseph
Bryan, Stanton L.	Evansville	Vanderburgh
Bryant, Edward G.	East Chicago	Lake
Buchanan, Wallace D.	South Bend	St. Joseph
Buche, Franklin P. (S)	Richmond	Wayne-Union
Buchholz, Ransom R.	Georgetown, Texas	Vanderburgh
Buckingham, Richard E.	Bloomington	Owen-Monroe
Buckles, David L.	Anderson	Madison
Buckner, George D.	Fort Wayne	Allen
Buckner, Joy F.	Bluffton	Wells
Buechler, William F.	Elwood	Madison
Buechner, Frederick W.	South Bend	St. Joseph
Buehler, George M.	Jeffersonville	Clark
Buehner, Donald F.	Evansville	Vanderburgh
Buell, Forrest R.	Denver, Colorado	Marion
Bugh, Charles W.	Indianapolis	Marion
Buhrmester, Harry C.	Lafayette	Tippecanoe
Bullard, Mattie J.	Gary	Lake

Name	City	County
Bullers, Robert C.	Franklin	Johnson
Bullington, George E.	Franklin	Johnson
Bunde, Carl A.	Indianapolis	Marion
Bunker, Ladoska Z.	North Manchester	Wabash
Burcham, James B.	Gary	Lake
Burdette, Harold F.	Indianapolis	Marion
Burger, Robert A.	Gary	Lake
Burger, Thomas C.	Evansville	Vanderburgh
Burghard, Rolla D.	Indianapolis	Marion
Burk, James M.	Decatur	Adams
Burket, Cecil R.	Bremen	Marshall
Burkhardt, Boyd A.	Tipton	Tipton
Burkle, John C. (S)	Lafayette	Tippecanoe
Burkle, Robert J.	Indianapolis	Marion
Burks, Jess E.	Crawfordsville	Montgomery
Burman, Leonard	Oceanside, Calif.	Marion
Burnett, Arthur B.	New Castle	Henry
Burnett, Paul C.	Logansport	Cass
Burnikel, Ray H.	Evansville	Vanderburgh
Burns, John T.	Lafayette	Tippecanoe
Burns, Paul E.	Montpelier	Delaware-Blackford
Burress, Clyde R.	Evansville	Vanderburgh
Burris, Floyd L.	Michigan City	La Porte
Burrous, E. Lee	Peru	Miami
Burton, Philip B.	Indianapolis	Marion
Burwell, Stanley W.	Muncie	Delaware-Blackford
Bush, Charles E.	Kirklin	Clinton
Bush, Hargis R.	Cannelton	Perry
Bush, Jack A.	F.P.O., San Francisco, Calif.	Tippecanoe
Bussard, Clifford F. (S)	South Bend	St. Joseph
Bussard, Frank	South Bend	St. Joseph
Butler, Joe B.	Crothersville	Jackson
Butler, John O.	Indianapolis	Marion
Butler, Robert M.	Indianapolis	Marion
Butterfield, Robert M.	Muncie	Delaware-Blackford
Butts, Milton A.	South Bend	St. Joseph
Buttz, Rose J. P. (S)	Indianapolis	Marion
Butz, Ralph O.	Muncie	Blackford Delaware-
Byrn, Howard W. (S)	New Albany	Floyd
Byrne, Louis E.	Roachdale	Putnam
Byrne, Robert J.	Bicknell	Knox

C

Cacia, John J.	Evansville	Vanderburgh
Cagle, Bob R.	New Palestine	Hancock
Cahn, Hugo M.	Indianapolis	Marion
CaJacob, Melville E.	Terre Haute	Vigo
Caldwell, Marilyn R.	Indianapolis	Marion
Caldwell, Milton V.	Terre Haute	Vigo
Caldwell, William C. (S)	Evansville	Vanderburgh
Call, Herbert F.	Indianapolis	Marion
Call, William H.	San Angelo, Tex.	Marion
Callaghan, Patrick E.	Eglin AFB, Fla.	Lake
Callaghan, Winship C.	Greensburg	Decatur
Callahan, Richard H.	East Chicago	Lake
Calli, Louis	North Vernon	Jennings
Calvert, Raymond R.	Lafayette	Tippecanoe
Calvin, Jessie C. (S)	Fort Wayne	Allen
Cameron, Don F.	Angola	Steuben
Cameron, Donald F.	Bryan, Ohio	Steuben
Cameron, Mary H.	Angola	Steuben
Campagna, Ettor A.	East Chicago	Lake
Campbell, John A.	Indianapolis	Marion
Campbell, Patrick B.	Elkhart	Elkhart
Campbell, Sam W.	Noblesville	Hamilton
Campbell, William T.	Bedford	Lawrence
Canaday, Clifford E. (S)	Memphis, Tenn.	Henry
Canaday, James W. (S)	Indianapolis	Marion
Canganelli, Vincent G.	Lafayette	Tippecanoe
Cannon, Daniel H.	New Albany	Floyd
Capestany, Max A.	Indianapolis	Marion
Caplin, Irvin	Indianapolis	Marion
Caplin, Samuel S.	Westville	LaPorte
Carberry, George A.	Gary	Lake
Carbone, Joseph A.	Gary	Lake
Carey, J. Albert	Gary	Lake
Carey, Willis W. (S)	Kendallville	Noble
Carlo, Ernest R.	Fort Wayne	Allen
Carlson, Edward A. (S)	Peru	Miami
Carlson, Norman R.	Michigan City	La Porte
Carlson, Ralph F.	Evansville	Vanderburgh
Carlyle, Ivan E. (S)	Michigantown	Clinton
Carmody, Raymond F.	Gary	Lake
Carneal, Thomas E. (S)	Winamac	Pulaski
Carney, Joel T.	Jeffersonville	Clark
Carney, John C.	Monticello	White
Carpenter, James B.	Lafayette	Tippecanoe
Carpenter, John L.	Alexandria	Madison
Carpenter, Ramesh S.	Garrett	DeKalb
Carpentier, Harry F.	Princeton	Gibson
Carr, Joseph H.	Henryville	Clark
Carrel, Francis E.	Frankfort	Clinton
Carroll, Bertha Rose	W. Lafayette	Tippecanoe
Carroll, John C.	Decatur	Adams
Carroll, Mary E.	Crown Point	Lake
Carson, Wayne	Indianapolis	Marion
Carter, F. R. Nicholas	South Bend	St. Joseph
Carter, Fred S.	La Porte	La Porte
Carter, Jean V.	Tipton	Tipton
Carter, John O.	Hobart	Lake
Carter, Oren E.	Indianapolis	Marion
Cartwright, Emor L. (S)	Fort Wayne	Allen
Cartwright, Jack D.	La Porte	La Porte
Casey, Stanley M.	Huntington	Huntington
Cassady, James V.	South Bend	St. Joseph
Cassady, John R.	South Bend	St. Joseph
Cattell, Lee M.	Kokomo	Howard
Cavins, Alexander W.	Terre Haute	Vigo
Caylor, Charles H.	Bluffton	Wells
Caylor, Harold D.	Bluffton	Wells
Caylor, Truman E.	Bluffton	Wells
Chael, Thomas C.	Hammond	Lake
Challman, William B.	Mt. Vernon	Posey
Chambers, Alan R.	Fort Wayne	Allen
Chambers, Leroy B.	Union City	Randolph
Chambers, Pauline D.	Greenwood	Johnson
Chandler, Leon H.	Goshen	Elkhart
Chappel, Alfred T.	Franklin	Johnson
Chappell, Harold R.	Canal Zone	Gibson
Chase, James A.	Ligonier	Noble
Chattin, Herbert O.	Vincennes	Knox
Chattin, Robert E.	Loogootee	Daviess-Martin
Chattin, William R.	Indianapolis	Marion
Chattin, Vance J.	Washington	Daviess-Martin
Chen, Ko K.	Indianapolis	Marion
Cheydleur, Eleanor P.	Evansville	Vanderburgh
Chernish, Stanley M.	Indianapolis	Marion
Chevalier, Robert A.	Indianapolis	Marion
Chevigny, Julius J.	Gary	Lake
Chidlaw, Benjamin W. (S)	Hammond	Lake
Childs, Alpha G. W. (S)	Madison	Jefferson-Switzerland
Childs, Wallace E.	Madison	Jefferson-Switzerland
Chivington, Paul V.	Indianapolis	Marion
Christiansen, Philip A.	Indianapolis	Marion
Christie, Marvin	Indianapolis	Marion

Name	City	County
Christie, Robert W.	Muncie	Delaware-Blackford
Christophel, Verna	Mishawaka	St. Joseph
Chroniak, Walter	Indianapolis	Marion
Chu, Johnson C. S.	Logansport	Cass
Chube, David D.	Gary	Lake
Cipparone, Joseph R.	Indianapolis	Marion
Clancy, James F.	Hammond	Lake
Clark, Cecil P.	Indianapolis	Marion
Clark, George A.	Birmingham, Michigan	Marion
Clark, Ivan A.	Paoli	Orange
Clark, Lawson J.	Indianapolis	Marion
Clark, Marion E.	Cambridge City	Wayne-Union
Clark, Robert M.	Muncie	Delaware-Blackford
Clark, Stanley A. (S)	South Bend	St. Joseph
Clark, Thomas W.	Evansville	Vanderburgh
Clark, William B., Jr.	Jeffersonville	Clark
Clark, William H.	South Bend	St. Joseph
Clark, William R.	Fort Wayne	Allen
Clarke, Elton R.	Kokomo	Howard
Clarkson, Clarence G.	Liberty	Wayne-Union
Classen, Pete R. C.	Elkhart	Elkhart
Clay, Eleanor	Columbus	Bartholomew-Brown
Claybourn, Norman L.	East Chicago	Lake
Clauser, Eldo H. M.	Muncie	Delaware-Blackford
Clements, Albert F.	Evansville	Vanderburgh
Cleveland, John B.	Michigan City	La Porte
Clevenger, Joseph H.	Muncie	Delaware-Blackford
Clevinger, William G.	Indianapolis	Marion
Cline, Kenneth L.	Wyatt	St. Joseph
Close, W. Donald	Indianapolis	Marion
Clouse, Paul A.	Evansville	Vanderburgh
Clunie, William A.	Huntington	Huntington
Coade, George E.	Indianapolis	Marion
Coates, Jacqueline	Indianapolis	Marion
Cobb, Clarence M.	Logansport	Cass
Coble, Frank H.	Richmond	Wayne-Union
Coble, Ralph R. (S)	Indianapolis	Marion
Cochran, Harry A., Jr.	Fort Wayne	Allen
Cochran, Robert B.	Muncie	Delaware-Blackford
Cockrum, William M.	Evansville	Vanderburgh
Coddens, Avery L.	Earl Park	Benton
Coddington, Robert C.	Indianapolis	Marion
Coffel, Melvin H.	Vincennes	Knox
Coggeshall, Warren E.	Indianapolis	Marion
Cohen, Irving	Plainfield	Hendricks
Cohn, Alvin F.	Indianapolis	Marion
Cole, Ira	Lafayette	Tippecanoe
Cole, William L.	Evansville	Vanderburgh
Coleman, Floyd B.	Waterloo	DeKalb
Coleman, Henry G.	Salem	Washington
Coleman, Joseph E.	Evansville	Vanderburgh
Colip, George D.	South Bend	St. Joseph
Collins, Hubert L.	Indianapolis	Marion
Collins, Le Roy	Gary	Lake
Collins, Robert C.	Indianapolis	Marion
Colvin, Robert C.	Newburgh	Warrick
Colosey, Frederick J.	South Bend	St. Joseph
Combs, Charles N. (S)	Terre Haute	Vigo
Combs, Herman T.	Evansville	Vanderburgh
Combs, John H.	Evansville	Vanderburgh
Combs, Loyal W.	W. Lafayette	Tippecanoe
Combs, Pearl B. (S)	Evansville	Vanderburgh
Combs, Stuart R.	Terre Haute	Vigo
Comeau, William J.	Marion	Grant
Comer, Kenneth E.	Mooresville	Morgan
Compton, George	Tipton	Tipton
Compton, Walter A.	Elkhart	Elkhart
Condit, David H.	South Bend	St. Joseph
Congleton, G. C. (S)	Terre Haute	Vigo
Conklin, James O.	Terre Haute	Vigo
Conklin, Raymond L.	South Bend	St. Joseph
Conley, John E.	Fort Wayne	Allen
Conley, Joseph L.	Indianapolis	Marion
Conley, Thomas M.	Kokomo	Howard
Connell, Paul S.	Plymouth	Marshall
Connell, Vactor O.	Bourbon	Marshall
Connelly, Richard D.	Fort Wayne	Allen
Connoy, Andrew F.	Westfield	Hamilton
Connoy, Leo F.	Westfield	Hamilton
Conrad, Henry W.	Lawrenceburg	Dearborn-Ohio
Conway, Chester C.	Indianapolis	Marion
Conway, Glenn	Indianapolis	Marion
Conway, Thomas J.	Terre Haute	Vigo
Cook, Charles E.	North Manchester	Wabash
Cook, George M.	Lake Worth, Fla.	Lake
Cook, Gordon C.	South Bend	St. Joseph
Cook, Norman R.	Richmond	Wayne-Union
Cook, Robert G.	Bluffton	Wells
Cooksey, Thomas L. (S)	Crawfordsville	Montgomery
Cooney, Charles J.	Fort Wayne	Allen
Coons, John D.	Lebanon	Boone
Coons, Ritchie	Lebanon	Boone
Cooper, B. Trent	Roanoke	Huntington
Cooper, Faith M.	Lafayette	Tippecanoe
Cooper, Harry L. (S)	South Bend	St. Joseph
Cooper, Leo K.	Gary	Lake
Cope, Stanton E.	Huntington	Huntington
Corcoran, Patrick J. V.	Evansville	Vanderburgh
Cormican, Herbert L.	Elkhart	Elkhart
Cornacchione, Matthew	Indianapolis	Marion
Cornell, Robert A.	Crawfordsville	Montgomery
Corpe, Kenneth F.	Rushville	Rush
Corrao, Gaetano	Gary	Lake
Corsentino, Bart	Vincennes	Knox
Cortese, James V.	Indianapolis	Marion
Cortese, Thomas A.	Indianapolis	Marion
Costello, Albert J.	Hammond	Lake
Cotter, Edward R.	Hammond	Lake
Cottrell, Robert F.	Indianapolis	Marion
Coughenour, J. Robert	Indianapolis	Marion
Countryman, Frank W.	Indianapolis	Marion
Coursey, James O.	Plymouth	Marshall
Covalt, Wendell E.	Muncie	Delaware-Blackford
Covell, Harry M.	Auburn	DeKalb
Covey, Thomas J.	Valparaiso	Porter
Cox, Clifford E.	Indianapolis	Marion
Cox, Leon T.	Richmond	Wayne-Union
Coyner, Alfred B.	Lafayette	Tippecanoe
Craft, Kenneth L.	Indianapolis	Marion
Craft, William F. (S)	Linton	Greene
Craig, Alexander F.	New Castle	Henry
Craig, Reuben	Kokomo	Howard
Craig, Reuben A.	Kokomo	Howard
Craig, Richard M.	Fort Wayne	Allen
Craig, Robert A.	Syracuse	Kosciusko
Crain, James W.	Williamsport	Fountain-Warren
Crampton, Chas. C. (S)	Delphi	Carroll
Crandall, Lathan A.	Elkhart	Elkhart
Crawford, James H.	Evansville	Vanderburgh
Crawford, John A.	Indianapolis	Marion
Crawford, Theodore R.	Kokomo	Howard
Creek, Jean A.	Bloomington	Owen-Monroe
Crevello, Albert J.	Evansville	Vanderburgh
Crimm, Paul D.	Evansville	Vanderburgh
Cring, George V. (S)	Portland	Jay
Cripe, Earl P.	Bremen	Marshall
Cripe, William	Portland	Jay
Crist, John R.	Mt. Vernon	Posey
Crockett, Franklin S. (H)	West Lafayette	Tippecanoe

Name	City	County
Cron, William J.	Warsaw	Kosciusko
Cross, David G.	Indianapolis	Marion
Crowder, James H.	Sullivan	Sullivan
Crowley, Joseph B.	South Bend	St. Joseph
Crudden, Charles H.	Evansville	Vanderburgh
Crum, Marion M.	Angola	Steuben
Culbertson, Carl S.	South Bend	St. Joseph
Culbertson, Clyde G.	Indianapolis	Marion
Cullen, Paul K.	Indianapolis	Marion
Cullen, Paul K., Jr.	Rochester, Minn.	Marion
Cullison, John L.	Indianapolis	Marion
Cullnane, Chris W.	Evansville	Vanderburgh
Culloden, William G.	Indianapolis	Marion
Culmer, Walter N. (S)	Indianapolis	Marion
Culp, John E.	Fort Wayne	Allen
Cummings, David J. (S)	Brownstown	Jackson
Cunningham, Gene C.	Indianapolis	Marion
Cunningham, Robert D.	Marion	Grant
Cure, Charles W.	Indianapolis	Marion
Cure, Elmer T.	Muncie	Delaware-Blackford
Curran, Frank J.	Indianapolis	Marion
Currie, Robert W.	Indianapolis	Marion
Curry, Claude A.	Terre Haute	Vigo
Curry, R. Louis	Indianapolis	Marion
Curtner, Myron L.	Vincennes	Knox
Custer, Edward W.	South Bend	St. Joseph
Cuthbert, Marvin P.	Indianapolis	Marion
Cutshaw, James A.	Monroeville	Allen
Czenkusch, Helen G.	Indianapolis	Marion
D		
Daggy, B. T.	Richmond	Wayne-Union
Daggy, James R.	Richmond	Wayne-Union
Dagley, H. R.	Butlerville	Jennings
Dahling, Clemens W.	New Haven	Allen
Dailey, James E.	Indianapolis	Marion
Dainko, Alfred J.	East Chicago	Lake
Dale, Maxwell H.	Connersville	Fayette-Franklin
Daley, Edward H.	Indianapolis	Marion
Dallas, Fred R.	Indianapolis	Marion
Dallas, Mary E.	Indianapolis	Marion
Dalton, John E.	Indianapolis	Marion
Dalton, William W.	Indianapolis	Marion
Dalton, Wilson L.	Shelbyville	Shelby
Daly, Joseph M.	Indianapolis	Marion
Dancer, Charles R. (S)	Fort Wayne	Allen
Daniel, John C.	Indianapolis	Marion
Daniel, Robert A.	Akron, Ohio	Lake
Danieleski, Ladislaus J.	Gary	Lake
Daniels, George R. (S)	Marion	Grant
Dannacher, William D.	Wabash	Wabash
Dare, Lee A.	Jeffersonville	Clark
Darling, Dorothy	Gary	Lake
Datzman, Richard C.	Fort Wayne	Allen
Daugherty, Fred N.	Crawfordsville	Montgomery
Daugherty, William L.	Hutsonville, Ill.	Sullivan
Daves, William L.	Evansville	Vanderburgh
Davidoff, Manuel A.	Ossian	Wells
Davidson, Harold H.	Evansville	Vanderburgh
Davidson, N. Cort	Indianapolis	Marion
Davies, Robert	New Castle	Henry
Davis, Alice Hall (S)	Hammond	Lake
Davis, Carl M.	Valparaiso	Porter
Davis, Edgar C.	Muncie	Delaware-Blackford
Davis, Howard B.	Lafayette	Tippecanoe
Davis, John A.	Flat Rock	Shelby
Davis John A.	Indianapolis	Marion
Davis, John C. (S)	Logansport	Cass
Davis, Joseph B.	Marion	Grant
Davis, Lloyd H.	Madison	Jefferson-Switzerland
Davis, Margaret M.	Indianapolis	Marion
Davis, Marvin R.	Columbus	Bartholomew-Brown
Davis, Merle J.	Terre Haute	Vigo
Davis, Merrill S.	Marion	Grant
Davis, Neal	Gary	Lake
Davis, Parvin M.	New Albany	Floyd
Davis, Richard	Marion	Grant
Davis, Sam J.	Indianapolis	Marion
Davis, Thomas N. III	Hammond	Lake
Davis, William H.	New Market	Montgomery
Day, William D. C.	Seymour	Jackson
Deal, Eleanor H.	Speedway City	Marion
Dean, Donald I.	Rushville	Rush
Dearmin, Robert M.	Indianapolis	Marion
DeArmond, Murray	Indianapolis	Marion
De Bois, Elon	East Chicago	Lake
Decker, Harvey B.	Terre Haute	Vigo
DeDario, Leonard M.	Elkhart	Elkhart
Deems, Myers B.	Evansville	Vanderburgh
Deever, John W.	Indianapolis	Marion
DeFries, John J.	New Paris	Elkhart
DeGrazia, Eugene J.	Valparaiso	Porter
Deitch, Robert D.	Indianapolis	Marion
DeMotte, C. Bowen	Indianapolis	Marion
DeNaut, James F.	Knox	Starke
Denham, Robert H.	South Bend	St. Joseph
Dennison, Alfred D., Jr.	Indianapolis	Marion
Denny, E. Rankin	Terre Haute	Vigo
Denny, Edgar C. (S)	Milton	Wayne-Union
Denny, Forrest L.	Indianapolis	Marion
Denny, Frank T.	Ladoga	Montgomery
Denny, James W.	Indianapolis	Marion
Denny, Melvin H.	Rushville	Rush
Denton, Larkin D.	Greentown	Howard
Denzer, Edward K.	Evansville	Vanderburg
Denzer, William O.	Evansville	Vanderburgh
Deppe, Charles F.	Franklin	Johnson
DeRenne, William L.	Newport	Parke-Vermillion
Derhammer, George L.	Brookston	White
DesJean, Paul A.	Indianapolis	Marion
Dester, Herbert E.	Greencastle	Putnam
Detrick, Herbert W. (S)	Sarasota, Fla.	Lake
Dettloff, Frederick	Greencastle	Putnam
Deutsch, William	Muncie	Delaware-Blackford
DeVoe, Kenneth	South Bend	St. Joseph
DeWees, Dwight L.	Indianapolis	Marion
Dhein, Donald T.	Crown Point	Lake
Diamond, Leo L.	Marion	Grant
Dian, August J.	Gary	Lake
Dian, Julia K.	Gary	Lake
Dickerson, W. Martin	Monticello	White
Dickey, William M.	Indianapolis	Marion
Dickson, Carolyn L.	Indianapolis	Marion
Dickson, Dale D.	Greensburg	Decatur
Dieckman, Herbert S.	Evansville	Vanderburgh
Diefendorf, Charles F. (S)	Evansville	Vanderburgh
Dielman, Franklin C. (S)	Fulton	Fulton
Dierdorf, Fred W.	APO 125, New York, NY.	Marion
Dierolf, Edward J.	Gary	Lake
Dieter, William J.	Fort Wayne	Allen
Dietl, Ernest L.	South Bend	St. Joseph
Dill, Charles W.	Indianapolis	Marion
Dill, Myron K.	Indianapolis	Marion
Dillman, Carl E.	Corydon	Harrison-Crawford
Dilts, Robert L.	Indianapolis	Marion
Dimmett, Robert P.	Boonville	Warrick
Dingle, Paul E.	Richmond	Wayne-Union
Dininger, William S.	Winchester	Randolph
Dintaman, Paul G.	Indianapolis	Marion

Name	City	County
Dirks, Kenneth R.	Tacoma, Washington	Marion
Ditmyer, Paul J. Jr.	Indianapolis	Marion
Dittmer, Jack E.	Valparaiso	Porter
Dittmer, Thomas L.	Valparaiso	Porter
Ditton, Irvin W. (S)	Fort Wayne	Allen
Dixon, Fritz R.	Indianapolis	Marion
Dixon, Rex W.	Anderson	Madison
Dluzansky, James J.	Indianapolis	Marion
Dodd, Robert D.	South Bend	St. Joseph
Dodd, Roberts K.	Evansville	Vanderburgh
Dodds, James U.	Hartford City	Delaware-Blackford
Dodds, Wemple	Crawfordsville	Montgomery
Doenges, James L.	Anderson	Madison
Doherty, Raymond J.	Crown Point	Lake
Dolezal, Bernard J.	South Bend	St. Joseph
Dollens, Claude (S)	Oolitic	Lawrence
Dome, Hardin S. (S)	Tell City	Perry
Donahue, Claude M.	Carmel	Hamilton
Donahue, George R.	Lafayette	Tippecanoe
Donahue, James M.	Indianapolis	Marion
Donaldson, Frank C.	Anderson	Madison
Donato, Albert M.	Indianapolis	Marion
Donchess, Joseph C.	Gary	Lake
Doneff, Ronald H.	Gary	Lake
Donnelly, Everett F.	South Bend	St. Joseph
Doran, J. Hal	Indianapolis	Marion
Dorman, Willis L.	Indianapolis	Marion
Dormire, Robert D.	Warsaw	Koscuisko
Dorrance, Thomas O.	Bluffton	Wells
Doty, James R., Jr.	Indianapolis	Marion
Doughty, Samuel R., Jr.	Indianapolis	Marion
Douglas, William T.	Montpelier	Delaware-Blackford
Dovey, Edward G.	Elkhart	Elkhart
Dowd, Joseph A.	Indianapolis	Marion
Dowell, Emil H.	Rockville	Parke-Vermillion
Downard, Leland F.	Gaston	Delaware-Blackford
Downer, Luther H.	Evansville	Vanderburgh
Drake, Dale W.	Evansville	Vanderburgh
Drake, John C.	Anderson	Madison
Drake, Marion G.	Elwood	Madison
Draper, Merlin H. (S)	St. Petersburg, Fla.	Allen
Drennen, Robert V.	Anderson	Madison
Drew, Arthur L., Jr.	Indianapolis	Marion
Dreyer, Ralph W.	Richmond	Wayne-Union
Drummy, W. W.	Terre Haute	Vigo
Dryden, Gale E.	Indianapolis	Marion
Dublin, Madeline P.	Francesville	Pulaski
DuBois, Charles C. (S)	Warsaw	Kosciusko
DuBois, Ramon B.	Lafayette	Tippecanoe
Dudding, Joseph E.	Hope	Bartholomew-Brown
Dudgeon, Charles A.	Hartford City	Delaware-Blackford
Duemling, Arnold H.	Fort Wayne	Allen
Dugan, William M.	Indianapolis	Marion
Dukes, Betty	Dugger	Sullivan
Dukes, David A.	Tell City	Perry
Dukes, David J.	Corydon	Harrison-Crawford
Dukes, Frederic M. (S)	Dugger	Sullivan
Dukes, Joe E.	Dugger	Sullivan
Dulin, Basil B.	Anderson	Madison
Dunbar, Colin V.	Indianapolis	Marion
Dunbar, Fred	Marion	Grant
Duncan, John S.	Gary	Lake
Duncan, Raymond	Bedford	Lawrence
Dunham, Henry H.	Evansville	Vanderburgh
Dunlap, D. Logan	South Bend	St. Joseph
Dunn, Ferrell W. (S)	Muncie	Delaware-Blackford
Dunning, Lehman M. (S)	Indianapolis	Marion
Dunning, Thomas W.	Muncie	Delaware-Blackford
Dunstone, Harry C.	Fort Wayne	Allen
Dupes, Lowell E.	Indianapolis	Marion
Durham, Lowell J.	La Porte	La Porte
Durkee, Melvin S.	Evansville	Vanderburgh
Dusard, Joseph C.	Bedford	Lawrence
DuSold, Donald D.	Crown Point	Lake
Dutchess, C. Toney	Galveston	Cass
Dutchman, William R.	Chandler	Warrick
DuVall, William N. (S)	Mishawaka	St. Joseph
Dyar, Edwin W.	Indianapolis	Marion
Dycus, Walter A.	Evansville	Vanderburgh
Dye, William E.	Oakland City	Gibson
Dyer, George W.	Terre Haute	Vigo
Dyer, Wallace K.	Evansville	Vanderburgh
Dyke, Richard W.	Indianapolis	Marion
Dyken, Mark L.	New Castle	Henry
Dykhuizen, Theodore A.	Frankfort	Clinton

E

Eades, R. Charles	South Bend	St. Joseph
Eades, Ralph C.	Valparaiso	Porter
Earl, Max M.	Kokomo	Howard
Earp, Evanson B.	Indianapolis	Marion
Easter, James N.	Butlerville	Jennings
Eastman, Joseph R., Jr.	Indianapolis	Marion
Eaton, Edwin R.	Indianapolis	Marion
Eaton, Lyman D.	Indianapolis	Marion
Eaton, Marion J.	Lafayette	Tippecanoe
Ebbinghouse, Tom	Richmond	Wayne-Union
Ebert, J. Wayne	Indianapolis	Marion
Eberwein, John H. (S)	Indianapolis	Marion
Ebin, Judah L.	South Bend	St. Joseph
Eby, Ida L. (S)	Warren	Huntington
Echsner, Herman J.	Columbus	Bartholomew-Brown
Eckert, Russell A.	Logansport	Cass
Edlavitch, Baruch M. (S)	Fort Wayne	Allen
Edmonds, Kendrick	Bedford	Lawrence
Edwards, Bernard E.	South Bend	St. Joseph
Edwards, Edward T., Jr.	Vincennes	Knox
Edwards, Henry G.	Terre Haute	Vigo
Edwards, Wendell L.	Indianapolis	Marion
Edwards, William F.	New Albany	Floyd
Egan, Sherman	South Bend	St. Joseph
Egbert, Herbert L.	Indianapolis	Marion
Eggers, Ernest L. (S)	Hammond	Lake
Eggers, Henry W.	Hammond	Lake
Eggers, Richard	Crawfordsville	Montgomery
Egnatz, Nicholas	Hammond	Lake
Ehrich, William S. (S)	Evansville	Vanderburgh
Eicher, Palmer O.	Indianapolis	Marion
Eikenberry, Hugh W.	Indianapolis	Marion
Eisaman, Jack L.	Bluffton	Wells
Eisenberg, David A.	Martinsville	Morgan
Eissman, Robert	Muncie	Delaware-Blackford
Eisterhold, John A.	Evansville	Vanderburgh
Eldridge, Gail E.	Indianapolis	Marion
Elkins, James P.	Indianapolis	Marion
Elkouri, Harvey D.	Columbus	Bartholomew-Brown
Elledge, Ray	Hammond	Lake
Ellett, John, Jr.	Coatesville	Hendricks
Elliott, John C. (S)	Guilford	Dearborn-Ohio
Elliott, Lloyd A. (S)	Elkhart	Elkhart
Elliott, Ralph A.	Gary	Lake
Elliott, Thomas A.	Elkhart	Elkhart
Ellis, Davis W.	Rushville	Rush
Ellis, George M.	Connersville	Fayette-Franklin
Ellis, Lyman H.	Lizton	Hendricks
Ellis, Seth W.	Anderson	Madison
Ellis, William N.	Indianapolis	Marion

Name	City	County
Ellison, Alfred	La Jolla, Calif.	St. Joseph
Elshout, Clem H.	La Porte	La Porte
Elsten, Aubrey W.	Anderson	Madison
Elston, Lynn W.	Fort Wayne	Allen
Elston, Ralph W.	Fort Wayne	Allen
Elward, Carl J.	Wabash	Wabash
Emenhiser, Donald C.	New Haven	Allen
Emenhiser, John L.	Fort Wayne	Allen
Emery, Charles B.	Bedford	Lawrence
Emhardt, John T.	Indianapolis	Marion
Emhardt, John W. A.	Indianapolis	Marion
Emme, Richard W.	Harlan	Allen
Endicott, Wayne	Greenfield	Hancock
Engel, Edward L.	Evansville	Vanderburgh
Engeler, James E.	Lafayette	Tippecanoe
Engle, Russell B.	Winchester	Randolph
Engleman, Harry K. (S)	Georgetown	Floyd
English, Hubert M.	Gary	Lake
English, John P.	South Bend	St. Joseph
Ensey, Philip L.	Richmond	Wayne-Union
Ensminger, Leonard A. (S)	Indianapolis	Marion
Entner, Charles L.	Connersville	Fayette-Franklin
Episcopo, Arsenius R.	Salem	Washington
Erdel, Milton W.	Frankfort	Clinton
Erehart, Archie D.	Anderson	Madison
Erehart, Mark G.	Huntington	Huntington
Ericksen, Lester G.	South Bend	St. Joseph
Erickson, Gustaf W.	South Bend	St. Joseph
Ericson, Harold L.	Windfall	Tipton
Eshelman, Henry R.	Monterey	Pulaski
Espino, Jose C.	Munster	Lake
Espy, Theodore R.	Gary	Lake
Estes, Ambrose C.	Bloomington	Owen-Monroe
Evans, Frederick H.	Indianapolis	Marion
Evans, Frederick J.	Clinton	Parke-Vermillion
Evans, Paul V.	Indianapolis	Marion
Everly, Ralph V.	Indianapolis	Marion
Eviston, John B.	Huntington	Huntington
Ewing, Nathaniel D.	Vincennes	Knox

F

Fadell, Matthew J.	Gary	Lake
Fadul, Armand	East Chicago	Lake
Fagaly, William J.	Lawrenceburg	Dearborn-Ohio
Failey, Robert B.	Indianapolis	Marion
Fair, Herbert D. (S)	Muncie	Delaware-Blackford
Faith, Ira L.	Evansville	Vanderburgh
Fargher, Francis M.	Michigan City	La Porte
Fargher, Robert A.	La Porte	La Porte
Farner, James E.	Mishawaka	St. Joseph
Farnsworth, Samuel A.	La Porte	La Porte
Farr, James C.	Paragon	Morgan
Farrell, John J., Jr.	Greenfield	Hancock
Farrell, Joseph T.	Indianapolis	Marion
Farris, John J.	Washington	Daviess-Martin
Faul, Henry J.	Evansville	Vanderburgh
Faulkner, Donald J.	Hobart	Lake
Fausset, C. Basil	Indianapolis	Marion
Faust, Howard M. Jr.	Anderson	Madison
Faw, Melvin L.	Evansville	Vanderburgh
Feferman, Martin E.	South Bend	St. Joseph
Feinn, Harry S.	La Porte	La Porte
Feldman, Max	South Bend	St. Joseph
Fenneman, Robert J.	Evansville	Vanderburgh
Ferguson, Arthur N.	Fort Wayne	Allen
Ferguson, Donald H.	Anderson	Madison
Ferguson, William B.	Lafayette	Tippecanoe
Ferrara, Donald W.	Peru	Miami
Ferrara, Joseph F.	Franklin	Johnson
Ferrara, Samuel J.	Peru	Miami
Ferrell, Mars B.	Fortville	Hancock
Ferry, Francis A.	Indianapolis	Marion
Ferry, John L.	Whiting	Lake
Ferry, Paul W.	Kokomo	Howard
Fessler, Gordon S.	Rising Sun	Dearborn-Ohio
Fichman, Abraham M.	Fort Wayne	Allen
Fickas, Dallas	Evansville	Vanderburgh
Fiedler, Howard W.	Indianapolis	Marion
Fields, Donald C.	Lafayette	Tippecanoe
Fields, Donald L.	Indianapolis	Marion
Filipek, Walter J.	South Bend	St. Joseph
Fine, Nathaniel J.	Indianapolis	Marion
Finfrock, James D.	Fayetteville, Ark.	Marion
Finneran, Joseph C.	Indianapolis	Marion
Fipp, August L.	Rome City	Noble
Firestein, Ben Z.	South Bend	St. Joseph
Firestein, Ray	South Bend	St. Joseph
Fisch, Charles	Indianapolis	Marion
Fischer, Albert A.	Indianapolis	Marion
Fischer, Burnell	Hammond	Lake
Fischer, Carlton N.	La Porte	La Porte
Fischer, Warren E.	Anderson	Madison
Fish, Clyde M. (S)	Deerfield, Fla.	St. Joseph
Fish, Edson C.	South Bend	St. Joseph
Fisher, Frank C.	Indianapolis	Marion
Fisher, Frank L.	Crawfordsville	Montgomery
Fisher, Gerald E.	Ippy French Equatorial Africa	Marion
Fisher, Henry	Marion	Grant
Fisher, John E.	Attica	Fountain-Warren
Fisher, John E.	Newcastle	Henry
Fisher, Lawrence F.	South Bend	St. Joseph
Fisher, Walter S.	Columbus	Bartholomew-Brown
Fisher, William C.	Evansville	Vanderburgh
Fitz Gerald, Maurice D.	Evansville	Vanderburgh
Fitzgerald, Brice E.	Logansport	Cass
Fitzgerald, William J.	Indianapolis	Marion
Fitzpatrick, H. W. (S)	Elwood	Madison
Fitzpatrick, James S.	Portland	Jay
Fitzpatrick, William J.	Hammond	Lake
Flack, Russell A.	Lafayette	Tippecanoe
Flaherty, Walter T.	Michigan City	La Porte
Flanagan, Estle P. (S)	Walton	Cass
Flanagan, Paul M.	Indianapolis	Marion
Flanders, Robert J.	Indianapolis	Marion
Flanigan, Meredith B.	Indianapolis	Marion
Flannigan, Harley F.	LaGrange	LaGrange
Fleetwood, Raymond A.	Nappanee	Elkhart
Fleischer, Jacob C.	East Chicago	Lake
Fleischl, Herbert	Indianapolis	Marion
Fleming, Claude F. (S)	Elkhart	Elkhart
Fleming, Thomas C.	Evansville	Vanderburgh
Fletcher, Charles F. (S)	Sunman	Ripley
Flick, John J.	Indianapolis	Marion
Flora, Fred W.	Frankfort	Clinton
Flora, Joseph O.	Indianapolis	Marion
Fogel, Ernest	Logansport	Cass
Folck, John K.	Princeton	Gibson
Folkening, Norval C.	Indianapolis	Marion
Foltz, Lloyd E.	Brownsburg	Hendricks
Fong, Theodore C. C.	Madison	Jefferson-Switzerland
Forbes, Violet Crabbe	Wolcott	White
Foreman, Walter A.	Brookville	Fayette-Franklin
Forry, Frank (S)	Indianapolis	Marion
Forsee, Norman E.	Jeffersonville	Clark
Fortuna, Frank W.	Indianapolis	Marion
Fosbrink, Ephriam L.	Syracuse	Kosciusko
Fosgate, Harold	Indianapolis	Marion

Name	City	County
Foster, Douglas L.	Hammond	Lake
Foster, Lee N.	Indianapolis	Marion
Foster, Ray D.	Indianapolis	Marion
Foster, Ray T.	Newcastle	Henry
Foster, Robert	Franklin	Johnson
Fountaine, Thomas J.	Bedford	Lawrence
Foust, Betty Jean	Indianapolis	Marion
Fouts, Dallas B.	Indianapolis	Marion
Fouts, Paul J.	Indianapolis	Marion
Fowler, Richard R.	Bloomington	Owen-Monroe
Fox, C. Philip	Washington	Daviess-Martin
Fox, Jack	Hammond	Lake
Foy, Hayward W.	Fort Wayne	Allen
Frable, Frank L. Jr.	Lawrenceburg	Dearborn-Ohio
Fralich, Joseph C.	Milwaukee, Wis.	Marion
Frank, Herbert	South Bend	St. Joseph
Frank, John R. (S)	Valparaiso	Porter
Frank, Lyall L.	South Bend	St. Joseph
Franke, Gordon R.	Fort Wayne	Allen
Frankhouser, Charles M. A.	Fort Wayne	Allen
Franklin, Philip L.	Gary	Lake
Franklin, William L.	Indianapolis	Marion
Frankowski, Clementine	Whiting	Lake
Frantz, Mount E.	Bryan A.F.B., Texas	Hendricks
Frasch, Mahlon G.	Lafayette	Tippecanoe
Frash, De Von W.	South Bend	St. Joseph
Freeborn, Warren S.	Oaklandon	Marion
Freeby, C. William	Decatur	Adams
Freed, Carl A.	Indianapolis	Marion
Freed, John E., Jr.	Terre Haute	Vigo
Freed, John E. (S)	Terre Haute	Vigo
Freeland, Bill	Batesville	Ripley
Freeman, Leslie W.	Indianapolis	Marion
Freeman, Max E.	Indianapolis	Marion
Fretz, Richard C.	Kokomo	Howard
Frey, Harley B.	Lafayette	Tippecanoe
Frey, William B.	South Bend	St. Joseph
Friedman, Isadore E.	Hammond	Lake
Friedman, Morris S.	South Bend	St. Joseph
Frith, Louis G.	South Bend	St. Joseph
Fromhold, Willis A.	Indianapolis	Marion
Frost, Robert J.	Michigan City	La Porte
Fry, Robert D.	Indianapolis	Marion
Fujawa, Matthew J.	Mishawaka	St. Joseph
Fukumoto, Richard I.	Gary	Lake
Fullam, Richard G.	Fort Wayne	Allen
Fullerton, Robert L.	Monticello	White
Fulton, William H.	Indianapolis	Marion
Fultz, Roy L.	Salem	Washington
Funk, John W.	Muncie	Delaware-Blackford
Funkhouser, Elmer (S)	Indianapolis	Marion
Fuqua, Harold B.	Terre Haute	Vigo
Fuson, Wenfred J.	Greencastle	Putnam
Futterknecht, James O.	Elkhart	Elkhart

G

Name	City	County
Gabe, William E.	Orinda, Calif.	Marion
Gabovitch, Edward R.	Indianapolis	Marion
Gachaw, Gabra S.	Rantoul, Ill.	Marion
Gaddy, Euclid T.	Indianapolis	Marion
Gaddy, Nelson D.	Indianapolis	Marion
Gaffney, Raymond	South Bend	St. Joseph
Gailey, Ivan	Chrisney	Spencer
Galante, Vincent J.	Gary	Lake
Galbreath, Jesse P. (S)	Burnettsville	White
Galliher, Marjorie J.	Muncie	Delaware-Blackford
Gallinatti, John J.	Gary	Lake
Gambill, William D.	Indianapolis	Marion
Gammell, Lindley L.	Edinburg	Johnson
Gammieri, Robert L.	Indianapolis	Marion
Gannon, George W. (S)	Gary	Lake
Ganser, Ralph V.	South Bend	St. Joseph
Ganser, Richard A.	Mishawaka	St. Joseph
Gante, Henry W. (S)	Anderson	Madison
Ganz, Max	Marion	Grant
Garber, J. Neill	Indianapolis	Marion
Garceau, George J.	Indianapolis	Marion
Gard, Daniel A.	Indianapolis	Marion
Gardiner, H. Glenn	East Chicago	Lake
Gardiner, Sprague H.	Indianapolis	Marion
Gardner, Austin L.	Indianapolis	Marion
Gardner, Buckman	Indianapolis	Marion
Gardner, Melvin D.	Michigan City	La Porte
Gardner, Russell A.	Michigan City	La Porte
Garfield, Martin D.	Indianapolis	Marion
Garland, Edgar A.	Evansville	Vanderburgh
Garling, Luvern C.	Muncie	Delaware-Blackford
Garner, W. Stanley	Indianapolis	Marion
Garner, William H.	New Albany	Floyd
Garner, William H., Jr.	New Albany	Floyd
Garrett, John D. (S)	Indianapolis	Marion
Garrett, Robert A.	Indianapolis	Marion
Garrison, James L.	Cumberland	Marion
Garrison, Leon J.	Gas City	Grant
Garton, Harry W.	Fort Wayne	Allen
Garvin, Donald B.	Brazil	Clay
Gastineau, David C.	Fort Wayne	Allen
Gatch, Willis D. (S)	Indianapolis	Marion
Gates, George E.	South Bend	St. Joseph
Gattman, George B.	Elkhart	Elkhart
Gatzimos, Christos D.	Logansport	Cass
Gaul, L. Edward	Evansville	Vanderburgh
Gaunt, Everett W.	Alexandria	Madison
Geckler, Charles E.	Muncie	Delaware-Blackford
Gehres, Robert W.	Shelbyville	Shelby
Geick, Raymond G.	Fort Branch	Gibson
Geider, Roy A.	Indianapolis	Marion
Geiger, Dillon D.	Bloomington	Owen-Monroe
Geisinger, Lewis N. (S)	Auburn	De Kalb
Geller, Samuel	Owensville	Gibson
Genovese, Pasquale	Indianapolis	Marion
Genna, Mary E. Miller	Indianapolis	Marion
Gentile, John P.	New Albany	Floyd
George, Charles L.	Indianapolis	Marion
Gerding, William J.	Fort Wayne	Allen
Geronimo, Manuel M.	East Chicago	Lake
Geronimo, Rita R. V.	East Chicago	Lake
Gerrish, Donald A.	Terre Haute	Vigo
Gerrish, Wakefield D. (S)	Clinton	Parke-Vermillion
Gery, Richard E.	Lafayette	Tippecanoe
Getty, William H.	Evansville	Vanderburgh
Gevirtz, Milton B.	Hammond	Lake
Geyer, Joseph	New Albany	Floyd
Geyer, C. Norman	Carbondale, Ill.	Allen
Gibbs, Charles (S)	Greenfield	Hancock
Gibbs, Joseph W.	Martinsville	Morgan
Gibson, Alois E.	Indianapolis	Marion
Gibson, Greta Maxine	Indianapolis	Marion
Gick, Herman H. (S)	Indianapolis	Marion
Gifford, Fred E.	Indianapolis	Marion
Gilbert, Ivan	Terre Haute	Vigo
Gilbert, Robert G.	Tell City	Perry
Gilkison, John S. (S)	Shoals	Daviess-Martin
Gill, Dee D.	Greenfield	Hancock
Gill, John R.	Denver, Colo.	Lake
Gill, Thomas A.	Muncie	Delaware-Blackford
Gillespie, Charles F.	Indianapolis	Marion
Gillespie, Garland R.	Brownstown	Jackson
Gillespie, Jacob E.	Indianapolis	Marion
Gillum, Eugene M.	Portland	Jay
Gilman, Marcus M.	South Bend	St. Joseph

Name	City	County
Gilmore, Robert W.	Michigan City	La Porte
Gilmore, Russell A.	Michigan City	La Porte
Gingerick, Charles M.	Liberty Center	Wells
Ginsberg, Stewart T.	Indianapolis	Marion
Giorgio, Douglas J.	Evansville	Vanderburgh
Girod, Arthur H.	Decatur	Adams
Girod, Donald A.	Dunkirk	Jay
Gish, Howard M.	Brookston	White
Gitlin, Max M.	Bluffton	Wells
Gitlin, William A.	Bluffton	Wells
Glackman, John C., Jr.	Rockport	Spencer
Glackman, John C. (S)	Rochester	Fulton
Gladstone, Nah H.	Fort Wayne	Allen
Glassey, Stephen H.	Fort Wayne	Allen
Glendening, John L. (S)	Indianapolis	Marion
Glendening, Richard L.	Logansport	Cass
Glenn, Fred C. (S)	Tell City	Perry
Glock, Homer E. (S)	Fort Wayne	Allen
Glock, Maurice E.	Fort Wayne	Allen
Glock, Wayne R.	Fort Wayne	Allen
Glosson, Jack R.	Clay City	Clay
Glover, William J.	Gary	Lake
Gobbel, Novy E.	English	Harrison-Crawford
Goebel, Carl W.	Fort Wayne	Allen
Godersky, George E.	South Bend	St. Joseph
Goethals, Charles J.	Mishawaka	St. Joseph
Goldberg, Harold B.	Gary	Lake
Goldenberg, Norman S.	Indianapolis	Marion
Golding, Robert F.	Gary	Lake
Goldman, Samuel	Indianapolis	Marion
Goldsmith, David A.	Marion	Grant
Goldstone, Adolph	Gary	Lake
Goldstone, Harry A.	California, Penn.	Wabash
Goldstone, Joseph	Gary	Lake
Goldstone, Sidney R.	Gary	Lake
Golper, Marvin N.	Kokomo	Howard
Good, Richard P.	Kokomo	Howard
Goodman, Eli S.	Charlestown	Clark
Goodman, Hubert T.	Terre Haute	Vigo
Gootee, Francis H.	Loogootee	Daviess-Martin
Gootee, Thomas H.	Jasper	Dubois
Gordon, Joseph L.	Wheeler	Porter
Gormley, Joseph J.	Indianapolis	Marion
Gosman, James H.	Indianapolis	Marion
Gossard, Meredith B.	Tipton	Tipton
Gossom, Donn R.	Terre Haute	Vigo
Govorchin, Alexander	East Chicago	Lake
Graber, Virgil R.	Elkhart	Elkhart
Graessle, Harold P.	Seymour	Jackson
Graf, Jerome A.	Bloomfield	Greene
Graf, John P.	South Bend	St. Joseph
Graham, George M.	Fort Wayne	Allen
Graham, James C.	Fort Wayne	Allen
Graham, John D.	Indianapolis	Marion
Graham, William E.	Indianapolis	Marion
Grant, Benjamin F.	Gary	Lake
Grant, M. Arthur	Fairmount	Grant
Grant, Phyllis	New Castle	Henry
Graves, Noel S.	Vevay	Jefferson-Switzerland
Graves, Orville M.	Princeton	Gibson
Gray, Clyde C. (S)	Cloverdale	Putnam
Gray, Daniel E.	Crown Point	Lake
Gray, Leon	Martinsville	Morgan
Gray, Paul M.	Huntington	Huntington
Grayston, Wallace S. (S)	Huntington	Huntington
Green, Carl L.	Vincennes	Knox
Green, Frank H.	Rushville	Rush
Green, George F.	South Bend	St. Joseph
Green, John H. (S)	North Vernon	Jennings
Green, Leonard J.	Valparaiso	Porter
Green, Morris	Indianapolis	Marion
Green, Norval E.	South Bend	St. Joseph
Green, Oscar	Indianapolis	Marion
Greene, Morgan E.	Indianapolis	Marion
Greene, Robert W.	Rensselaer	Jasper-Newton
Greene, William R.	Henryville	Clark
Greenlee, Robert L.	Fort Wayne	Allen
Gregg, Albert F.	Connersville	Fayette-Franklin
Gregg, Edwin E.	Thorntown	Boone
Gregoline, Amadeo F.	Gary	Lake
Gregory, Robert L.	Indianapolis	Marion
Greiber, Marvin F.	Muncie	Delaware-Blackford
Greisen, Jack G.	Whiting	Lake
Greist, John H.	Indianapolis	Marion
Greist, Walter D.	Fort Wayne	Allen
Griem, Sylvia F.	Gary	Lake
Griep, Arthur H.	Evansville	Vanderburgh
Griffen, Charles G.	Valparaiso	Porter
Griffin, Joseph P.	Gary	Lake
Griffis, Vierl C. (S)	Richmond	Wayne-Union
Griffith, Harold R.	Fort Wayne	Allen
Griffith, James W.	Sheridan	Hamilton
Griffith, Richard S.	Indianapolis	Marion
Griffith, Ross E.	Indianapolis	Marion
Grigsby, Hardin B.	Lebanon	Boone
Grillo, Donald	South Bend	St. Joseph
Grimes, Hubert N.	Indianapolis	Marion
Grindrod, John M.	Terre Haute	Vigo
Gripe, Richard P.	Lafayette	Tippecanoe
Grisell, Ted L.	Indianapolis	Marion
Grosso, William G.	East Chicago	Lake
Grorud, Alton C.	South Bend	St. Joseph
Grotts, Bruce F.	Michigan City	La Porte
Grove, James H.	South Bend	St. Joseph
Gruber, Charles M.	Indianapolis	Marion
Guckien, Joseph L.	Evansville	Vanderburgh
Gustafson, Carl J.	Marion	Grant
Gustafson, Milton	Muncie	Delaware-Blackford
Gustaitis, John W.	Whiting	Lake
Guthrie, James R.	Richmond	Wayne-Union
Guthrie, James U.	Rochester	Fulton
Guthrie, William H.	Butlerville	Jennings
Gutierrez, Peter E.	Crown Point	Lake
Gutstein, Richard R. (S)	Kendallville	Noble
Guttman, John B.	Wakarusa	Elkhart
Gwin, Merle D. (S)	Miami Beach, Fla.	Jasper-Newton

H

Haas, Charles F.	Lafayette	Tippecanoe
Habegger, Elmer D.	Indianapolis	Marion
Habich, Carl (S)	Indianapolis	Marion
Hackett, Walter G.	Fort Wayne	Allen
Hade, Frederick L. (S)	Bridgeport	Marion
Hadley, David	Indianapolis	Marion
Hadley, Harvey (S)	Richmond	Wayne-Union
Haffner, Herman G.	Fort Wayne	Allen
Haggard, David B.	Plainfield	Hendricks
Haggard, Edmund B.	Indianapolis	Marion
Hagie, Frank E.	Richmond	Wayne-Union
Hahn, E. Vernon	Indianapolis	Marion
Haley, Alvin J.	Fort Wayne	Allen
Haley, Paul E.	South Bend	St. Joseph
Halfast, Richard W.	Kokomo	Howard
Hall, Bernard R.	Logansport	Cass
Hall, Donald L.	Petersburg	Pike
Hall, Frank M.	Indianapolis	Marion
Hall, Jack H.	Boston, Mass.	Marion
Hall, James M.	South Bend	St. Joseph
Hall, Orville A.	Muncie	Delaware-Blackford
Hall, Robert S.	Muncie	Delaware-Blackford
Hall, Thomas C.	Chesterton	Porter
Hall, William H.	Indianapolis	Marion

Name	City	County
Halleck, Harold J.	Winamac	Pulaski
Haller, Richard C.	Indianapolis	Marion
Haller, Robert L.	Fort Wayne	Allen
Haller, Thomas C.	Crawfordsville	Montgomery
Hamer, Homer G. (S)	Indianapolis	Marion
Hamilton, Antha A.	Vevay	Jefferson-Switzerland
Hamilton, Charles O.	South Bend	St. Joseph
Hamilton, Emory D.	Fort Wayne	Allen
Hamilton, Guy W. (S)	Durati, Calif.	Jefferson-Switzerland
Hamilton, James R.	Mitchell	Lawrence
Hamilton, M. Luther (S)	Newberry	Greene
Hamilton, Orville G.	Bluffton	Wells
Hamilton, Thomas	Columbia City	Whitley
Hammel, Howard T.	Bedford	Lawrence
Hammer, Jay W.	Middletown	Henry
Hammersley, George K.	Frankfort	Clinton
Hammond, James B.	Indianapolis	Marion
Hammond, Keith	Paoli	Orange
Hammond, R. Case	Evansville	Vanderburgh
Hammond, Stanley M.	Portland	Jay
Hampshire, Donald R.	Indianapolis	Marion
Hampton, James N.	Argos	Marshall
Hancock, John G.	Indianapolis	Marion
Haney, William	Madison	Jefferson-Switzerland
Hanley, Harriet F.	South Bend	St. Joseph
Hann, Eldon C.	Indianapolis	Marion
Hanna, Thomas A.	Indianapolis	Marion
Hannah, Jack W.	Elkhart	Elkhart
Hanneken, Vincent J.	Wabash	Wabash
Hansell, Robert M.	Indianapolis	Marion
Hanson, Martin F.	Elwood	Madison
Harcourt, Allan K.	Indianapolis	Marion
Harden, Murray E.	Lafayette	Tippecanoe
Hardin, Wayne E.	Ossian	Wells
Harding, M. Richard	Indianapolis	Marion
Harding, Myron S.	Indianapolis	Marion
Hardtke, Eldred F.	Bloomington	Owen-Monroe
Hardy, John J. (S)	North Liberty	St. Joseph
Hare, Daniel M.	Evansville	Vanderburgh
Hare, Earl H.	Indianapolis	Marion
Hare, Francis W., Jr.	Madison	Jefferson-Switzerland
Hare, Laura	Indianapolis	Marion
Harger, Robert W.	Indianapolis	Marion
Harkcom, Harry E.	St. Paul	Decatur
Harkness, Robert G.	Terre Haute	Vigo
Harless, Clarence M.	Chesterton	Porter
Harless, Fred	Monroeville	Allen
Harmon, Carl J.	Richmond	Wayne-Union
Harmon, Wayne	Lynn	Randolph
Harned, Ben K.	Evansville	Vanderburgh
Harold, Albert H. (S)	Indianapolis	Marion
Harold, Norris E. (S)	Indianapolis	Marion
Harper, James W.	Gary	Lake
Harrington, James F.	Logansport	Cass
Harris, Carl B.	Indianapolis	Marion
Harris, Paul N.	Indianapolis	Marion
Harris, Robert F.	Noblesville	Hamilton
Harris, Robert W.	New Albany	Floyd
Harrison, Benjamin L.	New Castle	Henry
Harshman, James A.	Indianapolis	Marion
Harshman, Louis P.	Fort Wayne	Allen
Harstad, Casper	Rockville	Parke-Vermillion
Hart, L. Paul	Evansville	Vanderburgh
Hart, Robert B.	Columbus	Bartholomew-Brown
Hart, William D.	Anderson	Madison
Harter, Eli B.	Lafayette	Tippecanoe
Hartley, Clarence A., Jr.	Evansville	Vanderburgh
Hartman, John J.	Angola	Steuben
Hartsough, Ralph I.	Remington	Jasper-Newton
Hartz, F. Minton	Evansville	Vanderburgh
Harvey, Harry C.	Fort Wayne	Allen
Harvey, Ralph J.	Zionsville	Boone
Harvey, Verne K., Jr.	Indianapolis	Marion
Harvey, Verne K. Sr.	Indianapolis	Marion
Hasewinkel, Carroll W.	Indianapolis	Marion
Hasewinkle, August M.	Fort Wayne	Allen
Hash, John S.	Noblesville	Hamilton
Hashemi, Hossein	Warsaw	Kosciusko
Haslem, Ezra R.	Terre Haute	Vigo
Haslem, John R.	Terre Haute	Vigo
Haslinger, Clarence J.	Indianapolis	Marion
Hass, Caroline E.	W. Lafayette	Tippecanoe
Hass, Thomas W.	W. Lafayette	Tippecanoe
Hastings, Warren C.	Fort Wayne	Allen
Hatfield, Jack J.	Indianapolis	Marion
Hatfield, Nicholas W.	Indianapolis	Marion
Hathaway, Clayton B.	Butler	De Kalb
Hattendorf, Anton P.	Fort Wayne	Allen
Haugseth, Ellsworth K.	South Bend	St. Joseph
Hauss, Augustus P. (S)	New Albany	Floyd
Havens, A. Lyle	Jeffersonville	Clark
Havens, Thomas R.	Jeffersonville	Clark
Havens, Oscar	Cicero	Hamilton
Havens, Russell E.	Fort Wayne	Allen
Havice, Jay F.	Lake Lure, N. C.	Allen
Hawes, James K. (S)	Columbus	Bartholomew-Brown
Hawes, Marvin E.	Columbus	Bartholomew-Brown
Hawk, Edgar A.	Evansville	Vanderburgh
Hawk, James H.	Indianapolis	Marion
Hawkins, Richard D.	Bedford	Lawrence
Hay, Gene R.	Indianapolis	Marion
Hayes, Frank W.	East Chicago	Lake
Hayes, J. D., Jr.	Gary	Lake
Hayes, Jesse D.	East Chicago	Lake
Hayes, Robert E.	Grand Rapids, Michigan	Miami
Hayes, Theodore R.	Muncie	Delaware-Blackford
Haymond, George M.	Indianapolis	Marion
Haymond, Joseph L.	Indianapolis	Marion
Haynes, John T.	Indianapolis	Marion
Hays, Everett L.	Indianapolis	Marion
Haywood, John G.	Noblesville	Hamilton
Hazinski, Robert T.	Griffith	Lake
Headley, Lloyd M.	Lebanon	Boone
Healey, Robert J.	Indianapolis	Marion
Heard, Albert	Evansville	Vanderburgh
Heaton, Elton	Huntingburg	Dubois
Heck, Martin C.	Jasper	Dubois
Heck, Rolfe A.	College Corner	Wayne-Union
Hedde, Eugene L.	Logansport	Cass
Hedgcock, Robert A.	Frankfort	Clinton
Hedrick, James T.	Gary	Lake
Hedrick, Philip W.	Indianapolis	Marion
Heilman, William C., Jr.	New Castle	Henry
Heilman, William C., Sr.	New Castle	Henry
Heimburger, Robert F.	Indianapolis	Marion
Heinrich, Weston A.	Evansville	Vanderburgh
Heinrichs, Harry H. (S)	Muncie	Delaware-Blackford
Held, George A.	Jasper	Dubois
Heller, Nelson L. (S)	Dunkirk	Jay
Helmen, Harry W. (S)	South Bend	St. Joseph
Helmer, John F.	South Bend	St. Joseph
Heminway, Norman L.	Elkhart	Elkhart
Hemsworth, Dorothy N.	Indianapolis	Marion
Hendershot, Eugene L.	Evansville	Vanderburgh
Henderson, Francis G.	Indianapolis	Marion
Henderson, Norman C.	Michigan City	La Porte
Henderson, Ramon A.	Muncie	Delaware-Blackford
Henderson, Robert N.	Brookston	White
Henderson, Roscoe C.	Indianapolis	Marion

Name	City	County
Henderson, William P.	Indianapolis	Marion
Hendricks, Fred A.	Indianapolis	Marion
Hendricks, John W.	Indianapolis	Marion
Hendrix, Charles E.	Vincennes	Knox
Henn, R. Anthony	Greenfield	Hancock
Henry, Alvin L.	Columbus	Bartholomew-Brown
Henry, Howard J.	Knox	Starke
Henry, Russell S.	Indianapolis	Marion
Hensler, Benton M.	Anderson	Madison
Hepburn, C. K.	Indianapolis	Marion
Hepner, Herman	Kendallville	Noble
Hepner, Herman S.	Bloomington	Owen-Monroe
Herd, Cloyn R.	Peru	Miami
Herendeen, Elbie V.	Rochester	Fulton
Heritier, C. Jules	Columbia City	Whitley
Hermayer, Stephen	Evansville	Vanderburgh
Hernandez, I. C.	East Chicago	Lake
Herr, John W.	Tell City	Perry
Herrick, Charles L.	Akron	Fulton
Herring, George N.	Richmond	Wayne-Union
Herrmann, Gordon T.	Evansville	Vanderburgh
Herrold, George W.	Lafayette	Tippecanoe
Hershberger, Philip	Fort Wayne	Allen
Hershey, Ernest A. (S)	Churubusco	Whitley
Herzberg, Milton	Clinton	Parke-Vermillion
Herzer, Clarence C.	Evansville	Vanderburgh
Hess, Paul P.	New Albany	Floyd
Hetherington, A. M. (S)	Indianapolis	Marion
Hetherington, John A.	Indianapolis	Marion
Hetman, Mitchell J.	Westville	La Porte
Heubi, John E.	Indianapolis	Marion
Hiatt, Russell L.	Louisville, Ky.	Wayne-Union
Hibner, Kermit	Danville	Hendricks
Hibner, Nolan A.	Monticello	White
Hickam, John B.	Indianapolis	Marion
Hickman, A. Lee	Hammond	Lake
Hickman, Donald	Fort Wayne	Allen
Hickman, Jack W.	Indianapolis	Marion
Hickman, Walter F. (S)	Indianapolis	Marion
Hicks, Murwyn L.	Indianapolis	Marion
Hicks, Wilbur D.	Indianapolis	Marion
Hiestand, Harley J. (S)	Pennville	Jay
Higbee, Paul (S)	Sullivan	Sullivan
Higgins, James L.	Otis AFB, Mass.	Pike
Higgins, John R.	New Albany	Floyd
Higgins, Kenneth E.	Fort Wayne	Allen
High, Ralph L.	Muncie	Delaware-Blackford
Hilbert, John W.	South Bend	St. Joseph
Hildebrand, John O.	South Bend	St. Joseph
Hill, Gladys Marie	Richmond	Wayne-Union
Hill, Harold D.	Richmond	Wayne-Union
Hill, Howard E.	Muncie	Delaware-Blackford
Hill, James K.	Indianapolis	Marion
Hill, Kenneth G.	New Castle	Henry
Hill, Lloyd	Denver	Miami
Hill, Paul G.	Cambridge City	Wayne-Union
Hill, Robert E.	Yorktown	Delaware-Blackford
Hill, Theodore A.	South Bend	St. Joseph
Hill, Wallace C.	South Bend	St. Joseph
Hillenbrand, Charles	Michigan City	La Porte
Hillery, John	Warsaw	Kosciusko
Hillis, Lowell J.	Logansport	Cass
Hillman, Marion W.	South Bend	St. Joseph
Hillman, Wm. H. (S)	South Bend	St. Joseph
Himebaugh, Gilbert J.	Evansville	Vanderburgh
Himebaugh, James R. S.	Indianapolis	Marion
Himler, James M.	Indianapolis	Marion
Hinchman, Clarence P.	Geneva	Adams
Hinchman, Jean F.	Parker	Randolph
Hines, Archie V.	Auburn	De Kalb
Hines, Don C.	Indianapolis	Marion
Hines, John H.	Auburn	De Kalb
Hingeley, John E.	Butlerville	Jennings
Hinshaw, Horace D.	LaPorte	La Porte
Hippensteel, Harland V.	Auburn	De Kalb
Hipskind, Richard E.	Fort Wayne	Allen
Hirsch, Herman L.	Mt. Vernon	Posey
Hisrich, Lloyd W.	Batesville	Ripley
Hobbs, Arthur A.	Evansville	Vanderburgh
Hochhalter, Marian	Logansport	Cass
Hodges, Fletcher (S)	Indianapolis	Marion
Hodgin, Phillip T.	Orleans	Orange
Hodurski, Zigfield	Gary	Lake
Hoetzer, Eldore M.	New Haven	Allen
Hoffman, Arthur F.	Fort Wayne	Allen
Hoffman, Doris	Vincennes	Knox
Hoffman, Herman	Indianapolis	Marion
Hoffman, Max N.	Covington	Fountain-Warren
Hofmann, Andrew (S)	Hammond	Lake
Hofmann, J. William (S)	Indianapolis	Marion
Hogan, Thomas W.	Terre Haute	Vigo
Hogle, Frank D.	Logansport	Cass
Hoit, Leonard	Gary	Lake
Holdeman, Lillian S.	South Bend	St. Joseph
Holdeman, Richard W.	South Bend	St. Joseph
Holladay, Lloyd J.	Lafayette	Tippecanoe
Holland, Deward J. (S)	Bloomington	Owen-Monroe
Holland, Philip T.	Bloomington	Owen-Monroe
Hollenberg, Alfred E.	Hagerstown	Wayne-Union
Hollenberg, Edward L.	Winamac	Pulaski
Holloway, William A. (S)	Logansport	Cass
Holman, Jerome E., Sr. (S)	Indianapolis	Marion
Holman, Jerome E., Jr.	Indianapolis	Marion
Holmes, Claude D. (S)	Frankfort	Clinton
Holmes, John L.	Columbia, Mo.	Clinton
Holsinger, Robert E.	Fort Wayne	Allen
Holtzman, Norman N.	South Bend	St. Joseph
Holtzman, Paul W.	Bloomington	Owen-Monroe
Honan, Paul R.	Lebanon	Boone
Hood, Ainslee A.	Indianapolis	Marion
Hoopes, Jane M.	Evansville	Vanderburgh
Hoover, Dewey A.	Terre Haute	Vigo
Hoover, J. Guy	Evansville	Vanderburgh
Hoover, Peter B.	Boonville	Warrick
Hopkins, Joseph R.	Hammond	Lake
Hopkins, Lester H.	Versailles	Ripley
Hoppenrath, Wesley M.	Elwood	Madison
Hoppenrath, William (S)	Elwood	Madison
Horning, Richard R.	Fort Wayne	Allen
Horst, William N.	Crown Point	Lake
Horswell, Richard G.	Bristol	Elkhart
Horwitz, Thomas	Indianapolis	Marion
Hostetler, Carl M.	Goshen	Elkhart
Hostetter, Irwin S.	Muncie	Delaware-Blackford
Houser, D. Stanley	Lakeville	St. Joseph
Houser, Wayne W.	Monon	White
Houston, Fred D.	Lawrenceburg	Dearborn-Ohio
Hovda, Richard B.	Evansville	Vanderburgh
Hover, Galen	Marion	Grant
How, John T. (S)	Lakeville	St. Joseph
How, Louis E.	South Bend	St. Joseph
Howard, William F.	Indianapolis	Marion
Howard, Wm. Harry	Hammond	Lake
Howe, Fordyce L.	Fort Wayne	Allen
Howell, Arthur	Indianapolis	Marion
Howell, Joseph D.	Indianapolis	Marion
Howell, Robert D.	Indianapolis	Marion
Hoyt, John M.	Kokomo	Howard
Hoyt, Lester H.	Indianapolis	Marion
Hoyt, Millard L.	Indianapolis	Marion
Hrisomalos, Frank N.	Bloomington	Owen-Monroe

Name	City	County
Hubbard, Jesse D.	Indianapolis	Marion
Huber, Carl P.	Indianapolis	Marion
Huckleberry, Irvin E.	Salem	Washington
Huddle, John R.	Indianapolis	Marion
Hudson, Arlington M.	Connersville	Fayette-Franklin
Hudson, Foster J.	Indianapolis	Marion
Huffman, Galen C.	Columbus, O.	Marion
Huffman, Verlin P.	S. Whitley	Whitley
Hughes, Richard R.	Lafayette	Tippecanoe
Huggins, Victor S.	Evansville	Vanderburgh
Hull, Arthur W.	Elkhart	Elkhart
Hull, De Wayne L.	Indianapolis	Marion
Hull, James E.	Lafayette	Tippecanoe
Hull, Ronald H.	Indianapolis	Marion
Hummel, Russel M.	Marion	Grant
Hummons, Francis D.	Indianapolis	Marion
Humphrey, Edward M.	Covington	Fountain-Warren
Humphrey, Paul E.	Terre Haute	Vigo
Humphreys, Joe E.	Vincennes	Knox
Humphreys, John L.	Fort Wayne	Allen
Humphreys, John W.	Crawfordsville	Montgomery
Hunsberger, Walter G.	Lafayette	Tippecanoe
Hunt, Edgar J.	Terre Haute	Vigo
Hunt, Gayle J.	Richmond	Wayne-Union
Hunter, Donn	Greenfield	Hancock
Hunter, Frank P.	Lafayette	Tippecanoe
Hunter, Lowell G.	Lawrenceburg	Dearborn-Ohio
Huoni, John S.	Jeffersonville	Clark
Hurley, Anson G.	Muncie	Delaware-Blackford
Hurley, James W.	Elkhart	Elkhart
Hurley, John R.	Daleville	Delaware-Blackford
Hursey, Virgil G.	Milford	Koscuisko
Hurt, LaVerne B.	Indianapolis	Marion
Hurteau, William W.	Indianapolis	Marion
Huse, William M.	Indianapolis	Marion
Husted, Robert G.	Hammond	Lake
Hutchison, Donald R.	Fountain City	Wayne-Union
Hutto, William H.	Kokomo	Howard
Hyatt, Gilbert T.	Evansville	Vanderburgh
Hyde, Carroll C.	South Bend	St. Joseph
Hynes, Roy T.	Indianapolis	Marion

I

Imhof, Joseph D.	Muncie	Delaware-Blackford
Ingwell, Guy B.	Knox	Starke
Inlow, Herbert H.	Shelbyville	Shelby
Inlow, William D.	Shelbyville	Shelby
Irish, Wilbur J.	East Chicago	Lake
Irwin, Glenn W., Jr.	Indianapolis	Marion
Irwin, Seth (S)	Anderson	Madison
Iske, Paul G.	Indianapolis	Marion
Isler, Nathaniel C.	Jeffersonville	Clark
Iterman, George E. (S)	New Castle	Henry
Ivy, John H.	Elkhart	Elkhart

J

Jackson, Charles E.	Bluffton	Wells
Jackson, Dean B.	Hartford City	Delaware-Blackford
Jackson, Frederick E. (S)	Indianapolis	Marion
Jackson, James W. (S)	Indianapolis	Marion
Jackson, John F.	Fort Wayne	Allen
Jackson, John K.	Aurora	Dearborn-Ohio
Jacobs, E. Robert	Hope	Bartholomew-Brown
Jaeger, Alfred S. (S)	Indianapolis	Marion
Jahns, Albin A.	Gary	Lake
James, John M.	Tell City	Perry
James, Nicholas A. (S)	Tell City	Perry
James, Thomas, Jr.	Huntington	Huntington
Jannasch, Maurice C.	Gary	Lake
Jaquith, Orville S. (S)	Indianapolis	Marion
Jarrett, John C.	Marion	Grant
Jarrett, Paul E.	Anderson	Madison
Jay, Arthur N.	Indianapolis	Marion
Jay, James	Indianapolis	Marion
Jeffries, Kenneth I. (S)	Indianapolis	Marion
Jenkins, Robert E.	Indianapolis	Marion
Jennings, F. Lamont	Chicago, Ill.	Marion
Jennings, Frank L.	Indianapolis	Marion
Jernigan, William R.	Evansville	Vanderburgh
Jett, Clyde W.	Seelyville	Vigo
Jewell, Earl B. (S)	Logansport	Cass
Jewell, George M.	Kokomo	Howard
Jewett, Joe H.	Indianapolis	Marion
Jinnings, Loren E.	Garrett	De Kalb
Jobes, James E.	Indianapolis	Marion
Jobes, Norman E. (S)	Indianapolis	Marion
Johns, David R. (S)	East Chicago	Lake
Johns, Nicholas C.	South Bend	St. Joseph
Johnson, Arnold L.	Gary	Lake
Johnson, Cecil E.	Rensselaer	Jasper-Newton
Johnson, Frank P.	Rochester	Fulton
Johnson, Gardner C. (S)	Evansville	Vanderburgh
Johnson, George M.	Richmond	Wayne-Union
Johnson, Harold V.	Evansville	Vanderburgh
Johnson, Herbert S.	Lafayette	Tippecanoe
Johnson, James B.	Greencastle	Putnam
Johnson, Jerome M.	Palmyra	Harrison-Crawford
Johnson, John J.	Warsaw	Koscuisko
Johnson, Lonnie B.	Gary	Lake
Johnson, Lowell R.	Lafayette	Tippecanoe
Johnson, Owen	Peru	Miami
Johnson, Paul D.	Terre Haute	Vigo
Johnson, Paul S. (S)	Richmond	Wayne-Union
Johnson, Robert B.	Rushville	Rush
Johnson, Stephen L.	Evansville	Vanderburgh
Johnson, Thomas W.	Indianapolis	Marion
Johnson, William A. (S)	Perrysville	Parke-Vermillion
Johnson, William A.	North Vernon	Jennings
Johnson, William F. (S)	Indianapolis	Marion
Johnson, William H.	Indianapolis	Marion
Johnston, Alan	Plainfield	Hendricks
Johnston, Donald D.	Westville	La Porte
Johnston, John M.	Hammond	Lake
Johnston, Richard M.	Fort Wayne	Allen
Johnston, Robert G. (S)	Huntington	Huntington
Jolly, Lewis E.	Madison	Jefferson-Switzerland
Jolly, Wesley P.	Richland	Spencer
Jones, Albert T.	Anderson	Madison
Jones, Allen W.	Indianapolis	Marion
Jones, Charles A.	Franklin	Johnson
Jones, David	Lafayette	Tippecanoe
Jones, David E.	Indianapolis	Marion
Jones, David G.	Anderson	Madison
Jones, David H.	Charlestown	Clark
Jones, Eli S.	Hammond	Lake
Jones, Francis P.	Indianapolis	Marion
Jones, George L.	Wanamaker	Marion
Jones, Gordon C.	Indianapolis	Marion
Jones, Horace E.	Anderson	Madison
Jones, J. Carl	Logansport	Cass
Jones, John G. (S)	Vincennes	Knox
Jones, King S.	Michigan City	La Porte
Jones, Lawrence R.	Indianapolis	Marion
Jones, Robert B. (S)	La Porte	La Porte
Jones, Roland W.	Bethesda, Md.	Marion
Jordan, Leo E.	Lynn	Randolph
Jordan, Richard A.	Corydon	Harrison-Crawford

Name	City	County
Jordan, Stanley Y.	Gary	Lake
Joseph, Rex M.	Indianapolis	Marion
Jowitt, Richard H.	Indianapolis	Marion
Judd, Donald R.	Indianapolis	Marion
Judson, Walter E.	Indianapolis	Marion
Juergens, Richard B.	Fort Wayne	Allen
Jump, Charles A. (S)	Selma	Delaware-Blackford
Jurgensen, Walter T.	Fort Wayne	Allen
Justen, Jerome W.	Glendale, Calif.	Lake
K		
Kabel, Robert N.	Terre Haute	Vigo
Kahler, Maurice V.	Indianapolis	Marion
Kahn, Alexander J.	Indianapolis	Marion
Kahn, Howard L.	Indianapolis	Marion
Kaiser, George C.	Indianapolis	Marion
Kaiser, George D.	Whiting	Lake
Kalb, Everett L.	Indianapolis	Marion
Kamen, Jack M.	East Chicago	Lake
Kamm, Bernard A.	South Bend	St. Joseph
Kammen, Leo	Indianapolis	Marion
Kammen, Robert	Indianapolis	Marion
Kammer, Grace C.	Muncie	Delaware-Blackford
Kammer, Walter F.	Muncie	Delaware-Blackford
Kantzer, Floyd B.	Garrett	De Kalb
Karberg, Richard J.	Lafayette	Tippecanoe
Karlick, Joseph	Arcadia	Hamilton
Karn, John W.	South Bend	St. Joseph
Karn, William N.	Evansville	Vanderburgh
Karnafel, Eugene T.	Indianapolis	Marion
Karns, John D.	Winamac	Pulaski
Karol, Herbert J.	Fort Wayne	Allen
Karpel, Bernard	Mooresville	Morgan
Karsell, William A.	Bloomington	Owen-Monroe
Kasting, Gerald	Bedford	Lawrence
Katterjohn, James C.	Indianapolis	Marion
Kauffman, Harley M.	Evansville	Vanderburgh
Kauffman, Nelson N.	Indianapolis	Marion
Kaufman, Julian	Fort Wayne	Allen
Kay, Oran E.	Spencer	Owen-Monroe
Keating, John U.	Elkhart	Elkhart
Keck, Carleton A.	Fort Wayne	Allen
Keeling, Forrest E.	Portland	Jay
Keenan, George B.	Indianapolis	Marion
Keenan, Reid L.	Indianapolis	Marion
Keever, Charles H.	Indianapolis	Marion
Keiser, Venice D.	Indianapolis	Marion
Keller, Foster C.	Columbus, Ohio	Allen
Keller, Frank G. (S)	N. Manchester	Wabash
Kellsey, David C.	Indianapolis	Marion
Kelly, Don E.	Indianapolis	Marion
Kelly, Frank (S)	Argos	Marshall
Kelly, John F.	Indianapolis	Marion
Kelly, Walter F. (S)	Indianapolis	Marion
Kelly, Wendell C.	Anderson	Madison
Kelsey, Robert M.	La Porte	La Porte
Kemp, John T.	Michigan City	La Porte
Kemp, William A.	Connersville	Fayette-Franklin
Kempf, Gerald F.	Rockville	Parke-Vermillion
Kendall, Forest M.	Nappanee	Elkhart
Kendrick, Frank J.	Gary	Lake
Kendrick, William M.	Mooresville	Morgan
Kennedy, Eva N. (S)	Camden	Carroll
Kennedy, Hunter F.	Indianapolis	Marion
Kennedy, Joseph T.	Indianapolis	Marion
Kennedy, Robert O. (S)	Rushville	Rush
Kennedy, Walter U.	New Castle	Henry
Kenney, David B.	Indianapolis	Marion
Kenney, Francis D.	Hammond	Lake
Kenoyer, Wilbur L.	Lackland AFB Texas	Marion
Kent, Richard N.	Fort Wayne	Allen
Kenyon, Charles E.	Cambridge City	Wayne-Union
Kenzler, Jack	Indianapolis	Marion
Kephart, S. Bruce	Bluffton	Wells
Kepler, Robert W.	La Porte	La Porte
Kercheval, John M.	Clinton	Parke-Vermillion
Kern, Charles B. (S)	Muncie	Delaware-Blackford
Kern, Clarence G.	Lebanon	Boone
Kerr, Donald M.	Bedford	Lawrence
Kerr, Harry R.	Indianapolis	Marion
Kerr, John E.	Michigan City	La Porte
Kerrigan, John F.	Michigan City	La Porte
Kerrigan, Robert L.	Michigan City	La Porte
Kerrigan, William F.	Connersville	Fayette-Franklin
Keseric, N. E.	French Lick Springs	Orange
Kessler, Robert B.	Evansville	Vanderburgh
Ketcham, Jane M. (S)	Indianapolis	Marion
Keyes, Robert C.	Fort Wayne	Allen
Khaton, Odessa M.	Gary	Lake
Kidd, James G.	Wood, Wis.	Wabash
Kidder, Orva T.	Fort Wayne	Allen
Kiechle, Frederich L.	Evansville	Vanderburgh
Kiely, John T.	Anderson	Madison
Kilgore, Byron W.	Indianapolis	Marion
Killian, E. Camille	Logansport	Cass
Kilmer, Warren L.	Indianapolis	Marion
Kim, Young D.	Beech Grove	Marion
Kimbrough, Robert F.	Fort Wayne	Allen
Kime, Charles E.	Richmond	Wayne-Union
Kime, Edwin N.	Indianapolis	Marion
Kimmel, George E.	Stoneham, Mass.	Miami
Kincaid, Raymond K.	Tipton	Tipton
Kincaid, Robert S.	Evansville	Vanderburgh
Kindell, Hurschell D.	New Richmond	Montgomery
King, Harold	Indianapolis	Marion
King, Jay M.	Logansport	Cass
King, Joseph W.	Anderson	Madison
King, Peter D.	Madison	Jefferson-Switzerland
King, Robert W.	Cedar Lake	Lake
King, William E.	Indianapolis	Marion
Kingsbury, John K. (S)	Indianapolis	Marion
Kinnaman, Howard A.	Crawfordsville	Montgomery
Kinneman, Robert E.	Greenfield	Hancock
Kintner, Burton E.	Elkhart	Elkhart
Kinzel, Robert J. W.	Indianapolis	Marion
Kirby, Ted C.	Greenfield	Hancock
Kirkhoff, Paul J.	Indianapolis	Marion
Kirklin, Oren L.	Indianapolis	Marion
Kirshman, Forrest E.	Muncie	Delaware-Blackford
Kirtley, James M.	Crawfordsville	Montgomery
Kirtley, Robert W.	Danville	Hendricks
Kirtley, William R.	Indianapolis	Marion
Kissel, Wesley A.	Indianapolis	Marion
Kissinger, Knight L.	Angola	Steuben
Kistler, James J.	La Porte	La Porte
Kistner, Arthur W.	Elkhart	Elkhart
Kitterman, Harry E.	Indianapolis	Marion
Klain, Benjamin V.	Indianapolis	Marion
Klamer, Charles H.	Jasper	Dubois
Klatch, Ben Z.	Lafayette	Tippecanoe
Klatte, Eugene C.	Indianapolis	Marion
Kleifgen, William A.	Fort Wayne	Allen
Kleindorfer, Roscoe L.	Evansville	Vanderburgh
Kleinman, Francis J.	Hebron	Porter
Kleopfer, Ronald G.	Indianapolis	Marion

Name	City	County
Klepfer, Jefferson	Richmond	Wayne-Union
Klepinger, Harry E.	Lafayette	Tippecanoe
Klingler, Maurice O.	Plymouth	Marshall
Klooze, Kenneth W.	Fort Wayne	Allen
Klos, Stanley J.	Hobart	Lake
Kmak, Chester	East Chicago	Lake
Knapp, Arthur L. (S)	South Bend	St. Joseph
Kneidel, John H.	Indianapolis	Marion
Knepple, La Marr R. (S)	Kokomo	Howard
Knight, Lewis W.	Fort Wayne	Allen
Knode, Kenneth T.	South Bend	St. Joseph
Knotts, Slater	Columbus	Bartholomew-Brown
Knowles, Charles Y.	Indianapolis	Marion
Knowles, Robert P.	Indianapolis	Marion
Ko, Richard	Gaston	Delaware-Blackford
Kobrin, Meyer W.	Gary	Lake
Koch, Edwin F. Jr.	Indianapolis	Marion
Koch, Elmer L.	Danville	Hendricks
Koch, Howard W.	Winchester	Randolph
Koehler, Elmer G.	Elkhart	Elkhart
Koenig, Robert L.	Valparaiso	Porter
Kohlstaedt, Karl C.	Indianapolis	Marion
Kohlstaedt, Kenneth G.	Indianapolis	Marion
Kohne, Gerald J.	Decatur	Adams
Kohne, Robert W.	Lafayette	Tippecanoe
Kolanko, Leon A.	Hammond	Lake
Kolettis, John G.	Gary	Lake
Komoroske, John E.	East Chicago	Lake
Kooiker, John E.	Indianapolis	Marion
Koons, Karl M.	Indianapolis	Marion
Koontz, William A.	Gas City	Grant
Kopanko, Bernard F.	East Chicago	Lake
Kopcha, Joseph E.	Gary	Lake
Kopecky, Robert R.	Indianapolis	Marion
Kopp, Otis A.	Anderson	Madison
Kopp, William R.	Anderson	Madison
Koransky, David S.	Hammond	Lake
Korn, Jerome M.	Gary	Lake
Kornafel, L. H.	Indianapolis	Marion
Koss, K. William	Muncie	Delaware-Blackford
Krabill, Willard S.	Goshen	Elkhart
Kraft, Bennett	Indianapolis	Marion
Kraning, Kenneth K.	Kewanna	Fulton
Kreitl, Dorothy R.	Richmond	Wayne-Union
Kremers, George A.	Kokomo	Howard
Kresler, Leon E.	Kentland	Jasper-Newton
Krieble, William W.	Terre Haute	Vigo
Kriel, William B.	Indianapolis	Marion
Krsek, Archie J.	Knox	Starke
Krueger, John E.	Fort Wayne	Allen
Krueger, John E.	South Bend	St. Joseph
Krueger, Robert B.	Columbus	Bartholomew-Brown
Kruse, Edward H. (S)	Fort Wayne	Allen
Kruse, Walter E.	Fort Wayne	Allen
Kubik, Francis J.	Michigan City	La Porte
Kubley, James D.	Plymouth	Marshall
Kudele, Louis T.	Whiting	Lake
Kuhn, Arthur J.	Hammond	Lake
Kuhn, Frederick L.	South Bend	St. Joseph
Kuhn, Hedwig S.	Hammond	Lake
Kuhn, Robert W.	Wilkinson	Hancock
Kunkler, Arnold W.	Terre Haute	Vigo
Kunkler, Joseph (S)	Terre Haute	Vigo
Kunkler, William C.	Terre Haute	Vigo
Kuntz, Herman W.	Indianapolis	Marion
Kurlander, Gerald J.	Indianapolis	Marion
Kurtz, Fred B. (S)	Indianapolis	Marion
Kurtz, Philip L.	Indianapolis	Marion
Kurtz, Richard	Indianapolis	Marion
Kurtz, William A.	Tipton	Tipton
Kwitny, Isadore J.	Indianapolis	Marion
Kyle, Michael A.	Gary	Lake

Name	City	County
L		
LaBier, C. Russell	Terre Haute	Vigo
LaBier, Clarence R. (S)	Terre Haute	Vigo
Lacy, John D., Jr.	Medaryville	Pulaski
Ladig, Donald S.	Fort Wayne	Allen
LaDine, Clarence B.	Indianapolis	Marion
LaDuron, Jules F.	Muncie	Delaware-Blackford
LaFollette, Donald	New Albany	Floyd
LaFollette, Forrest R.	Hammond	Lake
LaFollette, Robert E.	New Albany	Floyd
Lahr, Richard E.	Marion	Grant
Laird, Leslie A.	Richmond	Wayne-Union
Lalonde, Alban H.	Indianapolis	Marion
Lamb, Emmett B.	Indianapolis	Marion
Lamb, J. Leonard	South Bend	St. Joseph
Lamb, Russell W.	Indianapolis	Marion
Lamber, Chet K.	Indianapolis	Marion
Lambert, Ross W.	Indianapolis	Marion
Lamey, James L.	Anderson	Madison
Lamey, Paul T.	Anderson	Madison
Lampe, Elfred H.	Fort Wayne	Allen
Lancet, Robert O.	Terre Haute	Vigo
Land, Francis L.	Fort Wayne	Allen
Landon, David J.	Union City	Randolph
Landwehr, Alfons	Indianapolis	Marion
Lane, Charlotte E.	Indianapolis	Marion
Lane, William H.	South Bend	St. Joseph
Lang, Joseph E.	South Bend	St. Joseph
Langdon, Harry K. (S)	Indianapolis	Marion
Langohr, John	Columbia City	Whitley
Langrall, Harrison M. Jr.	Marion	Grant
Lanman, John U.	Munster	Lake
Lanning, R. Adrian	Noblesville	Hamilton
Lansford, Kenneth G.	Indianapolis	Marion
Laramore, Ward	Indianapolis	Marion
Larkin, Bernard J. (S)	Indianapolis	Marion
Larmore, Joseph L.	Anderson	Madison
Larmore, Sarah H.	Anderson	Madison
Larrabee, James F.	Hammond	Lake
Larrabee, Wm. H. (S)	New Palestine	Hancock
Larson, Goyt O.	La Porte	La Porte
LaSalle, Richard M.	Wabash	Wabash
LaSalle, Robert M. Jr.	Wabash	Wabash
LaSalle, Robert M., Sr.	Wabash	Wabash
Lasich, Anthony R.	Indianapolis	Marion
Laubscher, Clarence	Evansville	Vanderburgh
Laudeman, Walter A.	Elwood	Madison
Lauer, Dorothy B.	Dana	Parke-Vermillion
Lautz, Herbert A.	Hammond	Lake
Lavengood, Russell W.	Marion	Grant
Lawler, George F.	Indianapolis	Marion
Lawrence, Joseph C.	Evansville	Vanderburgh
Laws, Kenneth F.	Lafayette	Tippecanoe
Lawson, Isaac H. (S)	Kendallville	Noble
Laycock, Richard M.	Fort Wayne	Allen
Lazo, Vicente R.	Gary	Lake
Leahy, Howard J.	Pendleton	Madison
Leak, Robert H.	Boswell	Benton
Leasure, J. Kent	Indianapolis	Marion
Leasure, Kenneth	Elkhart	Elkhart
Leatherman, Harter L.	Indianapolis	Marion
Lebioda, Henry S.	Gary	Lake
Lee, Glen Ward	Richmond	Wayne-Union
Lee, James	Terre Haute	Marion
Lee, Raymond A.	Indianapolis	Vigo
Lee, Robert L.	De Motte	Jasper-Newton
Leff, Abe	Indianapolis	Marion
Leffel, James M.	Indianapolis	Marion
Leffler, William T.	Indianapolis	Marion
Lehman, Harold	Charlestown	Clark
Lehman, Kenneth M.	Topeka	LaGrange
Lehmberg, Otto F. C.	Columbia City	Whitley
Leibundguth, Henry	Evansville	Vanderburgh

Name	City	County
Leich, Charles F.	Evansville	Vanderburgh
Lein, John	Indianapolis	Marion
Leinbach, Earl	Hamlet	Starke
LeMaster, Theodore R.	Indianapolis	Marion
Leming, Ben L.	Fort Wayne	Allen
Lemon, Herbert K. (S)	Camden	Carroll
Lenk, George G.	Fort Wayne	Allen
Lenox, Jack	Lebanon	Boone
Leo, Renate G.	Williamsport	Fountain-Warren
Leonard, Henry S. (S)	Indianapolis	Marion
Leroy, Alvin G.	Alexandria	Madison
Leser, Ralph U.	Indianapolis	Marion
Lett, Emory B.	Loogootee	Daviess-Martin
Levatin, Bernard I.	South Bend	St. Joseph
Levering, Guy P. (S)	Lafayette	Tippecanoe
Levi, Leon	Indianapolis	Marion
Levin, Eli	East Chicago	Lake
Levin, Ralph T.	Indianapolis	Marion
Levkoff, Abner H.	South Bend	St. Joseph
Lewis, George N.	Gary	Lake
Lewis, James F.	Liberty	Wayne-Union
Lewis, Paul S.	Indianapolis	Marion
Lewis, R. Earl	Indianapolis	Marion
Lewis, Robert J.	Lawrence	Marion
Libbert, Edwin L., Jr.	Edinburg	Johnson
Lichtenberg, Melvin	Indianapolis	Marion
Liddell, Charles K.	Michigan City	La Porte
Lidikay, Edward C.	Indianapolis	Marion
Life, Homer L.	New Castle	Henry
Lind, Jaap J.	Mulberry	Clinton
Lindenborg, Paul G.	Indianapolis	Marion
Lindsay, Hamlin B.	Washington	Daviess-Martin
Ling, John F.	Richmond	Wayne-Union
Lingeman, Byron N.	Crawfordsville	Montgomery
Lingeman, Raleigh E.	Indianapolis	Marion
Lingeman, Roger E.	Indianapolis	Marion
Link, Goethe (S)	Indianapolis	Marion
Link, William C.	Bloomington	Owen-Monroe
Lionberger, John R.	South Bend	St. Joseph
Lippoldt, Charles L.	Oldenburg	Ripley
Lipschutz, Harold	Gary	Lake
Lipsey, Alfred J.	Gary	Lake
Liss, Emanuel C.	South Bend	St. Joseph
Little, John W. (S)	Indianapolis	Marion
Littlefield, Paul A.	Indianapolis	Marion
Littlefield, Shirley	Indianapolis	Marion
Litzenberger, Sam W.	Anderson	Madison
Llamas, Dominardor F.	East Chicago	Lake
Lloyd, Claude A.	Washington	Daviess-Martin
Lloyd, Frank P.	Indianapolis	Marion
Lloyd, Joe R.	Noblesville	Hamilton
Lloyd, Robert P.	Fort Wayne	Allen
Lochry, Ralph L. (S)	Ft. Lauderdale, Fla.	Marion
Lockhart, Jack M.	Connersville	Fayette-Franklin
Lockhart, Philip R.	South Bend	St. Joseph
Loehr, William M.	Indianapolis	Marion
Loewenstein, Werner L.	Terre Haute	Vigo
Logan, James Z.	Richmond	Wayne-Union
Lohman, Robert M.	Fort Wayne	Allen
Lohoff, Lewis C.	Tell City	Perry
Loh, Hwei Ya (Chang)	Gary	Lake
Loh, Wei-Ping	Gary	Lake
Long, Keith	Hammond	Lake
Long, Max R.	Marion	Grant
Long, Paul L.	Anderson	Madison
Longo, Amerigo V.	Columbus	Bartholomew-Brown
Lonngren, Dudley H.	Marion	Grant
Loomis, Charles H.	Richmond	Wayne-Union
Loomis, Norman S.	Indianapolis	Marion
Loop, Frederick A.	Lafayette	Tippecanoe
Lord, Glen C.	Indianapolis	Marion
Lorenty, Thaddeus B.	Gary	Lake
Lorman, James G.	Fort Wayne	Allen
Louden, Robert W.	Indianapolis	Marion
Loudermilk, Jack L.	Fort Wayne	Allen
Love, George N.	Indianapolis	Marion
Love, V. Logan	Marion	Grant
Lovell, Martin H.	Gary	Lake
Lovett, Harvey D.	Whitestown	Boone
Loving, Jury B.	New Goshen	Vigo
Lozow, David	Indianapolis	Marion
Lucas, Clarence A., Jr.	Indianapolis	Marion
Luckett, Coen L.	Terre Haute	Vigo
Luckey, Harold A.	Wolf Lake	Noble
Luckey, Robert C.	Wolf Lake	Noble
Ludwig, Oscar D. (S)	Indianapolis	Marion
Luginbill, Howard M.	Berne	Adams
Lukemeyer, George T.	Indianapolis	Marion
Lukemeyer, St. John	Jasper	Dubois
Lundblad, Wilfred M.	Bloomington	Owen-Monroe
Lundeberg, Ralph A.	Griffith	Lake
Lundt, Milo O.	Elkhart	Elkhart
Lunsford, Thomas E.	Indianapolis	Marion
Lurie, Paul R.	Indianapolis	Marion
Luros, J. Theodore	Indianapolis	Marion
Lutes, David L. (S)	Edinburg	Johnson
Lutz, Georgianna	Gary	Lake
Lutz, Robert J.	Eaton	Delaware-Blackford
Luzadder, John E.	New Carlisle	St. Joseph
Lybrook, Daniel E. (S)	Young America	Cass
Lybrook, William B.	Indianapolis	Marion
Lyman, Frank L.	Evansville	Vanderburgh
Lynch, Harold D.	Evansville	Vanderburgh
Lynch, Otis R.	Marengo	Harrison-Crawford
Lyon, Florence M.	Portland	Jay
Lyon, William C.	Fort Wayne	Allen
Lyons, L. Mason	Terre Haute	Vigo
Lyons, Robert E.	Bloomington	Owen-Monroe

M

MacCollum, M. Speers	Luke AFB, Ariz.	Marion
MacDougall, John D.	Indianapolis	Marion
MacKenzie, Pierce	Evansville	Vanderburgh
MacLeod, Donald F.	W. Lafayette	Tippecanoe
MacLeod, John K.	South Bend	St. Joseph
Machledt, John H.	Whiteland	Johnson
Mackel, Frederick O.	Fort Wayne	Allen
Mackey, Harry S. (S)	Indianapolis	Marion
Mackey, John E.	Indianapolis	Marion
Macy, George W.	Columbus	Bartholomew-Brown
Madlang, R. M.	East Chicago	Lake
Madden, Robert J.	Indianapolis	Marion
Mader, John H.	Richmond	Wayne-Union
Madston, A. Ricks	Indianapolis	Marion
Magennis, Herbert L. (S)	Indianapolis	Marion
Mahaffey, John E.	Indianapolis	Marion
Mahank, Camiel C.	Mishawaka	St. Joseph
Mahoney, Charles L.	Terre Haute	Vigo
Majsterek, Stanley L.	Gary	Lake
Makovsky, Theodore	Valparaiso	Porter
Malcolm, Russell	Richmond	Wayne-Union
Malone, Leander A.	Terre Haute	Vigo
Malott, Fred R.	Converse	Miami
Malouf, Stephen D.	Peru	Miami
Manalan, Maurice M.	Indianapolis	Marion
Manalo, Francisco M.	Gary	Lake
Manders, Karl L.	Indianapolis	Marion
Mangan, Frank P.	Gary	Lake
Manifold, Harold M.	Fortville	Hancock
Manion, Marlow W.	Indianapolis	Marion
Mankin, William J.	Terre Haute	Vigo

Name	City	County
Mann, Mortimer	Indianapolis	Marion
Mann, Richard E.	Indianapolis	Marion
Manning, George	Fort Wayne	Allen
Manning, K. Randolph	Indianapolis	Marion
Manship, Stanley	Paoli	Orange
Mansueto, Mario D.	Hammond	Lake
Manzie, Michael W.	Indianapolis	Marion
Maple, James B. (S)	Sullivan	Sullivan
Marchand, Edwin V.	Haubstadt	Gibson
Marchant, Clarence H.	Bloomington	Owen-Monroe
Marcus, Emanuel	Hammond	Lake
Marcus, Morris C.	Gary	Lake
Maris, Lee J.	Attica	Fountain-Warren
Markel, Ivan J.	Elkhart	Elkhart
Markle, Joseph G.	Hobart	Lake
Marks, Howard H.	Huntington	Huntington
Marks, Maurice I.	Indianapolis	Marion
Marks, Ora L.	East Chicago	Lake
Marks, Salvo P.	Hammond	Lake
Marquinez, Adoracion A.	East Chicago	Lake
Marquis, Gordon	South Bend	St. Joseph
Marr, Griffith	Columbus	Bartholomew-Brown
Marsh, Carl M.	Indianapolis	Marion
Marsh, Chester A. (S)	Los Angeles, Calif.	Wayne-Union
Marsh, George W.	Lafayette	Tippecanoe
Marsh, Myrle F.	Indianapolis	Marion
Marshall, Albert L., Jr.	Indianapolis	Marion
Marshall, Caesar L.	Fort Wayne	Allen
Marshall, Cavins R. (S)	Indianapolis	Marion
Marshall, George L. (S)	Bourbon	Marshall
Marshall, Lloyd C. (S)	Mt. Summit	Henry
Marshall, Millard R.	Gary	Lake
Marshall, Thomas R.	Indianapolis	Marion
Marske, Robert L.	Michigan City	La Porte
Martin, Charles E. (S)	Lynn	Randolph
Martin, Charles F.	Mishawaka	St. Joseph
Martin, Floyd S.	Goshen	Elkhart
Martin, Guy	Seymour	Jackson
Martin, Hugh E.	Indianapolis	Marion
Martin, Loren H.	Indianapolis	Marion
Martin, Joe	Lafayette	Tippecanoe
Martin, Paul H.	Elkhart	Elkhart
Martin, Samuel W.	Corydon	Harrison-Crawford
Martinov, William E.	South Bend	St. Joseph
Martirez, Napoleon A.	Crown Point	Lake
Marty, Sophocles D.	Corpus Christi, Texas	Marion
Martz, Bill L.	Indianapolis	Marion
Martz, Carl D.	Indianapolis	Marion
Marvel, Howard R.	Lafayette	Tippecanoe
Marvel, Robert J.	Indianapolis	Marion
Marymount, Jesse H.	Indianapolis	Marion
Maschmeyer, Robert H.	Logansport	Cass
Mason, Bernard A.	South Bend	St. Joseph
Mason, Donald G.	Angola	Steuben
Mason, Everett E.	Evansville	Vanderburgh
Mason, Lester M.	Terre Haute	Vigo
Mason, Richard L.	Hammond	Lake
Masters, John M.	Indianapolis	Marion
Masters, Robert J.	Indianapolis	Marion
Massanari, Walter	Millersburg	Elkhart
Mather, Charles R.	Lafayette	Tippecanoe
Mather, J. Winford	East Gary	Lake
Mather, Robert L.	Frankfort	Clinton
Matheu, Heracleo	Logansport	Cass
Matheus, Charles	Indianapolis	Marion
Mathews, James R.	Evansville	Vanderburgh
Mathewson, Russell C.	Muncie	Delaware-Blackford
Mathys, Alfred (S)	Mauckport	Harrison-Crawford
Matthew, John R.	North Judson	Starke
Matthew, W. Burleigh	Indianapolis	Marion
Matthews, Bernard J.	Indianapolis	Marion
Matthews, Charles B. (S)	Hammond	Lake
Matthews, Dennis W. (S)	North Vernon	Jennings
Matthews, William M.	Indianapolis	Marion
Mattmiller, Everette D.	Avilla	Noble
Mattox, Don M.	Terre Haute	Vigo
Maurer, J. Frank	Brazil	Clay
Maurer, Robert M.	Brazil	Clay
Maxam, B. T.	Indianapolis	Marion
Maxson, Roy V.	Anderson	Madison
May, George A.	Madison	Jefferson-Switzerland
May, Richard M.	Gary	Lake
May, William D.	New Albany	Floyd
Mayberry, Alton	Evansville	Vanderburgh
Mayes, Warren E.	Fort Wayne	Allen
Mayfield, Clifford H. (S)	Reynolds	White
McAdams, Hugh B.	Lafayette	Tippecanoe
McAdams, Robert	Lafayette	Tippecanoe
McArdle, Edward G.	Fort Wayne	Allen
McAree, Francis E.	Indianapolis	Marion
McArt, Bruce A.	Elkhart	Elkhart
McAtee, Ott B.	Madison	Jefferson-Switzerland
McBride, James S.	Indianapolis	Marion
McBride, Noel S.	Terre Haute	Vigo
McCabe, James E. (S)	Otterbein	Benton
McCalla, Charles X.	Paoli	Orange
McCallister, John W.	Fort Wayne	Allen
McCallum, Donald C.	Indianapolis	Marion
McCallum, Joseph T. C.	Indianapolis	Marion
McCallum, Robert N.	Indianapolis	Marion
McCarthy, Jeremiah A.	Whiting	Lake
McCartney, Donald H.	Indianapolis	Marion
McCarty, Virgil	Princeton	Gibson
McCaskey, Carl H. (S)	Indianapolis	Marion
McClain, Edwin S.	Indianapolis	Marion
McClain, Marvin L.	Scottsburg	Scott
McClelland, Donald C.	Lafayette	Tippecanoe
McClelland, Harry N.	Alexandria	Madison
McClintock, James A.	Muncie	Delaware-Blackford
McClure, Clark	Knox	Starke
McClure, Morris E.	Union City	Randolph
McClure, Stanley E.	Monon	White
McClure, Warren N.	Kokomo	Howard
McConnell, William C.	Sunman	Ripley
McCool, Joseph H.	Evansville	Vanderburgh
McCord, Carl B. (S)	Veedersburg	Fountain-Warren
McCormack, Lloyd L.	Fremont	Steuben
McCormick, Charles O., Jr.	Indianapolis	Marion
McCormick, Hubert D. (S)	Vincennes	Clay
McCormick, Wilbur C.	Brazil	Knox
McCoy, George E.	Muncie	Delaware-Blackford
McCoy, Melvin H.	Indianapolis	Marion
McCoy, Roy R.	Fort Wayne	Allen
McCraley, William J.	South Bend	St. Joseph
McCrea, Fred R.	Terre Haute	Vigo
McCullough, Henry G.	Columbus	Bartholomew-Brown
McCullough, James Y.	New Albany	Floyd
McDaniel, Franklin P. (S)	Atlanta	Hamilton
McDevitt, Daniel R.	Indianapolis	Marion
McDonald, Frank C.	New Castle	Henry
McDonald, Joseph D.	Evansville	Vanderburgh
McDonald, Ralph M.	South Bend	St. Joseph
McDonald, Vergil G. (S)	Anderson	Madison
McDowell, Fletcher W.	Muncie	Delaware-Blackford

Name	City	County
McDowell, George A.	Fort Wayne	Allen
McDowell, Mordecai M.	Vincennes	Knox
McEachern, Cecil G.	Fort Wayne	Allen
McElroy, James S.	New Castle	Henry
McElroy, Robert S.	Princeton	Gibson
McEwen, James W.	Terre Haute	Vigo
McFadden, James M.	Lafayette	Tippecanoe
McFall, J. R. S.	Coral Gables, Fla	Allen
McGauvran, Theodore	East Chicago	Lake
McGee, Robert R.	New Castle	Henry
McGrath, Michael F.	Indianapolis	Marion
McGuff, Paul E.	Indianapolis	Marion
McGuire, D. F. (S)	East Chicago	Lake
McIlwain, Eleanor E.	Warren	Huntington
McIlwain, Robert E.	Warren	Huntington
McIndoo, Ralph E.	Kokomo	Howard
McIntire, Clarence R.	Bloomington	Owen-Monroe
McIntosh, Wilbert	Riley	Vigo
McIntyre, Charles J. (S)	Indianapolis	Marion
McIntyre, James M.	Indianapolis	Marion
McKee, Harry G.	Rushville	Rush
McKee, Roy G.	New Castle	Henry
McKeeman, Donald H.	Fort Wayne	Allen
McKeeman, Leland S.	Fort Wayne	Allen
McKinley, A. David	Indianapolis	Marion
McKinley, Joseph	Lafayette	Tippecanoe
McKinney, Daniel H.	Lafayette	Tippecanoe
McKittrick, Jack	Washington	Daviess-Martin
McLaren, David E.	Indianapolis	Marion
McLaughlin, Calvin P.	Pendleton	Madison
McLaughlin, Gordon C.	Terre Haute	Vigo
McLaughlin, James R.	Flora	Carroll
McLaughlin, William T.	Indianapolis	Marion
McLean, James S.	Munster	Lake
McLelland, Mary R.	Bloomington	Owen-Monroe
McMahan, Virgil C.	Vincennes	Knox
McMath, Samuel B.	Gary	Lake
McMichael, Frank J. (S)	Hernando, Fla.	Lake
McMillan, Frederick G. (S)	Indianapolis	Marion
McNabb, George B.	Carthage	Rush
McNabb, Richard C.	Knightstown	Henry
McNaughton, Lawrence M.	Washington	Daviess-Martin
McNeely, Matthew J.	Dillsboro	Dearborn-Ohio
McQuiston, Ralph J.	Indianapolis	Marion
McTurnan, Robert W.	Indianapolis	Marion
McVey, Clarence A.	Hammond	Lake
McWilliams, William B.	Liberty	Wayne-Union
Mead, Clarence H. (S)	Bluffton	Wells
Mead, Frank E.	La Porte	La Porte
Meade, Walter W.	Bicknell	Knox
Meaney, James J.	Indianapolis	Marion
Medcalf, Norman L. (S)	Lamar	Spencer
Megenhardt, Dennis S.	Indianapolis	Marion
Mehne, Richard G.	Brazil	Clay
Meier, Donald W.	Bluffton	Wells
Meikle, Louise J. (S)	W. Lafayette	Tippecanoe
Meiks, Lyman T.	Indianapolis	Marion
Meiser, Robert D.	Huntington	Huntington
Meister, Doris (S)	Anderson	Madison
Melin, John R.	Indianapolis	Marion
Melloh, Ardis F.	Indianapolis	Marion
Mendelson, Stanley M.	Kokomo	Howard
Mendenhall, Clarence D.	Indianapolis	Marion
Mendez, Carlos	Elkhart	Elkhart
Mensch, James R.	Fort Wayne	Allen
Mentendiek, Maurice H.	Indianapolis	Marion
Mercer, Samuel R.	Fort Wayne	Allen
Meredith, Elwood J.	Richmond	Wayne-Union
Mericle, Earl W.	Indianapolis	Marion
Merrell, Basil M.	Rockville	Parke-Vermillion
Merrell, Paul	Indianapolis	Marion
Mershon, Jack B.	Indianapolis	Marion
Mertz, Henry O. (S)	Nokomis, Fla.	Marion
Mertz, John H. O.	Indianapolis	Marion
Messer, Frank W.	Kendallville	Noble
Metcalfe, Grant E.	South Bend	St. Joseph
Meulbroek, Harvey	Indianapolis	Marion
Meyer, Hans	Fort Wayne	Allen
Meyer, Herman A.	Fort Wayne	Allen
Meyer, Milo G.	Michigan City	La Porte
Meyer, Theodore O.	Fort Wayne	Allen
Meyn, Werner P.	Terre Haute	Vigo
Michael, Isaac E.	Indianapolis	Marion
Michael, Robert L.	Kokomo	Howard
Michaelis, Stephen C.	Fort Wayne	Allen
Middleton, Harvey N.	Indianapolis	Marion
Middleton, Ramona J.	Elkhart	Elkhart
Middleton, Thomas O	Bloomington	Owen-Monroe
Mikan, V. Robert	Logansport	Cass
Miklozek, John E.	Terre Haute	Vigo
Milan, Joseph F.	Bloomington	Owen-Monroe
Millar, Glenn C.	Indianapolis	Marion
Miller, Arthur H. (S)	Russiaville	Howard
Miller, Dan T. (S)	Fowler	Benton
Miller, David I.	Indianapolis	Marion
Miller, Donald C.	Cedar Lake	Lake
Miller, Donald G.	Middlebury	Elkhart
Miller, Edward D.	Fort Wayne	Allen
Miller, Frank H.	Indianapolis	Marion
Miller, Galen R.	Elkhart	Elkhart
Miller, H. Allison	Marion	Grant
Miller, H. Paul	Fort Wayne	Allen
Miller, Harold E.	Seymour	Jackson
Miller, Harold L.	Indianapolis	Marion
Miller, Henderson L. (S)	West Baden Springs	Orange
Miller, Hugh A.	Elkhart	Elkhart
Miller, J. Don (S)	Indianapolis	Marion
Miller, James C.	Greensburg	Decatur
Miller, Jerry R.	Indianapolis	Marion
Miller, John D.	Indianapolis	Marion
Miller, John M.	Bloomington	Owen-Monroe
Miller, Joseph A.	Oaklandon	Marion
Miller, Kenneth D.	Gary	Lake
Miller, LaVerne B.	Evansville	Vanderburgh
Miller, Mahlon F.	Fort Wayne	Allen
Miller, Milton	Evansville	Vanderburgh
Miller, Milo K.	South Bend	St. Joseph
Miller, Minor	Evansville	Vanderburgh
Miller, Orval J.	Fort Wayne	Allen
Miller, Raleigh S.	Indianapolis	Marion
Miller, Ray D.	Martinsville	Morgan
Miller, Richard C.	Shelbyville	Shelby
Miller, Richard H.	Fort Wayne	Allen
Miller, Robert B.	Fort Wayne	Allen
Miller, Robert J.	Evansville	Vanderburgh
Miller, Roland E.	Lafayette	Tippecanoe
Miller, Roscoe E.	Indianapolis	Marion
Miller, Samuel T. (S)	Elkhart	Elkhart
Miller, Virgil C.	Akron	Fulton
Miller, William A.	Hagerstown	Wayne-Union
Miller, William J.	Fort Wayne	Allen
Milleson, Ann L. M.	Terre Haute	Vigo
Million, Rodney R.	Indianapolis	Marion
Millis, Arthur B.	Richmond	Wayne-Union
Mills, Fred E.	Evansville	Vanderburgh
Mills, John F.	Wabash	Wabash
Milne, Walter S.	Michigan City	La Porte
Milos, Robert J.	Gary	Lake
Milroy, Robert A.	Bluffton	Wells
Minczewski, Richard C.	Gary	Lake
Minick, Linus J.	Churubusco	Whitley
Mininger, Edward P.	Elkhart	Elkhart
Mino, Raymond W.	Evansville	Vanderburgh
Mino, Robert A.	Evansville	Vanderburgh
Mintz, Alfred M.	Hammond	Lake
Mirro, John A.	Lowell	Lake
Misch, William	Cedar Lake	Lake

Name	City	County
Mishkin, Irving	Elkhart	Elkhart
Mishler, Joe B.	Pierceton	Kosciusko
Mitchell, Edgar T. (S)	Romney	Tippecanoe
Mitchell, Edward O.	Indianapolis	Marion
Mitchell, George H.	Indianapolis	Marion
Mitchell, George L. (S)	Smithville	Owen-Monroe
Mitman, Floyd B.	Huntington	Huntington
Moats, Carl F.	Fort Wayne	Allen
Moats, George E. (S)	Fort Wayne	Allen
Mock, Harry E. Jr.	Franklin	Johnson
Modisett, Jackson W.	Madison	Jefferson-Switzerland
Modisett, Marcella S.	Madison	Jefferson-Switzerland
Modjeski, Joseph R.	Hammond	Lake
Moehlenkamp, Chas. E.	Evansville	Vanderburgh
Moeller, Victor C.	Fort Wayne	Allen
Moenning John E.	Indianapolis	Marion
Moenning, Walter P.	Indianapolis	Marion
Mohler, Floyd W.	Columbus	Bartholomew-Brown
Molengraft, Cornelius J.	Gary	Lake
Molloy, William J. (S)	Muncie	Delaware-Blackford
Monar, Michael	Rockport	Spencer
Monroe, F. Bruce	Hines, Ill.	Lake
Montgomery, Lall G.	Muncie	Delaware-Blackford
Montgomery, Samuel B. (S)	Cynthiana	Posey
Montgomery, William F.	Indianapolis	Marion
Moon, Charles E.	Center Point	Clay
Moore, Donald F.	Indianapolis	Marion
Moore, E. Gregory	Gary	Lake
Moore, Edwin G.	Gary	Lake
Moore, Harold T.	Indianapolis	Marion
Moore, Martha	Madison	Jefferson-Switzerland
Moore, Richard B.	Indianapolis	Marion
Moore, Robert G.	Vincennes	Knox
Moore, Thomas C.	Muncie	Delaware-Blackford
Moore, Will C.	Muncie	Delaware-Blackford
Moore, William G.	Indianapolis	Marion
Moosey, Louis	Union Mills	La Porte
Moran, Mark M. (S)	Portland	Jay
Moravec, Arthur E.	Fort Wayne	Allen
Morchan, Samuel	Indianapolis	Marion
Morgan, Margaret E.	Indianapolis	Marion
Mori, Victor M.	Louisville, Ky.	Marion
Moriarty, John R.	Indianapolis	Marion
Morrical, Russell J.	Logansport	Cass
Morris, Hyman	Gary	Lake
Morris, Jean W.	Muncie	Delaware-Blackford
Morris, Robert A.	Anderson	Madison
Morris, Warren V.	Monticello	White
Morrison, George C.	Portland	Jay
Morrison, George G.	Lawrenceburg	Dearborn-Ohio
Morrison, James T.	Greensburg	Decatur
Morrison, Lindsey (S)	Hammond	Lake
Morrison, Lewis E.	Indianapolis	Marion
Morrison, William R.	Kokomo	Howard
Morrow, Dean H.	Indianapolis	Marion
Morrow, Robert E.	Indianapolis	Marion
Morrow, Robert J.	Bedford	Lawrence
Mortenson, Leland J.	Fort Wayne	Allen
Morton, David P.	Westville	La Porte
Morton, Joseph L.	Indianapolis	Marion
Morton, Walter P.	Indianapolis	Marion
Moser, Elmer B. (S)	Windfall	Tipton
Moser, Edward (S)	Woodburn	Allen
Moser, Rollin H.	Indianapolis	Marion
Moses, George E.	Worthington	Greene
Moses, Robert E.	Worthington	Greene
Moss, Bobby L.	Indianapolis	Marion
Moss, Harlan B.	Iowa City, Ia.	Marion
Moss, Herschel C.	Indianapolis	Marion
Moss, Mavor J.	Yorktown	Delaware-Blackford
Moswin, Jack A.	Gary	Lake
Mothersill, Mark H. (S)	Indianapolis	Marion
Mott, Cassell A.	South Bend	St. Joseph
Moulton, Lillian G.	Indianapolis	Marion
Mount, Mathias S.	Bloomfield	Greene
Mount, William M.	Crawfordsville	Montgomery
Mountain, Francis B.	Connersville	Fayette-Franklin
Mouser, Robert W.	Indianapolis	Marion
Muelchi, Adeline F.	Evansville	Vanderburgh
Mueller, Edwin C.	LaPorte	LaPorte
Mueller, Hilbert M.	South Bend	St. Joseph
Mueller, Lawrence W.	Fort Wayne	Allen
Mueller, Lillian B. (S)	Indianapolis	Marion
Muhleman, Charles E.	La Porte	La Porte
Muller, Lullus P.	Indianapolis	Marion
Muller, Paul F.	Indianapolis	Marion
Muller, Victor H.	Indianapolis	Marion
Mumford, E. Bishop (S)	Indianapolis	Marion
Murdock, Harvey L.	Fort Wayne	Allen
Murphy, Edward U.	Evansville	Vanderburgh
Murphy, Eugene C.	South Bend	St. Joseph
Murphy, Harold O.	Claypool	Kosciusko
Murphy, Harry E.	Franklin	Johnson
Murphy, Joseph F.	Lansing, Ill.	Lake
Murphy, Josephine F.	South Bend	St. Joseph
Murphy, Maurice G. (S)	Morgantown	Morgan
Murray, Ernest C.	Kokomo	Howard
Murray, James S.	Beverly Hills, Calif.	Marion
Murray, William E.	New Castle	Henry
Musselman, Glen G.	Terre Haute	Vigo
Musser, A. Wendell	Indianapolis	Marion
Myers, Charles W.	Indianapolis	Marion
Myers, Roy V.	Indianapolis	Marion
Myre, Theodore T.	Evansville	Vanderburgh

N

Nachman, Elias	Bluffton	Wells
Nafe, Cleon A.	Indianapolis	Marion
Nagan, Robert F.	Indianapolis	Marion
Napper, Floyd S.	Scottsburg	Scott
Nash, Justin R.	Albion	Noble
Nason, Robert A.	Garrett	De Kalb
Navin, Hugh K.	Fortville	Hancock
Navarre, Vincent J.	Whiting	Lake
Nay, Ernest O.	Terre Haute	Vigo
Nay, Richard M.	Indianapolis	Marion
Nayyar, Som N.	Indianapolis	Marion
Neal, Leonard W.	Hammond	Lake
Neale, Alfred E.	Anderson	Madison
Need, Louis T.	Indianapolis	Marion
Neely, Alonzo S. (S)	Indianapolis	Marion
Neidballa, Edward G.	Bristol	Elkhart
Neifert, Noel L.	Tell City	Perry
Nelson, Audrey H.	Indianapolis	Marion
Nelson, Carl A.	West Lebanon	Fountain-Warren
Nelson, F. Dale	South Bend	St. Joseph
Nelson, Harold E.	Muncie	Delaware-Blackford
Nelson, John W.	Indianapolis	Marion
Nelson, Paul L.	Anderson	Madison
Nelson, Raymond E.	South Bend	St. Joseph
Nelson, Walfred A.	Gary	Lake
Nenneker, Henry (S)	Evansville	Vanderburgh
Nesbit, Leonard L.	Anderson	Madison

Name	City	County
Nester, Henry G.	Indianapolis	Marion
Netherton, Clyde R. (S)	Chalmers	White
Neudorff, Louis G.	Terre Haute	Vigo
Neukamp, Frank H.	Connersville	Fayette-Franklin
Neumann, Kenneth O.	Lafayette	Tippecanoe
Newby, Eugene	Sheridan	Hamilton
Newcomb, William K.	Royal Center	Cass
Newland, Arthur E.	Bedford	Lawrence
Newman, Alvin E.	Evansville	Vanderburgh
Newsome, C. K.	Evansville	Vanderburgh
Niccum, Warren L.	Columbia City	Whitley
Nicholas, Dennis	Indianapolis	Marion
Nichols, Anne Sackett	Greencastle	Putnam
Nichols, Robert J.	Vincennes	Knox
Nicholson, Ray W.	Evansville	Vanderburgh
Nicosia, John B.	East Chicago	Lake
Nie, Grover M. (S)	Huntington	Huntington
Nie, Louis W.	Indianapolis	Marion
Niedermayer, Alfred J.	Evansville	Vanderburgh
Nigh, Rufus M.	Fairland	Shelby
Nilges, Richard G.	Gary	Lake
Nill, John H.	Fort Wayne	Allen
Nisenbaum, Harold	Evansville	Vanderburgh
Nixon, Byron	Farmland	Randolph
Nixon, Richard R.	Gunter, Ala.	Lake
Nodinger, Louis	Hammond	Lake
Noe, William R.	Bedford	Lawrence
Nohl, John M.	Indianapolis	Marion
Nolan, Gerald R.	Fort Wayne	Allen
Nolin, Richard T.	Indianapolis	Marion
Nolt, Ernest V. (S)	Columbia City	Whitley
Nolting, Henry F. (S)	Indianapolis	Marion
Nonte, Leo R.	Evansville	Vanderburgh
Norman, William H.	Indianapolis	Marion
Norris, Allen A. (S)	Elkhart	Elkhart
Norris, Ernest B.	Culver	Marshall
Norris, Howard L.	Indianapolis	Marion
Norris, Mary Alice	A.P.O. 757, New York	Marion
Norris, Marvin G.	Rushville	Rush
Norris, Max S.	Indianapolis	Marion
Norton, Harold J.	Columbus	Bartholomew-Brown
Norton, Horace	Washington	Daviess-Martin
Nourse, Myron H.	Indianapolis	Marion
Novy, Charles A.	Garrett	De Kalb
Nugen, Harold	Auburn	De Kalb
Nugent, Edwin J.	Indianapolis	Marion
Nurnberger, John I.	Indianapolis	Marion
Nutter, Wyndham H.	Rushville	Rush

O

Oak, David D., Sr. (S)	LaCrosse	La Porte
Oak, David D., Jr.	Hanna	La Porte
Oatman, Jack G.	Marion	Grant
O'Brian, Earl J.	Indianapolis	Marion
O'Brian, John F.	Fort Wayne	Allen
O'Brien, Francis E.	Rensselaer	Jasper-Newton
O'Bryan, Richard B.	Columbus	Bartholomew-Brown
Ochsner, Harold C.	Indianapolis	Marion
Ockerman, Kenneth R.	Rensselaer	Jasper-Newton
Offutt, Andrew C.	Indianapolis	Marion
Olcott, Charles W.	Aurora	Dearborn-Ohio
Oldag, George E.	Elwood	Madison
Oliphant, Frank W.	Mount Vernon	Posey
Oliphant, Robert W.	Terre Haute	Vigo
Olson, John R.	Indianapolis	Marion
Olson, Kenneth L.	South Bend	St. Joseph
Olson, William H.	Michigan City	La Porte
Olvey, Ottis N.	Indianapolis	Marion
O'Malley, Martha A.	Indianapolis	Marion
Omstead, Milton	Petersburg	Pike
Omstead, Trevalyn W.	Huntington	Huntington
O'Neill, Martin J.	Valparaiso	Porter
Onorato, Joseph J.	Lafayette	Tippecanoe
Onyett, Harold R.	Greenwood	Johnson
Oppenheimer, Ernst	New York, N. Y.	Vanderburgh
Orders, Clarke E. (S)	Indianapolis	Marion
Oren, William F.	South Bend	St. Joseph
Ormiston, Michael W.	Indianapolis	Marion
Ornelas, Joseph P.	Gary	Lake
O'Rourke, Carroll	Fort Wayne	Allen
Orr, W. Robert	Kansas City, Kans.	St. Joseph
Oster, Jack H.	Westville	La Porte
Osterman, Louis H.	Seymour	Jackson
Oswald, Robert H.	Evansville	Vanderburgh
Oswalt, James T.	Mitchell	Lawrence
Otten, Claude F.	Indianapolis	Marion
Otten, Ralph E.	Darlington	Montgomery
Ottinger, Ross C. (S)	Indianapolis	Marion
Overhulse, Paul R.	Indianapolis	Marion
Overpeck, Charles	Greensburg	Decatur
Overpeck, George H.	Alexandria	Madison
Overshiner, Lyman (S)	Columbus	Bartholomew-Brown
Owen, John E.	Indianapolis	Marion
Owen, Margaret A.	Bloomington	Owen-Monroe
Owens, Richard R.	Muncie	Delaware-Blackford
Owens, Thomas R.	Muncie	Delaware-Blackford
Owens, Tracy C.	Indianapolis	Marion
Owsley, Guy A.	Hartford City	Delaware-Blackford
Oyer, John H.	Fort Wayne	Allen

P

Pace, Jerome V.	Rockville	Parke-Vermillion
Paff, William A.	Elkhart	Elkhart
Paine, George E.	Elkhart	Elkhart
Painter, Donald S.	Fort Wayne	Allen
Painter, Lowell W.	Winchester	Randolph
Palmer, Charman F.	Indianapolis	Marion
Palmer, Harley P.	Southport	Marion
Palmer, Robert M.	Indianapolis	Marion
Palmer, Robert W.	Indianapolis	Marion
Palmer, Russell H.	Gary	Lake
Panares, Solomon V.	Hammond	Lake
Pancost, Vernon K.	Elkhart	Elkhart
Pandolfo, Harry	Indianapolis	Marion
Panos, Constantine O.	Bluffton	Wells
Pappas, Eddie T.	Gary	Lake
Pappas, Paul N.	Indianapolis	Marion
Paris, Durward W.	Kokomo	Howard
Paris, John M.	New Albany	Floyd
Park, Byron J.	Richmond	Wayne-Union
Parker, Carey B.	Fort Wayne	Allen
Parker, Carl B.	Wingate	Montgomery
Parker, George F., Jr.	Indianapolis	Marion
Parker, Harry C. (S)	Hobart	Lake
Parker, John B.	Versailles	Ripley
Parker, John C.	Goodland	Jasper-Newton
Parker, John F.	Indianapolis	Marion
Parker, L. Burton	Indianapolis	Marion
Parker, Portia	Indianapolis	Marion
Parks, George	Hartford City	Delaware-Blackford
Parmenter, Harry B.	Sullivan	Sullivan
Parr, Robert L.	Indianapolis	Marion
Parratt, Louis W.	Gary	Lake
Parrish, Richard K.	Decatur	Adams
Parrot, Donald J.	Fort Wayne	Allen
Parshall, Dale B.	Elkhart	Elkhart

Name	City	County
Parsons, Robert L.	South Bend	St. Joseph
Paskind, J.	Indianapolis	Marion
Passino, James	Richmond	Wayne-Union
Pastor, Julius W.	Evansville	Vanderburgh
Patrick, Glenn B.	Elkhart	Elkhart
Patterson, William K.	Anderson	Madison
Pattison, John D.	Marion	Grant
Patton, Martin T.	Indianapolis	Marion
Paul, Leonard G.	Michigan City	La Porte
Pauly, Leonard R.	Fort Wayne	Allen
Paulissen, George T.	Indianapolis	Marion
Pauszek, Thomas B.	South Bend	St. Joseph
Payne, Arthur C.	East Chicago	Lake
Paynter, Morris B.	Southport	Marion
Paynter, William	Pekin	Washington
Paz, Luis	Indianapolis	Marion
Peacock, Norman F.	Crawfordsville	Montgomery
Peacock, Robert C.	Muncie	Delaware-Blackford
Pearce, Roy V.	Terre Haute	Vigo
Pearlman, Samuel S. (S)	Lafayette	Tippecanoe
Pearson, Huey L.	Fort Wayne	Allen
Pearson, John S.	Indianapolis	Marion
Pearson, Lyman R.	Indianapolis	Marion
Pearson, William E.	Wabash	Wabash
Pebworth, Aubrey C. (S)	Indianapolis	Marion
Peck, Edward A.	Hammond	Lake
Peck, Franklin B., Jr.	Indianapolis	Marion
Peck, Franklin B. Sr.	Indianapolis	Marion
Peck, James F.	Princeton	Gibson
Peiffer, Geraldine M.	Hammond	Lake
Peirce, James D.	Indianapolis	Marion
Pemberton, Jack J.	Evansville	Vanderburgh
Penn, Robert A.	East Gary	Lake
Pennington, W. E. (S)	Indianapolis	Marion
Perkins, Powell L.	Kokomo	Howard
Perlov, Sylvan H.	Indianapolis	Marion
Permer, Erwin	Indianapolis	Marion
Perrin, Kermit F.	Fort Wayne	Allen
Perry, Frederic G.	Fort Wayne	Allen
Person, Theodore C.	Veedersburg	Fountain-Warren
Peters, Elmer E.	Brookville	Fayette-Franklin
Peterson, Deward D.	Indianapolis	Marion
Peterson, Joel A.	Lafayette	Tippecanoe
Petitjean, Harold G.	Haubstadt	Gibson
Petranoff, Theodore V.	Indianapolis	Marion
Petrass, Andrew	South Bend	St. Joseph
Petrich, Peter R.	Attica	Fountain-Warren
Petry, T. Neal	Delphi	Carroll
Pettijohn, Fred L. (S)	Indianapolis	Marion
Peyton, Frank W.	Lafayette	Tippecanoe
Pfaff, Dudley A.	Indianapolis	Marion
Pfeifer, James M.	Lawrenceburg	Dearborn-Ohio
Pfuetze, Max	Logansport	Cass
Phares, Robert W.	Kokomo	Howard
Phelps, Stephen R.	South Bend	St. Joseph
Philbert, Richard N.	Fort Wayne	Allen
Philbrook, Seth S.	La Porte	La Porte
Phillips, David L.	Indianapolis	Marion
Phillips, John F.	Bluffton	Wells
Phillips, John H.	Michigan City	LaPorte
Phipps, Leland K.	Union City	Randolph
Piazza, Leonard F.	Michigan City	La Porte
Pickett, Merle E.	Fort Wayne	Allen
Pickett, Robert D.	Indianapolis	Marion
Pierce, Emmett, Jr.	Indianapolis	Marion
Pierce, Gene S.	New Albany	Floyd
Pierce, Harold J. (S)	Terre Haute	Vigo
Pierce, William J.	Indianapolis	Marion
Pierson, Allen D.	Crawfordsville	Montgomery
Pierson, Pearl H.	Silver Lake	Kosciusko
Pierson, Robert H.	Crawfordsville	Montgomery
Pierson, Thomas A.	New Palestine	Hancock
Pietz, David G.	Bluffton	Wells
Pike, Warren H.	Hobart	Lake
Pilcher, Jack E.	Indianapolis	Marion
Pilecki, Peter J.	Michigan City	La Porte
Pilot, Jean	Hammond	Lake
Pinsky, Sheldon T.	Bellaire, Ohio	Marion
Pippenger, Wayne G.	Muncie	Delaware-Blackford
Pirkle, Hubert B.	Rockville	Parke-Vermillion
Pitkin, Edward M.	Martinsville	Morgan
Pitkin, McKendree C.	Martinsville	Morgan
Pizzo, Anthony	Bloomington	Owen-Monroe
Plain, George	South Bend	St. Joseph
Plank, C. Robert	Michigan City	La Porte
Plasterer, Edward D.	Indianapolis	Marion
Ploetner, Edward J.	Jasper	Dubois
Ploughe, Ralph R.	Elwood	Madison
Polhemus, Warren C.	Anderson	Madison
Polite, Nicholas L.	Chicago, Ill.	Lake
Pollard, Walter S. (S)	Evansville	Vanderburgh
Pomeroy, Rex K.	Plymouth	Marshall
Ponczek, Edward	Fort Wayne	Allen
Pontius, Edwin E.	Indianapolis	Marion
Poolitsan, George C.	Bloomington	Owen-Monroe
Popp, Milton F.	Fort Wayne	Allen
Popplewell, Arvine G.	Indianapolis	Marion
Poracky, Bernard F.	Gary	Lake
Porro, Francis W.	Evansville	Vanderburgh
Porter, Carl M.	Jasonville	Greene
Porter, Edward A.	Westport	Decatur
Porter, George S.	Indianapolis	Marion
Porter, Jack	Lebanon	Boone
Porter, Robert A.	Westport	Decatur
Porterfield, Hubert W.	Indianapolis	Marion
Portteus, Walter L.	Franklin	Johnson
Poston, Clement L.	Laurel	Fayette-Franklin
Potter, Richard M.	Ridgeville	Randolph
Powell, J. Paxton	Marion	Grant
Powell, M. Jack	Fort Wayne	Allen
Powell, Richard C.	Indianapolis	Marion
Prather, Philip E.	Kokomo	Howard
Pratt, Ralph M., Jr.	Madison	Jefferson-Switzerland
Predd, Adolph C.	La Porte	La Porte
Premuda, Franklin F.	Hammond	Lake
Prenatt, Francis	Madison	Jefferson-Switzerland
Prentiss, Nelson H.	Oteen, N. C.	Allen
Present, Julian	Evansville	Vanderburgh
Pribble, Robert H.	Indianapolis	Marion
Price, Ambrose M.	Marion	Grant
Price, Douglas W.	Nappanee	Elkhart
Price, Francis W.	Indianapolis	Marion
Price, James O.	Indianapolis	Marion
Price, Shirley G.	Evansville	Vanderburgh
Priddy, Marvin E.	Fort Wayne	Allen
Priebe, Fred H.	Indianapolis	Marion
Proudfit, Charles H.	South Bend	St. Joseph
Province, Oran A.	Franklin	Johnson
Province, William D.	Franklin	Johnson
Pruitt, J. Edward	Gary	Lake
Pryor, Richard C.	Indianapolis	Marion
Pugh, Willis L.	Evansville	Vanderburgh
Pulskamp, Bertrand H.	Wolcottville	Noble
Purcell, Richard J.	Griffith	Lake
Puterbaugh, Karl E.	Albany	Delaware-Blackford
Pyle, Harold D.	South Bend	St. Joseph

Q

Quarles, E. Bryan	Bloomington	Owen-Monroe
Quick, William J.	Muncie	Delaware-Blackford
Quickel, Daniel S. (S)	Anderson	Madison
Quigley, Joseph B.	Indianapolis	Marion
Quilty, Thomas J.	Goshen	Elkhart

Name	City	County
	R	
Rabb, Harry S.	Indianapolis	Marion
Raber, Robert M.	Indianapolis	Marion
Rader, George S.	Indianapolis	Marion
Radigan, Leo R.	Indianapolis	Marion
Rafalski, Thomas A.	Indianapolis	Marion
Ragan, William D.	Indianapolis	Marion
Rainey, Everett A. (S)	Lebanon	Boone
Ralston, John D.	Indianapolis	Marion
Ramage, Walter F.	Beech Grove	Marion
Ramey, John W.	Kokomo	Howard
Ramker, Daniel T.	Hammond	Lake
Ramsdell, Glen A.	Richmond	Wayne-Union
Ramsey, Frank B.	Indianapolis	Marion
Ramsey, Hugh S.	Bloomington	Owen-Monroe
Ranck, Benjamin	Gary	Lake
Randall, Thomas A.	North Liberty	St. Joseph
Raney, Ben B.	Linton	Greene
Rang, A. A. (S)	Washington	Daviess-Martin
Rang, Robert H.	Washington	Daviess-Martin
Rapp, George F.	Indianapolis	Marion
Rasch, George C., Jr.	Hammond	Lake
Rasmussen, Ruth F.	South Bend	St. Joseph
Ratcliff, Frank W.	Lafayette	Tippecanoe
Ratcliffe, Albert W.	Evansville	Vanderburgh
Rathkey, Arthur S.	Muncie	Delaware-Blackford
Rau, Charles A.	Gary	Lake
Rauh, Robert A.	Wabash	Wabash
Rausch, Norman W.	Angola	Steuben
Rawles, Lyman T. (S)	Fort Wayne	Allen
Rawlins, Carolyn M.	Hammond	Lake
Ray, Herbert A. (S)	Fort Wayne	Allen
Raymundo, Vivencio F.	Attica	Fountain-Warren
Read, John E.	Chesterton	Porter
Reck, John L. (S)	Sheridan	Hamilton
Records, Arthur W.	Franklin	Johnson
Reed, Donald	Culver	Marshall
Reed, Edsel S.	Jeffersonville	Clark
Reed, John	Hobart	Lake
Reed, John D.	Detroit, Mich.	Clinton
Reed, Nelle C. (S)	Michigan City	La Porte
Reed, Philip B.	Indianapolis	Marion
Reed, Robert C.	Terre Haute	Vigo
Reed, Robert F.	Mishawaka	St. Joseph
Reed, Robert G., Jr.	Plymouth	Marshall
Reed, Roger R.	Anderson	Madison
Reed, Ronald R.	Indianapolis	Marion
Reed, William C.	Bloomington	Owen-Monroe
Rees, Russel C.	Indianapolis	Marion
Regan, George L.	Sellersburg	Clark
Reibel, Donald B.	Indianapolis	Marion
Reich, Clarence E.	Evansville	Vanderburgh
Reid, Charles A.	Indianapolis	Marion
Reid, Donald B.	Columbia City	Whitley
Reid, James D.	Indianapolis	Marion
Reid, Robert H.	Indianapolis	Marion
Reid, Robert M.	Columbus	Bartholomew-Brown
Reid, Robert W. (S)	Union City	Randolph
Reilly, Eva Ferro	Beech Grove	Marion
Reilly, James F.	Vincennes	Knox
Reilly, Richard W.	Crete, Ill.	Lake
Reisler, Simon (S)	Indianapolis	Marion
Remich, Antone C.	Hammond	Lake
Renbarger, Lester L.	Marion	Grant
Rendel, Donald T.	Hammond	Lake
Rendel, Harold E.	Mexico	Miami
Rentschler, Lewis C. (S)	Clay City	Clay
Reppert, Roland L.	Decatur	Adams
Rettig, Arthur C.	Muncie	Delaware-Blackford
Reynolds, James S.	Gary	Lake
Reynolds, Russell P.	Garrett	De Kalb
Reynolds, Richard J.	Terre Haute	Vigo
Rhamy, Arthur P.	Marion	Grant
Rhamy, Donald	Gary	Lake
Rhamy, Robert K.	Indianapolis	Marion
Rhea, Gilbert D.	Greencastle	Putnam
Rhea, James C.	Beech Grove	Marion
Rheinheimer, Floyd L.	Milford	Kosciusko
Rhind, Alexander W.	Hammond	Lake
Rhodes, Theodore D.	Nokomis, Fla.	Marion
Rhorer, Herbert M.	Kokomo	Howard
Rhorer, John G.	Marion	Grant
Rice, Frederic A.	Indianapolis	Marion
Rice, Raymond M.	Indianapolis	Marion
Rice, Reed P.	Rochester, Minn.	Marion
Rice, Wilkie B. (S)	Fort Wayne	Allen
Rich, Norval	Decatur	Adams
Richard, Norman F.	Shelbyville	Shelby
Richards, David H. (S)	Vincennes	Knox
Richards, Edgar E.	Russellville	Putnam
Richardson, Charles L.	Rochester	Fulton
Richardson, Thad T.	Indianapolis	Marion
Richart, James V.	Terre Haute	Vigo
Richer, Orville H.	Warsaw	Kosciusko
Richter, Arthur B.	Indianapolis	Marion
Richter, John C.	La Porte	La Porte
Richter, Samuel	Gary	Lake
Ricketts, Joseph W. (S).	Indianapolis	Marion
Ridgeway, Ora W. (S)	Indianapolis	Marion
Ridgway, Alton H.	Lapel	Madison
Ridolfo, Anthony S.	Indianapolis	Marion
Rieger, I. Taylor	Bloomington	Owen-Monroe
Rietman, H. Jerome	Evansville	Vanderburgh
Rifner, Eugene S.	Van Buren	Grant
Rigg, John F.	Indianapolis	Marion
Riggs, Floyd C.	Terre Haute	Vigo
Rigley, Edward L.	South Bend	St. Joseph
Riley, Frank H. (S)	Jamestown	Boone
Rimel, James F.	Plymouth	Marshall
Riner, Jack K.	Indianapolis	Marion
Rinne, John I. (S)	Lapel	Madison
Ripley, John W.	Seymour	Jackson
Rissing, Walter J.	Fort Wayne	Allen
Ritchey, James O.	Indianapolis	Marion
Ritchie, William D.	Evansville	Vanderburgh
Ritteman, George W.	Franklin	Johnson
Ritter, Wayne L.	Indianapolis	Marion
Rivers, Glynn A.	Muncie	Delaware-Blackford
Robb, John A.	Indianapolis	Marion
Robertson, Addis N.	New Albany	Floyd
Robertson, David W. (S)	Deputy	Jefferson-Switzerland
Robertson, James S.	Plymouth	Marshall
Robertson, Ray B.	Indianapolis	Marion
Robertson, William C.	Chesterton	Porter
Robertson, William S.	Spiceland	Henry
Robinson, Earle U.	Evansville	Vanderburgh
Robinson, Frank C. (S)	Newport Beach, Calif	Marion
Robinson, Nan	New Albany	Floyd
Robinson, Walter K.	Gary	Lake
Robinson, William H.	Mitchell	Lawrence
Roby, Alma L.	Jeffersonville	Clark
Rockey, Noah A.	Fort Wayne	Allen
Rodriguez, Juan	Fort Wayne	Allen
Roesch, Ryland	Indianapolis	Marion
Roeske, Nancy A.	Indianapolis	Marion
Rogers, Arthur R.	Newburgh	Warrick
Rogers, Donald L.	Indianapolis	Marion
Rogers, Evered E.	Auburn	De Kalb
Rogers, Otto F.	Bloomington	Owen-Monroe
Rogers, R. Shirrell	West Terre Haute	Vigo

Name	City	County
Rogers, Thomas P.	San Diego, Calif.	Marion
Roggenkamp, Milton W.	Indianapolis	Marion
Rohn, Robert J.	Indianapolis	Marion
Rohrbacker, Donald M.	Williams AFB, Ariz.	Lake
Rohrer, Bryce B.	Gary	Marion
Rohrer, James R.	Elnora	Daviess-Martin
Roll, John W.	Indianapolis	Marion
Roller, Charles W. (S)	Indianapolis	Marion
Rollins, Thomas K.	Bloomington	Owen-Monroe
Romberger, Floyd T., Jr.	Indianapolis	Marion
Rommel, Clarence H.	W. Lafayette	Tippecanoe
Roose, Lisle W.	Nappanee	Elkhart
Ropp, Eldon R.	Oakland City	Gibson
Ropp, Harold E.	New Harmony	Posey
Rosenak, Bernard D.	Indianapolis	Marion
Rosenbaum, David	Indianapolis	Marion
Rosenbaum, Irving, Jr.	Indianapolis	Marion
Rosenbaum, Lloyd E.	Anderson	Madison
Rosenblatt, Bernard B.	Evansville	Vanderburgh
Rosenbloom, Philip J.	Gary	Lake
Rosenheimer, George M.	South Bend	St. Joseph
Rosenthal, Carl	Hammond	Lake
Rosenwasser, Jacob	Mishawaka	St. Joseph
Roser, Arthur J.	Fort Wayne	Allen
Rosevear, Henry J.	Hammond	Lake
Roshe, Joseph	Indianapolis	Marion
Ross, Alexander T.	Indianapolis	Marion
Ross, Ben R.	Bloomington	Owen-Monroe
Ross, Glenn E.	Washington	Daviess-Martin
Ross, Guy E.	Anderson	Madison
Ross, Harry P.	Richmond	Wayne-Union
Ross, James B.	Bloomington	Owen-Monroe
Ross, James S.	Richmond	Wayne-Union
Rossiter, Dudley L.	Fort Wayne	Allen
Roth, Bertram S.	Indianapolis	Marion
Roth, James R.	Wolf Lake	Noble
Roth, Leo	Gary	Lake
Roth, Melvin I.	Gary	Lake
Rothberg, Maurice	Fort Wayne	Allen
Rothring, Howard E.	Columbus	Bartholomew-Brown
Rothrock, Philip W.	Lafayette	Tippecanoe
Rothschild, Charles J. (S)	Fort Wayne	Allen
Rotman, Harry G.	Jasonville	Greene
Rotman, Sam I.	Jasonville	Greene
Rouen, Robert	Elkhart	Elkhart
Rousseau, John W.	Fort Wayne	Allen
Row, D. Hamilton	Indianapolis	Marion
Row, George S.	Osgood	Ripley
Row, Perrie Q.	Hammond	Lake
Rowe, Howard H.	Rochester	Fulton
Royster, George M. (S)	Evansville	Vanderburgh
Royster, Robert A.	Evansville	Vanderburgh
Rozelle, Clarence V.	Anderson	Madison
Rubens, Eli	South Bend	St. Joseph
Rubin, Gerald S.	Indianapolis	Marion
Rubin, Milton M.	Terre Haute	Vigo
Rubin, Simon S.	Gary	Lake
Rubright, Robert L.	Hammond	Lake
Ruby, Fred McK. (S)	Wauwatosa, Wis.	Randolph
Ruddell, Karl R. (S)	Indianapolis	Marion
Ruddell, Keith R.	Indianapolis	Marion
Rudesill, Cecil L. (S)	Indianapolis	Marion
Rudesill, Robert L.	Indianapolis	Marion
Rudicel, Max	Kokomo	Howard
Rudolph, Carl J.	South Bend	St. Joseph
Rudolph, Franklin G.	Hammond	Lake
Rudolph, Kenneth J.	Indianapolis	Marion
Rudolph, Stephen J., Jr.	Cannon AFB, New Mexico	Marion
Rudser, Donald H.	Whiting	Lake
Rudy, Donald B.	Bluffton	Wells
Runge, Paul W.	Richmond	Wayne-Union
Ruoff, William	New Albany	Floyd
Rupe, Lloyd O.	Elkhart	Elkhart
Rupel, Ernest	Clearwater, Fla.	Marion
Rusche, Henry J.	Evansville	Vanderburgh
Ruschli, Edward B.	Lafayette	Tippecanoe
Rusk, Hubert M.	Wallace	Fountain-Warren
Russell, John R.	Indianapolis	Marion
Russell, Richard H.	Evansville	Vanderburgh
Russo, Andrew E.	Crown Point	Lake
Rust, Byron K.	Indianapolis	Marion
Rust, Roland B.	Indianapolis	Marion
Ruth, Martin L.	Indianapolis	Marion
Rutherford, Cyrus W. (S)	Indianapolis	Marion
Rutherford, Charles E.	Otterbein	Benton
Ryan, Glen V.	Indianapolis	Marion
Ryan, Hubert J.	Gary	Lake
Ryan, William J.	Columbus	Bartholomew-Brown

S

Sage, Charles V.	Richmond	Wayne-Union
Sage, Russell A.	Indianapolis	Marion
Sahlman, Hans	Fort Wayne	Allen
Saint, William K.	New Castle	Henry
Sala, Joseph J.	Gary	Lake
Sala, Walter R.	Gary	Lake
Salb, John P.	Jasper	Dubois
Salb, Leo A. (S)	Jasper	Dubois
Salb, Max C.	Indianapolis	Marion
Sallee, William T.	Greensburg	Decatur
Salon, Harry W.	Fort Wayne	Allen
Salon, Joel W.	Fort Wayne	Allen
Salon, Nathan L.	Fort Wayne	Allen
Salzman, Morris	New York, N. Y.	Marion
Samter, Thomas G.	Indianapolis	Marion
Sanders, Bertram W.	Connersville	Fayette-Franklin
Sanders, Harry M.	Indianapolis	Marion
Sanders, Jesse A. (S)	Auburn	De Kalb
Sanderson, Robert B.	South Bend	St. Joseph
Sandock, Isadore	South Bend	St. Joseph
Sandock, Louis F.	South Bend	St. Joseph
Sandorf, Marvin H.	Indianapolis	Marion
Sandoz, Harry H.	South Bend	St. Joseph
Santare, Vincent J.	Hammond	Lake
Santiago, Carmen	Hammond	Lake
Saperstein, Morris	Muncie	Delaware-Blackford
Sargent, Wallace B.	Hammond	Lake
Sarver, Francis E.	Fort Wayne	Allen
Savage, Arthur R.	Fort Wayne	Allen
Savery, Charles E.	Deerfield Beach, Fla.	St. Joseph
Sayers, Frank E.	Terre Haute	Vigo
Saylors, Rodger D.	Fort Wayne	Allen
Sazama, Francis J.	East Chicago	Lake
Scales, Alfred B.	Huntingburg	Dubois
Scales, Allen D.	Huntingburg	Dubois
Scamahorn, Malcolm O.	Pittsboro	Hendricks
Scamahorn, Oscar T. (S)	Pittsboro	Hendricks
Scea, Wallace A.	Elwood	Madison
Schaaf, Alvin D.	Jamestown	Boone
Schaefer, C. Richard (S)	Indianapolis	Marion
Schafer, William C.	Washington	Daviess-Martin
Schaffer, Edward V.	Indianapolis	Marion
Schantz, Richard	Remington	Jasper-Newton
Scharbrough, William	Medora	Jackson
Schauwecker, Cleon M.	Greencastle	Putnam

Name	City	County
Schechter, John S.	Indianapolis	Marion
Scheetz, Marion R.	Lewisville	Henry
Scheier, Emil W.	Indianapolis	Marion
Scheimann, Lois	Valparaiso	Porter
Schell, Harry D.	Bloomington	Owen-Monroe
Schellhouse, Earl M.	Fort Wayne	Allen
Schenck, Foss (S)	Logansport	Cass
Schenck, Ralph E.	Portland	Jay
Scherb, Burton E.	Terre Haute	Vigo
Scherschel, John P.	Bedford	Lawrence
Schetgen, Joseph V.	Geneva	Adams
Scheurich, Virgil	Oxford	Benton
Schiller, Herbert A.	South Bend	St. Joseph
Schimmelpfennig, Robert W.	Evansville	Vanderburgh
Schirmer, Robert H.	Evansville	Vanderburgh
Schlademan, Karl R.	Fort Wayne	Allen
Schlaegel, Theo. F., Jr.	Indianapolis	Marion
Schlegel, Donald M.	Indianapolis	Marion
Schlemmer, George H.	Warsaw	Kosciusko
Schlesinger, Daniel J.	Hammond	Lake
Schlosser, Herbert C.	Elkhart	Elkhart
Schmalhausen, Ansel W.	Indianapolis	Marion
Schmidt, Eugene E.	Fort Wayne	Allen
Schmidt, Loren F.	Indianapolis	Marion
Schmidt, Richard H.	Valparaiso	Porter
Schmiedicke, Paul H.	Lafayette	Tippecanoe
Schmitt, Richard K.	Columbus	Bartholomew-Brown
Schmitt, Robert J.	Michigan City	LaPorte
Schmoll, Robert J.	Fort Wayne	Allen
Schmoyer, Maurice R.	Indianapolis	Marion
Schneider, Carl J.	Indianapolis	Marion
Schneider, Charles P.	Evansville	Vanderburgh
Schneider, Kenneth D.	Nashville	Bartholomew-Brown
Schneider, Louis A.	Fort Wayne	Allen
Schnute, Richard B.	Indianapolis	Marion
Schoen, Frederic L.	Fort Wayne	Allen
Schoolfield, William E.	Orleans	Orange
Schoonveld, Arthur	Brook	Jasper-Newton
Schott, Edward J. (S)	Terre Haute	Vigo
Schreiner, John E.	Bremen	Marshall
Schrepferman, Wayne	Hamilton	Steuben
Schriefer, Victor V.	Evansville	Vanderburgh
Schroeder, Henry R.	Washington	Daviess-Martin
Schroeder, Robert W.	Marion	Grant
Schubert, Jerome C.	Fort Wayne	Allen
Schuchman, Abe	Indianapolis	Marion
Schuchman, Gabriel	Indianapolis	Marion
Schulfer, Richard J.	Hammond	Lake
Schulhof, Maurice G.	Muncie	Delaware-Blackford
Schulz, Kurt J.	Gary	Lake
Schulze, Hans A.	Westville	LaPorte
Schulze, William	Vincennes	Knox
Schumaker, Robert A.	Terre Haute	Vigo
Schuman, Edith B.	Bloomington	Owen-Monroe
Schuster, Dwight W.	Indianapolis	Marion
Schut, Almon L.	Indianapolis	Marion
Schwartz, Frederick C.	Kokomo	Howard
Schwarz, Anton	Indianapolis	Marion
Scoins, William H.	Fort Wayne	Allen
Scott, Frank M.	South Bend	St. Joseph
Scott, George E.	Indianapolis	Marion
Scott, H. Vaughn	Fort Wayne	Allen
Scott, Irvin H.	Sullivan	Sullivan
Scott, I. Winfield	Indianapolis	Marion
Scott, John S.	La Porte	La Porte
Scott, John R.	Indianapolis	Marion
Scott, Mildred E.	Hammond	Lake
Scott, Robert P.	Indianapolis	Marion
Scott, Robert S.	Charlottesville	Hancock
Scott, Samuel L.	Indianapolis	Marion
Scott, V. Brown	Shelbyville	Shelby
Scudder, Arthur N.	Brownsburg	Hendricks
Scully, John T.	Gary	Lake
Seal, Perry F.	Brookville	Fayette-Franklin
Seaman, Charles F.	Indianapolis	Marion
Sears, Don	Odon	Daviess-Martin
Sears, M. Maywood (S)	Elkhart	Elkhart
Seat, Marshall H.	Washington	Daviess-Martin
Sedam, Herbert L.	Indianapolis	Marion
Seese, Robert M.	Delphi	Carroll
Segar, Louis H.	Indianapolis	Marion
Segar, William E.	Indianapolis	Marion
Seibel, Robert	Nashville	Bartholomew-Brown
Seipel, Stanley	Lanesville	Harrison-Crawford
Selby, Keith E.	South Bend	St. Joseph
Sellers, Francis M.	South Bend	St. Joseph
Sellmer, George W.	Indianapolis	Marion
Selsam, Etta B. (S)	Terre Haute	Vigo
Senese, Thomas J.	Gary	Lake
Sennett, Cecil M.	Westville	La Porte
Sennett, William K.	Macy	Miami
Senseny, Eugene F.	Fort Wayne	Allen
Sensenich, Roscoe L. (H)	South Bend	St. Joseph
Seward, George W.	North Manchester	Wabash
Sexson, Hiram T.	Indianapolis	Marion
Seyler, Anna G.	LaVerne, Calif	Lake
Shafer, Marion R.	Indianapolis	Marion
Shafer, Richard H.	Alexandria	Madison
Shafer, Sid J.	Chicago, Ill.	Lake
Shaffer, Kenneth L.	Vincennes	Knox
Shaffer, William R.	Greensburg	Decatur
Shallenberger, Henry R.	Modoc	Randolph
Shanafelt, Donald K.	Indianapolis	Marion
Shanklin, Jack L.	Bicknell	Knox
Shanklin, Vernon A. (S)	Terre Haute	Vigo
Shanks, Ray W.	Noblesville	Hamilton
Shannon, Wesley	Crawfordsville	Montgomery
Shapiro, Joseph	East Chicago	Lake
Shapiro, Seymour W.	East Chicago	Lake
Sharp, John L.	Crawfordsville	Montgomery
Sharp, Merle C.	South Bend	St. Joseph
Sharp, William L.	Anderson	Madison
Shattuck, John C.	Brazil	Clay
Shaw, Houston W.	Jeffersonville	Clark
Shaw, James E.	Fort Wayne	Allen
Sheehan, Francis G.	Indianapolis	Marion
Sheek, Kenneth I.	Greenwood	Johnson
Sheets, Charles E.	Manilla	Rush
Sheldon, Suel A.	Anderson	Madison
Sheller, Tom G.	Logansport	Cass
Shelley, Edward S.	South Bend	St. Joseph
Shelley, Richard	Indianapolis	Marion
Shellhouse, Michael	Gary	Lake
Shelton, Clyde F.	New Albany	Floyd
Shenk, Earl M.	Kokomo	Howard
Shepard, Fred F.	College Corner, Ohio	Wayne-Union
Sherer, Kenneth E.	Richmond	Wayne-Union
Sherster, Harry	Indianapolis	Marion
Sherwood, Clarence E.	Fort Wayne	Allen
Sherwood, J. Vincent	Fort Wayne	Allen
Shevick, Alexander	Gary	Lake
Shields, Jack E.	Brownstown	Jackson
Shields, Tom S.	Richmond	Wayne-Union
Shina, Heskel S.	Charlestown	Clark
Shinabery, Lawerence	Fort Wayne	Allen
Shipley, Edward	Indianapolis	Marion
Shively, John L.	Lafayette	Tippecanoe
Shoemaker, Richard L.	Marion	Grant
Sholty, William M.	Lafayette	Tippecanoe

Name	City	County
Shonk, Harold W.	Noblesville	Hamilton
Shoptaugh, A. Glenn, Jr.	Wichita Falls, Texas	Marion
Short, John T.	Fort Wayne	Allen
Shoup, Homer B.	Greentown	Howard
Showalter, John P.	Waterloo	De Kalb
Showalter, John R.	Terre Haute	Vigo
Shrader, Carl E.	Warsaw	Kosciusko
Shriner, Richard L.	South Bend	St. Joseph
Shrock, Ethan E.	Amboy	Miami
Shroyer, Herbert	Dunkirk	Jay
Shuck, William A.	Madison	Jefferson-Switzerland
Shullenberger, Wendell A.	Indianapolis	Marion
Shulruff, Harry I.	East Chicago	Lake
Shultz, Harry M. (S)	Logansport	Cass
Shumacker, Harris B., Jr.	Indianapolis	Marion
Sibbitt, Joseph W.	Bloomington	Owen-Monroe
Sicks, Okla W.	Indianapolis	Marion
Sidebottom, Earl W.	Indianapolis	Marion
Sidell, James P.	Indianapolis	Marion
Siderys, Harry	Indianapolis	Marion
Siebe, Jack C.	Indianapolis	Marion
Siebenmorgen, Louis (S)	Terre Haute	Vigo
Siebenmorgen, Paul	Terre Haute	Vigo
Siekierski, Joseph M.	Griffith	Lake
Siersdorfer, Theodore N. (S)	Indianapolis	Marion
Sigmond, Harvey W.	Indianapolis	Marion
Sigmund, William B.	Columbus	Bartholomew-Brown
Silver, Richard A.	Indianapolis	Marion
Silverman, Norman M.	Terre Haute	Vigo
Silvian, Harry A.	Whiting	Lake
Simmons, Frederick H.	Marion	Grant
Simmons, James E.	Indianapolis	Marion
Simmons, Lloyd H.	Goshen	Elkhart
Simms, J. Leon	Indianapolis	Marion
Simpson, Robert L.	Bluffton	Wells
Simpson, William D.	Indianapolis	Marion
Sims, J. Lawrence	Indianapolis	Marion
Singer, Elmer C.	Fort Wayne	Allen
Singer, Paul J.	Jasper	Dubois
Sinn, Charles M.	Evansville	Vanderburgh
Sirlin, Edward M.	Mishawaka	St. Joseph
Sisson, Norvel D.	South Bend	St. Joseph
Skeen, Earl D. (S)	Walkerton	St. Joseph
Skillern, Penn G. (S)	South Bend	St. Joseph
Skillern, Scott D.	South Bend	St. Joseph
Skomp, Claud E.	Marion	Grant
Skrentny, Stanley H.	Hammond	Lake
Slabaugh, Jancy S. (S)	Nappanee	Elkhart
Slama, George F.	Gary	Lake
Slama, John T.	Gary	Lake
Slaughter, Howard C.	Evansville	Vanderburgh
Slaughter, John C.	Evansville	Vanderburgh
Slaughter, Owen L.	Evansville	Vanderburgh
Slichenmyer, Jack E.	Indianapolis	Marion
Slick, Crystal R.	Winchester	Randolph
Sloan, Herbert P.	New Albany	Floyd
Sloan, W. Keith	Madison	Jefferson-Switzerland
Slominski, Harry H.	South Bend	St. Joseph
Slough, O. Thomas	Kendallville	Noble
Sluss, David H.	Indianapolis	Marion
Sluss, John W. (S)	Indianapolis	Marion
Smelser, Herman W.	Connersville	Fayette-Franklin
Smith, A. Wilson	Greencastle	Putnam
Smith, Barton T.	Marion	Grant
Smith, Byron J.	Kingman	Fountain-Warren
Smith, Charles F.	Noblesville	Hamilton
Smith, David J.	Indianapolis	Marion
Smith, David L.	Indianapolis	Marion
Smith, Don C.	Columbus	Bartholomew-Brown
Smith, Edward B.	Indianapolis	Marion
Smith, E. Rogers	Indianapolis	Marion
Smith, Francis C.	Indianapolis	Marion
Smith, Fred, Jr.	Tell City	Perry
Smith, Frederick R.	Spencer	Owen-Monroe
Smith, Gloster J.	Kokomo	Howard
Smith, Herbert N.	Brookville	Fayette-Franklin
Smith, Herschel S.	Bloomington	Owen-Monroe
Smith, James S.	Muncie	Delaware-Blackford
Smith, John H.	Greenfield	Hancock
Smith, John R.	Richmond	Wayne-Union
Smith, Lee J.	North Liberty	St. Joseph
Smith, Lloyd H.	North Manchester	Wabash
Smith, Lowell C.	Lafayette	Tippecanoe
Smith, Mark E.	New Castle	Henry
Smith, Philip L.	Fort Wayne	Allen
Smith, Ralph O.	Vincennes	Knox
Smith, Richard B.	Fort Wayne	Allen
Smith, Rodney D. (S)	Bloomington	Owen-Monroe
Smith, R. Lee	Osgood	Ripley
Smith, Roger C.	Fort Wayne	Allen
Smith, Roy Lee	Indianapolis	Marion
Smith, Roy M.	Evansville	Vanderburgh
Smith, S. Joseph	Vincennes	Knox
Smith, Theodore J.	Whiting	Lake
Smith Truman S.	South Bend	St. Joseph
Smith, William B.	Indianapolis	Marion
Smith, William M.	Westville	La Porte
Smoot, Emory B.	Washington	Daviess-Martin
Smoot, Samuel A. (S)	Terre Haute	Vigo
Snapp, Richard A.	Indianapolis	Marion
Sneary, Kenneth D.	Avilla	Noble
Sneary, Max E.	Avilla	Noble
Snider, Byron	Indianapolis	Marion
Snively, William D., Jr.	Evansville	Vanderburgh
Snodgrass, Robert E.	Greenwood	Johnson
Snowhite, Arthur B.	Marion	Grant
Snyder, Earl R. (S)	Troy	Perry
Snyder, Morris C.	Richmond	Wayne-Union
Snyder, Parker M.	Peru	Miami
Snyderman, Sanford C.	Fort Wayne	Allen
Sobol, Z. W.	Elkhart	Elkhart
Sokol, Allen B.	Whiting	Lake
Solis, Roger V.	Hammond	Lake
Solomon, Reuben A.	Indianapolis	Marion
Somers, Gerald H.	Fort Wayne	Allen
Sommers, Stephen D.	Indianapolis	Marion
Sonne, Irvin S., Jr.	New Albany	Floyd
Soper, Hunter A.	Indianapolis	Marion
Sorenson, Raymond	Kokomo	Howard
Souder, Bonnell M.	Auburn	De Kalb
Souter, Martha C.	Indianapolis	Marion
Southard, James E.	Danville	Hendricks
Southworth, John W.	Indianapolis	Marion
Sovine, Joe W.	Indianapolis	Marion
Spahr, Donald E.	Portland	Jay
Spahr, John F. Jr.	Indianapolis	Marion
Spalding, Joseph J.	Indianapolis	Marion
Spalding, Wendell L.	Mishawaka	St. Joseph
Spangler, Jesse S.	Kokomo	Howard
Sparks, Alan L.	Indianapolis	Marion
Sparks, Paul W.	Winchester	Randolph
Spears, John K.	Paoli	Orange
Spears, John M.	Indianapolis	Marion
Speas, Robert C.	Terre Haute	Vigo
Speck, Carlson R.	Muncie	Delaware-Blackford
Speckman, Glenn H.	Indianapolis	Marion
Spellman, Frank W.	Gary	Lake
Spencer, Beaufort A.	Bloomington	Owen-Monroe

Name	City	County
Spencer, Frederic	Vincennes	Knox
Spencer, C. Herbert	Fort Wayne	Allen
Spenner, Raymond W.	South Bend	St. Joseph
Spindler, Robert D.	Shelbyville	Shelby
Spinning, Alva L. (S)	Palm Springs, Calif.	La Porte
Spivack, Mary	Gary	Lake
Spivey, Russell J.	Indianapolis	Marion
Spolyar, Louis W.	Indianapolis	Marion
Sponder, Joseph (S)	Gary	Lake
Spray, Page E.	Elkhart	Elkhart
Sprecher, Herman C.	Evansville	Vanderburgh
Sprenger, Thomas R.	Indianapolis	Marion
Springstun, George H.	Oaktown	Knox
Springstun, Walter R.	Evansville	Vanderburgh
Sputh, Carl B., Jr.	Indianapolis	Marion
Sroka, Alexander G.	Hammond	Lake
Sroka, Stanley J.	Highland	Lake
Stadler, Harold E.	Indianapolis	Marion
Staff, Robert A.	Indianapolis	Marion
Stafford, James C. (S)	Plainfield	Hendricks
Stafford, William C.	Plainfield	Hendricks
Stahl, Edward T.	Lafayette	Tippecanoe
Stallman, Carl F.	Kendallville	Noble
Stalter, Gaylord W.	North Webster	Kosciusko
Stamper, Joseph H.	Anderson	Madison
Stamper, Lucian A.	Richmond	Wayne-Union
Stamper, Robert J.	Anderson	Madison
Stangle, William J.	Bloomington	Owen-Monroe
Stanley, John R.	Muncie	Delaware-Blackford
Stanley, John S.	Miami, Fla.	Marion
Stanley, Robert G.	Fort Wayne	Allen
Stansbury, William E.	Indianapolis	Marion
Stansell, Gilbert B.	West Lafayette	Tippecanoe
Stanton, James J. (S)	Logansport	Cass
Starks, William O.	Muncie	Delaware-Blackford
Stasick, Murray	Hammond	Lake
Staten, Jesse C.	Indianapolis	Marion
Stauffer, George E.	Mooreland	Henry
Stauffer, Richard C.	Fort Wayne	Allen
Stauffer, Walter A. (S)	Elkhart	Elkhart
Staunton, Henry A.	South Bend	St. Joseph
Stayton, Chester A., Jr.	Indianapolis	Marion
Steckler, Robert J.	Evansville	Vanderburgh
Stecy, Peter	Whiting	Lake
Steele, Dick J.	Greencastle	Putnam
Steele, Everett B.	Crown Point	Lake
Steele, Frank M.	Muncie	Delaware-Blackford
Steele, Hugh H.	Lafayette	Tippecanoe
Steele, Paul W.	Evansville	Vanderburgh
Steen, Lowell H.	Whiting	Lake
Steffen, Arthur J.	Wabash	Wabash
Steffen, Julian T.	Wabash	Wabash
Steffy, Ralph M.	Portland	Jay
Steigmeyer, David J.	Fort Wayne	Allen
Stein, Richard H.	Vincennes	Knox
Steinem, Joseph L.	Connersville	Fayette-Franklin
Steinkamp, Emil F. (S)	Huntingburg	Dubois
Steinmetz, Edward F.	Indianapolis	Marion
Stellner, Howard A.	Fort Wayne	Allen
Stephens, Donald E.	Indianapolis	Marion
Stephens, Kuhrman H.	Indianapolis	Marion
Stephens, Lowell R.	Covington	Fountain-Warren
Stepleton, John D.	Richmond	Wayne-Union
Stern, Samuel L.	Hammond	Lake
Sterne, John H.	Evansville	Vanderburgh
Steury, Ernest M.	Kenya Colony, B. E. Africa	Marion
Steussy, Calvin N.	New Castle	Henry
Stevens, Adam C.	Bluffton	Wells
Stevens, Edwin W.	Hammond	Lake
Stevens, Sydney L.	Indianapolis	Marion
Stewart, J. Frank W.	Vincennes	Knox
Stewart, Milton B. (S)	Logansport	Cass
Stewart, Walter E. (S)	Terre Haute	Vigo
Stibbins, Warren E.	Muncie	Delaware-Blackford
Stier, Paul L.	Fort Wayne	Allen
Stillwell, William R.	Richmond	Wayne-Union
Stimson, Harry R.	Gary	Lake
Stine, Marshall E.	Bremen	Marshall
Stinson, Dean K.	Rochester	Fulton
Stinson, William M.	Anderson	Madison
Stiver, Daniel D.	South Bend	St. Joseph
Stoelting, J. Lewis	Terre Haute	Vigo
Stoelting, Vergil K.	Indianapolis	Marion
Stogdill, William J.	South Bend	St. Joseph
Stogsdill, Willis W.	Franklin	Johnson
Stoltz, Robert M.	Valparaiso	Porter
Stone, Alvin T.	Indianapolis	Marion
Stone, David F.	Indianapolis	Marion
Stone, Robert C.	Indianapolis	Marion
Stoops, Jean T.	Wabash	Wabash
Storey, D. Edmund	Indianapolis	Marion
Storey, Joseph L.	Indianapolis	Marion
Stork, Harvey K.	Huntingburg	Dubois
Stork, Urban	Evansville	Vanderburgh
Storms, Roy B. (S)	Indianapolis	Marion
Stouder, Albert E.	Kempton	Tipton
Stouder, Charles E.	Ellettsville	Owen-Monroe
Stout, Francis E.	Muncie	Delaware-Blackford
Stout, Harry T.	Frankfort	Clinton
Stout, Richard B.	Elkhart	Elkhart
Stout, Walter M.	New Castle	Henry
Stover, Wendell C.	Boonville	Warrick
Stoycoff, Christ M. (S)	Gary	Lake
Stratigos, Joseph S.	South Bend	St. Joseph
Strayer, Joseph W.	Lafayette	Tippecanoe
Streck, Francis A.	Lawrenceburg	Dearborn-Ohio
Strecker, William L.	Terre Haute	Vigo
Streepey, Jefferson I.	New Albany	Floyd
Streeter, Ralph T.	Indianapolis	Marion
Strickland, Karl S. (S)	Princeton	Gibson
Strickland, Neil R.	Indianapolis	Marion
Strong, Daniel S. (S)	Terre Haute	Vigo
Stroup, Tyler J.	Indianapolis	Marion
Strueh, Paul E.	Evansville	Vanderburgh
Stubbins, William M.	Elkhart	Elkhart
Stucky, Elsworth K.	Indianapolis	Marion
Stuckey, Jerry L.	Fort Wayne	Allen
Studebaker, Lloyd R.	LaGrange	LaGrange
Stultz, Quentin F.	Ligonier	Noble
Stumer, Myer	Michigan City	La Porte
Stump, Loyd K.	Indianapolis	Marion
Stump, Richard L.	Chesterfield	Madison
Stump, Thomas A.	Indianapolis	Marion
Stumpf, Edwin E.	New Haven	Allen
Sturgis, Donald G.	Sellersburg	Clark
Stygall, James H. (S)	Indianapolis	Marion
Suelzer, John G.	Indianapolis	Marion
Sugarman, Benjamin E.	French Lick Springs	Orange
Sullenger, Adron A.	Vincennes	Knox
Sullivan, John M.	Terre Haute	Vigo
Sullivan, Robert E.	Fort Wayne	Allen
Summerlin, Jack D.	Indianapolis	Marion
Sutton, William E.	Indianapolis	Marion
Suzuki, Tsutomu T.	Covington	Fountain-Warren
Swan, John R.	Indianapolis	Marion
Swan, Richard C.	Anderson	Madison
Sweet, Howard E.	Richmond	Wayne-Union
Swihart, Danny D.	Elkhart	Elkhart
Swihart, Homer R.	Elkhart	Elkhart

Name	City	County
Swihart, Leonard F.	Elkhart	Elkhart
Syler, Robert W.	Westville	La Porte
Symmes, Alfred T.	Indianapolis	Marion
Symon, William E.	Bluffton	Wells
Szumilas, Peter P.	Indianapolis	Marion
Szynal, John S.	Indianapolis	Marion
T		
Tabaka, Francis B.	La Porte	La Porte
Tager, Stephen N.	Evansville	Vanderburgh
Talarico, Leonard H.	St. Louis, Mo.	Marion
Talbert, Pierre C.	Bluffton	Wells
Talbott, Dan E.	Indianapolis	Marion
Tan, Constancio C.	Peru	Miami
Tanner, Henry S.	Indianapolis	Marion
Taraba, Ralph W.	Kokomo	Howard
Tasher, Dean C.	Westville	La Porte
Tate, Elizabeth	Dunkirk	Jay
Taub, Robert G.	Michigan City	La Porte
Taube, Jack I.	Indianapolis	Marion
Taylor, Clifford C.	Indianapolis	Marion
Taylor, Cyril	Indianapolis	Marion
Taylor, Donald J.	Terre Haute	Vigo
Taylor, Donald R.	Muncie	Delaware-Blackford
Taylor, Everett C.	Upland	Grant
Taylor, Frederic W.	Indianapolis	Marion
Taylor, James A.	Muncie	Delaware-Blackford
Taylor, John R.	Palestine, Ill.	Sullivan
Taylor, Loren F.	Martinsville	Morgan
Taylor, Max T.	Indianapolis	Marion
Taylor, Richard A.	Detroit, Mich.	Marion
Taylor, Robert G.	Fort Wayne	Allen
Taylor, William R.	Richmond	Wayne-Union
Teaboldt, George	Peru	Miami
Teague, Frank W.	Indianapolis	Marion
Teal, Dorothy D.	Columbus	Bartholomew-Brown
Tedford, John H.	Tucson, Ariz.	Clinton
Teegarden, Joseph A. (S)	East Chicago	Lake
Teegarden, Joseph A., Jr.	East Chicago	Lake
Teixler, Victor A.	Indianapolis	Marion
Templeton, Ames R.	Mishawaka	St. Joseph
Templeton, Ian S.	Seymour	Jackson
Templin, David B.	Lowell	Lake
Tennant, David L.	Fort Wayne	Allen
Tennis, George T.	Greencastle	Putnam
Teplinsky, Louis L.	East Chicago	Lake
Terrill, Richard W.	Fort Wayne	Allen
Terry, Lloyd	Danville	Hendricks
Terry, Robert H.	Boonville	Warrick
Terveer, John B.	Decatur	Adams
Test, Charles E.	Indianapolis	Marion
Teter, George V.	Indianapolis	Marion
Teters, Melvin S.	Middlebury	Elkhart
Tether, Joseph E.	Indianapolis	Marion
Tharpe, Ray	Indianapolis	Marion
Thatcher, Hugh K., Jr.	Indianapolis	Marion
Thayer, Benet W.	North Vernon	Jennings
Theobald, Sterling	Dyer	Lake
Thegze, George A.	East Chicago	Lake
Thimlar, James W. (S)	Fort Wayne	Allen
Thomas, Charles R.	Indianapolis	Marion
Thomas, Daniel D.	Gary	Lake
Thomas, Edward P.	Indianapolis	Marion
Thomas, Everett W.	Warsaw	Kosciusko
Thomas, Fred A.	Indianapolis	Marion
Thomas, Gerald J.	Gary	Lake
Thomas, Lowell I.	Indianapolis	Marion
Thomas, Morris E.	Indianapolis	Marion
Thomas W. Clayton	Carmel	Hamilton
Thompson, Alfred A. (S)	Tyner	Marshall
Thompson, B. Jay	Marion	Grant
Thompson, Claude N.	Waynetown	Montgomery
Thompson, Frank M.	Huntington	Huntington
Thompson, Holland	Fort Wayne	Allen
Thompson, John M.	South Bend	St. Joseph
Thompson, John V.	Indianapolis	Marion
Thompson, Joseph F.	Indianapolis	Marion
Thompson, Naiad Mason	Evansville	Vanderburgh
Thompson, Paul D.	Indianapolis	Marion
Thompson, Robert A.	South Bend	St. Joseph
Thompson, Walter	Jeffersonville	Clark
Thompson, Wayne H.	Indianapolis	Marion
Thompson, Will A. (S)	Liberty	Wayne-Union
Thompson, Wm. R.	Winamac	Pulaski
Thornburg, Kenneth E.	Indianapolis	Marion
Thorne, Charles E.	New Castle	Henry
Thornton, Harold C.	Indianapolis	Marion
Thornton, Maurice J.	South Bend	St. Joseph
Thornton, Walter E. (S)	Fort Wayne	Allen
Thrasher, John R. (S)	New Augusta	Marion
Throop, Frank B.	Indianapolis	Marion
Thurston, Harrison S. (S)	Dayton, Ohio	Marion
Tilden, Margaret H.	Evansville	Vanderburgh
Tiley, George A.	Greenwood	Johnson
Tilka, Edward C.	Hammond	Lake
Tindall, George T.	Indianapolis	Marion
Tindall, Paul R. (S)	Shelbyville	Shelby
Tindall, William R.	Shelbyville	Shelby
Tinney, William E. (S)	Pass-A-Grille, Fla.	Marion
Tinsley, Frank W.	Indianapolis	Marion
Tinsley, Walter B. (S)	Indianapolis	Marion
Tinsley, Walter B., Jr.	Indianapolis	Marion
Tipton, William R.	Greencastle	Putnam
Tirman, Wallace S.	South Bend	St. Joseph
Tischer, E. Paul	Indianapolis	Marion
Tisserand, John B. Jr.	Evansville	Vanderburgh
Tobin, Walter W.	Westville	La Porte
Todd, David D. (S)	LaJolla, Calif.	Elkhart
Tomak, Milton E.	Linton	Greene
Tomlin, Hugh M.	Muncie	Delaware-Blackford
Tondra, John M.	Indianapolis	Marion
Topolgus, James N.	Bloomington	Owen-Monroe
Topping, Malachi C.	Terre Haute	Vigo
Torella, Jose A.	Indianapolis	Marion
Tosick, William A.	Indianapolis	Marion
Toumey, Fred L.	Indianapolis	Marion
Tower, James H., Jr.	Shelbyville	Shelby
Tower, Thomas K.	Campbellsburg	Washington
Trachtenberg, Lee	Hammond	Lake
Tranter, William F.	Sharpsville	Tipton
Traver, Perry C. (S)	South Bend	St. Joseph
Travis, Mary F.	Corte Madera, Calif.	Cass
Tremain, Milton A. (S)	Adams	Decatur
Treon, James F. (S)	Aurora	Dearborn-Ohio
Trepagnier, Francis B.	E. Chicago	Lake
Trimble, John G.	Kokomo	Howard
Trinosky, Frank G.	Gary	Lake
Trout, Carl J.	Lafayette	Tippecanoe
Troutwine, William R.	Crown Point	Lake
Troy, Jack M.	Whiting	Lake
Troyer, Dana	Goshen	Elkhart
Truman, E. Michael	Brookville	Fayette-Franklin
Trusler, Harold M.	Indianapolis	Marion
Tubbs, George R. (S)	Lafayette	Tippecanoe
Tuchman, Joseph H.	Indianapolis	Marion
Tucker, Oral A.	Daleville	Delaware-Blackford
Tucker, Warren S.	Indianapolis	Marion
Tuholski, James M.	Evansville	Vanderburgh
Tully, John A. (S)	New Castle	Henry
Turgi, Robert W.	Gary	Lake

Name	City	County
Turley, Verne L.	Fowler	Benton
Turner, Anna Goss	Madison	Jefferson-Switzerland
Turner, Harold B.	Bloomfield	Greene
Turner, Isabel B.	Evansville	Vanderburgh
Turner, Jack J.	Bloomfield	Greene
Turner, John P.	Goshen	Elkhart
Turner, Oscar A. (S)	Madison	Jefferson-Switzerland
Tweedall, Daniel C.	Evansville	Vanderburgh
Tyler, Frank T. (S)	New Albany	Floyd
Tyner, Harlan H.	Indianapolis	Marion
Tyrrell, Joseph J.	Chicago, Ill.	Lake
Tyrrell, Thomas C.	Calumet City, Ill.	Lake
U		
Ullom, Ralph B.	Indianapolis	Marion
Ulmer, David R. (S)	Terre Haute	Vigo
Ulrey, Robert P.	Elwood	Madison
Underwood, George M.	Lafayette	Tippecanoe
Urschel, Dan L.	Mentone	Kosciusko
V		
Vagner, S. Bernard	South Bend	St. Joseph
Vail, George A.	Lawrenceburg	Dearborn-Ohio
Valencia, M. M.	Gary	Lake
VanArsdall, Clarence R.	Terre Haute	Vigo
Van Bokkelen, Robert W.	Mooresville	Morgan
Van Buskirk, Edmund L.	Lafayette	Tippecanoe
Vance, William C.	Richmond	Wayne-Union
Van Den Bosch, Wallace R.	Lafayette	Tippecanoe
Vandivier, Robert M.	Indianapolis	Marion
Van Dorn, Myron J.	Indianapolis	Marion
Van Fleet, Josephine	Indianapolis	Marion
Van Kirk, John R.	Burlington	Carroll
Van Kirk, Paul P.	Frankfort	Clinton
Van Meter, C. Powell	Indianapolis	Marion
Van Ness, William C.	Summitville	Madison
VanNest, Willard A.	New Smyrna Beach, Fla.	De Kalb
Van Nuys, John D.	Indianapolis	Marion
Van Rie, Leo P. (S)	Mishawaka	St. Joseph
Van Sandt, Frank A. (S)	Bloomfield	Greene
Van Tassel, Charles J.	Indianapolis	Marion
Van Vactor, Helen D.	Indianapolis	Marion
Van Wienen, John	Martinsville	Morgan
Vaughn, Walter R.	Vincennes	Knox
Veach, Lester W.	Bainbridge	Putnam
Veach, William L.	Terre Haute	Vigo
Veach, Richard L.	Bainbridge	Putnam
Vellios, Frank	Indianapolis	Marion
Venable, George L.	North Manchester	Wabash
Venis, Kemper N.	Muncie	Delaware-Blackford
Vermilya, Robert W.	Lafayette	Tippecanoe
Verplank, Grover L. (S)	Gary	Lake
Viehe, Robert W.	Evansville	Vanderburgh
Vietzke, Paul C. F.	Valparaiso	Porter
Vingis, Bronie	Greenfield	Hancock
Viney, Charles L.	Logansport	Cass
Visher, John W.	Evansville	Vanderburgh
Vivian, Donald E.	New Castle	Henry
Vlaskamp, Elaine M.	Muncie	Delaware-Blackford
Vogel, John L.	Columbia City	Whitley
Vogel, Lloyd A., Jr.	Fort Wayne	Allen
Vogel, L. John	Mount Vernon	Posey
Voges, Edward C.	Terre Haute	Vigo
Vollrath, Victor J.	Indianapolis	Marion
VonAsch, George	La Porte	La Porte
von der Lieth, Wm. C.	Vincennes	Knox
Von Der Haar, Gerard	Indianapolis	Marion
Voorhies, McKinley	Gary	Lake
Vore, Hugh A.	East Chicago	Lake
Vore, Louring W.	Plymouth	Marshall
Vore, Robert E.	Indianapolis	Marion
Voyles, Charles F. (S)	Indianapolis	Marion
Voyles, Harry E.	New Albany	Floyd
Vurpillat, Francis J.	South Bend	St. Joseph
Vye, James P.	Gary	Lake
W		
Wachob, Tom W., Jr.	Kokomo	Howard
Wade, Alfred A. (S)	Howe	LaGrange
Wade, Reynolds W.	New Haven	Allen
Wagner, Arthur L.	Jasper	Dubois
Wagner, David G.	Goshen	Elkhart
Wagner, Richard	Huntington	Huntington
Wagoner, B. D.	Union City	Randolph
Wagoner, George W.	Delphi	Carroll
Wagoner, John R.	Houston, Tex.	Tippecanoe
Wainscott, Clinton S.	Indianapolis	Marion
Wait, Jerome H.	Columbia City	Whitley
Waits, Chester L.	Colfax	Clinton
Waitt, Paul M.	Sheridan	Hamilton
Waldo, Guy H.	Bedford	Lawrence
Waldo, J. Thayer	Indianapolis	Marion
Walerko, Frank	Mishawaka	St. Joseph
Walker, Adolph P.	Munster	Lake
Walker, Edwin M., Jr.	South Bend	St. Joseph
Walker, Floyd B.	Fort Wayne	Allen
Walker, Frank C. (S)	Indianapolis	Marion
Walker, Jack M.	Muncie	Delaware-Blackford
Walker, James L. (S)	LaFontaine	Wabash
Walker, Louis	Greensburg	Decatur
Walker, Robert K.	Indianapolis	Marion
Walker, William F.	Evansville	Vanderburgh
Walker, William G.	East Chicago	Lake
Wallace, Collins R.	Indianapolis	Marion
Wallace, Elmer L.	New Albany	Floyd
Wallace, Hawthorne C.	Crawfordsville	Montgomery
Walter, Robert F.	Evansville	Vanderburgh
Walters, Charles E.	Mishawaka	St. Joseph
Walters, Eleanore	Gary	Lake
Walters, Jack	Franklin	Johnson
Walters, Richard E.	Columbus	Bartholomew-Brown
Walters, William H.	Michigan City	La Porte
Walther, Joseph E.	Indianapolis	Marion
Walton, William M.	Indianapolis	Marion
Wanninger, Horace	Richmond	Wayne-Union
Warbinton, Fred P.	Indianapolis	Marion
Ward, Gerald F.	Fort Wayne	Allen
Ward, James W.	South Bend	St. Joseph
Ward, Paula B.	Fort Wayne	Allen
Ward, Wesley C.	Indianapolis	Marion
Ware, Herbert E.	Muncie	Delaware-Blackford
Warfel, Frederick C. (S)	Indianapolis	Marion
Warfield, Chester H.	Fort Wayne	Allen
Warman, Alvah P. (S)	Indianapolis	Marion
Warn, William J.	Milan	Ripley
Warner, Charles L.	Evansville	Vanderburgh
Warren, Carroll B.	Marion	Grant
Warren, Lewis T.	Michigan City	La Porte
Warrick, Francis B.	Richmond	Wayne-Union
Warrick, Homer L.	Osceola	St. Joseph
Warriner, James B.	Indianapolis	Marion
Warshaw, Seymour	Indianapolis	Marion
Warvel, John H.	Indianapolis	Marion
Warvel, Joseph L. (S)	North Manchester	Wabash
Washington, G. Kenneth	Gary	Lake
Waters, George W.	Evansville	Vanderburgh
Watson, James L.	Evansville	Vanderburgh
Watterson, Gerald T.	Connersville	Fayette-Franklin
Waymire, William	Franklin	Johnson

Name	City	County
Weaver, Marlin	Indianapolis	Marion
Weaver, Timothy M. (S)	Brazil	Clay
Weaver, Wm. W.	New Albany	Floyd
Webb, Harry D.	Anderson	Madison
Webb, Lawrence C.	Warren	Huntington
Weber, Edgar H.	Evansville	Vanderburgh
Weber, John R.	Fort Wayne	Allen
Weber, Joseph G. S.	Terre Haute	Vigo
Weber, Norbert	Indianapolis	Marion
Webster, Joel S.	Bluffton	Wells
Webster, Paul L.	Ligonier	Noble
Webster, Robert K.	Brazil	Clay
Weddle, Chas. O.	Lebanon	Boone
Weeks, Patrick H. (S)	Michigan City	La Porte
Weems, Mallory P.	Jeffersonville	Clark
Wehrman, Jule O. (S)	Indianapolis	Marion
Weigand, Clayton G.	Indianapolis	Marion
Weinbaum, Jack G.	Terre Haute	Vigo
Weinberg, Benjamin A.	Whiting	Lake
Weinberg, Samuel	Marion	Grant
Weinland, George C.	Indianapolis	Marion
Weinstein, Edwin B.	Richmond	Wayne-Union
Weinstock, Adolph	Rolling Prairie	La Porte
Weir, Dale	LaGrange	LaGrange
Weirich, Charles I.	Butler	De Kalb
Weisenberger, Brockton L.	Rosebud, S. Dakota	Marion
Weiskopf, Henry S.	Gary	Lake
Weiss, Albert E.	Michigan City	LaPorte
Weiss, Eugene	South Bend	St. Joseph
Weiss, Henry G.	Evansville	Vanderburgh
Weiss, Jason	Indianapolis	Marion
Weiss, John T.	Hobart	Lake
Weiss, Louis L.	Anderson	Madison
Weissman, Charles G.	Hammond	Lake
Weitemier, Raymond A.	Richmond	Wayne-Union
Weitzel, Roland	Princeton	Gibson
Welborn, Mell B.	Evansville	Vanderburgh
Welch, Norbert M.	Vincennes	Knox
Weldy, Bryce P.	Hartford City	Delaware-Blackford
Weller, Charles A. (S)	Indianapolis	Marion
Welpott, Jean F.	Bloomington	Owen-Monroe
Welty, Scudder G.	Fort Wayne	Allen
Wenzler, Paul J.	Bloomington	Owen-Monroe
Werry, Leslie E.	Hartford City	Delaware-Blackford
Wertenberger, Morris D.	Richmond	Wayne-Union
West, Joseph L.	Indianapolis	Marion
Westfall, B. Kemper	Indianapolis	Marion
Westfall, George S.	Goshen	Elkhart
Westfall, John B.	Indianapolis	Marion
Westhaysen, Peter	Hammond	Lake
Whallon, Arthur J. (S)	Richmond	Wayne-Union
Wharton, Russell O. (S)	Gary	Lake
Wheeler, David E.	Indianapolis	Marion
Whipps, Charles E. (S)	Carlisle	Sullivan
Whisler, Frederick M.	Wabash	Wabash
Whitcomb, Roger F.	Shelbyville	Shelby
White, Charles G.	Bluffton	Wells
White, Donald G.	Colorado Springs, Colo.	Marion
White, Donald J.	Indianapolis	Marion
White, Douglas H.	Indianapolis	Marion
White, Gilbert H., Jr.	Hammond	Lake
White, Harvey E.	Farmland	Randolph
White, James V.	Terre Haute	Vigo
White, John B.	Indianapolis	Marion
White, Nicholas	Indianapolis	Marion
White, Philip T.	Indianapolis	Marion
Whitlock, Francis C.	Mishawaka	St. Joseph
Whitlock, Merle E.	Mishawaka	St. Joseph
Whitsitt, Schuyler A. (S)	Madison	Jefferson-Switzerland
Wiatt, Leonard	Knightstown	Henry
Wible, James H.	Kokomo	Howard
Widdifield, G. E.	Indianapolis	Marion
Wiedemann, Frank E. (S)	Terre Haute	Vigo
Wierzalis, Edward F.	Hartford City	Delaware-Blackford
Wiethoff, Clifford A.	Seymour	Jackson
Wiggins, Dulania S. (S)	Newcastle	Henry
Wiland, Olin K.	Richmond	Wayne-Union
Wilder, Gordon B.	Anderson	Madison
Wildman, Roscoe E.	Peru	Miami
Wilhelm, Agatha M.	South Bend	St. Joseph
Wilhelmus, C. Kenneth	Evansville	Vanderburgh
Wilhelmus, Charles M. (S)	Newburgh	Warrick
Wilhelmus, Gilbert M.	Evansville	Vanderburgh
Wilkens, Irvin W.	Indianapolis	Marion
Willan, Horace R.	Martinsville	Morgan
Williams, A. Berniece	Fort Wayne	Allen
Williams, Aubrey H.	Fort Wayne	Allen
Williams, Alexander S.	Gary	Lake
Williams, Charles D.	Indianapolis	Marion
Williams, Clifford L.	Indianapolis	Marion
Williams, Earl K.	Rensselaer	Jasper-Newton
Williams, Edwin D.	Gary	Lake
Williams, Everett W.	Columbus	Bartholomew-Brown
Williams, Francis M.	Anderson	Madison
Williams, Fred	Gary	Lake
Williams, Fielding P.	Huntingburg	Dubois
Williams, Harold O.	Kendallville	Noble
Wililams, Harold W.	Indianapolis	Marion
Williams, Howard S.	Indianapolis	Marion
Williams, Hugh L.	Indianapolis	Marion
Williams, John H.	Shipshewana	LaGrange
Williams, Paul D.	Indianapolis	Marion
Williams, Robert D.	Markleville	Madison
Williams, Robert E.	Lafayette	Tippecanoe
Williams, Robert H.	Anderson	Madison
Williams, Russell S.	APO 696, New York, N.Y.	Marion
Willis, Charles F.	Evansville	Vanderburgh
Willison, George W.	Evansville	Vanderburgh
Willitts, Bruce K.	Indianapolis	Marion
Willner, Alan	Clarksville	Clark
Wills, Max	Auburn	De Kalb
Wilmore, Ralph C.	Indianapolis	Marion
Wilms, John H.	W. Lafayette	Tippecanoe
Wilson, David	Evansville	Vanderburgh
Wilson, Fred L.	Terre Haute	Vigo
Wilson, Fred M.	Indianapolis	Marion
Wilson, Guy H.	Bicknell	Knox
Wilson, James M.	South Bend	St. Joseph
Wilson, John	Columbia City	Whitley
Wilson, John D.	Evansville	Vanderburgh
Wilson, Leslie	Fort Wayne	Allen
Wilson, Ned A.	Marietta, Georgia	Marion
Wilson, Oliver R.	Indianapolis	Marion
Wilson, Orley E.	Elkhart	Elkhart
Wilson, Paul E. (S)	Boonville	Warrick
Wilson, Paul H.	Logansport	Cass
Wilson, Ralph	Evansville	Vanderburgh
Wilson, Roland B.	Fort Wayne	Allen
Wilson, Talmage L.	Bloomington	Owen-Monroe
Wilson, Wymond B.	Mentone	Kosciusko
Wimmer, Robert N. (S)	Gary	Lake
Winter, Donald K.	Logansport	Cass
Winter, William P.	Martinsville	Morgan
Wise, Charles L.	Camden	Carroll
Wise, William R.	Indianapolis	Marion
Wiseheart, Oscar H. (S)	North Salem	Hendricks
Wiseheart, Robert H.	Lebanon	Boone

Name	City	County
Wiseman, V. Earle	Greencastle	Putnam
Wisener, Guthrie H. (S)	Richmond	Wayne-Union
Wishard, Wm. N., Jr.	Indianapolis	Marion
Wissman, William L.	Columbus	Bartholomew-Brown
Witham, Robert L.	Indianapolis	Marion
Witt, William R.	Jeffersonville	Clark
Wixted, John F.	Mishawaka	St. Joseph
Wixted, Julia F.	Mishawaka	St. Joseph
Wohlfeld, Gerald	New Albany	Floyd
Wohlfeld, Julius B.	Bedford	Lawrence
Wojcik, Ladislas D.	Marion	Grant
Wolfe, William E.	La Porte	La Porte
Wolfe, Nelson	New Albany	Floyd
Wolfram, Don J.	Indianapolis	Marion
Wolverton, George M.	Clarksville	Clark
Woner, John W.	Linton	Greene
Wong, Norman F.	Linden	Montgomery
Wong, Samuel N.	Hammond	Lake
Wood, Donald E.	Indianapolis	Marion
Wood, Elmer U. (S)	Columbus	Bartholomew-Brown
Wood, Opal L.	Brazil	Clay
Wood, Russell W.	Oakland City	Gibson
Wood, William H.	Indianapolis	Marion
Woodall, Robert	Gary	Lake
Woodard, Abram S., Jr.	Indianapolis	Marion
Woodbury, John W.	Marion	Grant
Woodcock, Charles E. (S)	Greenwood	Johnson
Wooden, Thomas F.	Indianapolis	Marion
Woods, Arba L. (S)	Poseyville	Posey
Woods, Haldon C.	Markle	Huntington
Woods, James R., Jr.	Greenfield	Hancock
Woods, Wm. P. (S)	Evansville	Vanderburgh
Woodson, Dan E.	Boonville	Warrick
Woolery, Richard H.	Bedford	Lawrence
Woolling, Kenneth R.	Indianapolis	Marion
Work, Bruce A.	Frankfort	Clinton
Work, James A., Jr. (S)	Elkhart	Elkhart
Worley, Ansel C.	Fort Wayne	Allen
Worley, Henry L.	New Albany	Floyd
Worley, Joseph P.	Indianapolis	Marion
Worley, Richard H.	Indianapolis	Marion
Worth, C. Willard	Milroy	Rush
Wrege, Malcolm L.	Indianapolis	Marion
Wright, Cecil S.	Anderson	Madison
Wright, J. Wm., Jr.	Indianapolis	Marion
Wright, Wm. C.	Fort Wayne	Allen
Wurster, Herbert C.	Mishawaka	St. Joseph
Wyatt, James L., II	Fort Wayne	Allen
Wyatt, James L., III	Fort Wayne	Allen
Wyeth, Charles (S)	Terre Haute	Vigo
Wygant, Marion D.	Westville	La Porte
Wyland, Byron J. (S)	Mishawaka	St. Joseph
Wynegar, David E.	Richmond	Wayne-Union
Wynn, Justice F.	Evansville	Vanderburgh
Wynne, Roland E. (S)	Bedford	Lawrence
Wyttenbach, John E.	Indianapolis	Marion

Name	City	County
Y		
Yacko, Michael L.	Indianapolis	Marion
Yale, Charles A.	Fairmount	Grant
Yanson, Mannfredo R. S.	Bluffton	Wells
Yast, Charles J.	Gary	Lake
Yegerlehner, Roscoe S.	Kentland	Jasper-Newton
Yencer, Martin W. (S)	Richmond	Wayne-Union
Yingling, Robert J.	Indianapolis	Marion
Yocum, Paul S.	Gary	Lake
Yocum, Paul S., Jr.	Gary	Lake
Yocum, William S.	Gary	Lake
Yoder, Albert C. (S)	Goshen	Elkhart
Yoder, C. Richard	Elkhart	Elkhart
Yoder, Dewey D.	Columbus	Bartholomew-Brown
Yoder, Jonathan G.	Goshen	Elkhart
Yoder, Richard P.	Bluffton	Wells
Young, C. Curtis	Evansville	Vanderburgh
Young, George M.	Gary	Lake
Young, Gerald S.	Muncie	Delaware-Blackford
Young, James W.	Indianapolis	Marion
Young, John E.	Indianapolis	Marion
Young, John M.	Indianapolis	Marion
Young, Ralph H.	Goshen	Elkhart
Young, Robert G.	Marion	Grant
Young, Robert L.	Gary	Lake
Yunker, Philip E.	Howe	LaGrange
Yurdin, Donald H.	Indianapolis	Marion
Z		
Zalac, Donald A.	Michigan City	La Porte
Zallen, Stanley G.	East Chicago	Lake
Zaring, Byron K.	Columbus	Bartholomew-Brown
Zehr, Noah (S)	Fort Wayne	Allen
Zeiger, Irvin	South Bend	St. Joseph
Zell, Evertson H.	Indianapolis	Marion
Zeps, E. Frances	Richmond	Wayne-Union
Zerfas, Charles P. A.	Beech Grove	Marion
Zerfas, Leon G.	Camby	Marion
Zerfas, Phyllis K.	Indianapolis	Marion
Zeier, Francis G.	Evansville	Vanderburgh
Zimmer, Henry J.	Mishawaka	St. Joseph
Zimmerman, Harold	Evansville	Vanderburgh
Zimmerman, Wm. H.	Dublin	Wayne-Union
Zink, Robert O.	Madison	Jefferson-Switzerland
Ziperman, H. Haskell	Ft. Sam Houston, Tex.	Marion
Ziss, Robert C.	Evansville	Vanderburgh
Zivich, J. M.	East Chicago	Lake
Zore, Joseph J.	Indianapolis	Marion
Zucker, Edward	Gary	Lake
Zullo, Robert S.	Michigan City	La Porte
Zweig, Elmer S.	Fort Wayne	Allen
Zwerner, Paul F.	Terre Haute	Vigo
Zwick, Harold F.	Decatur	Adams
Zwickel, Ralph E.	Evansville	Vanderburgh

ROSTER OF MEMBERS BY COUNTIES

Physicians are listed in the counties in which they reside.

(Paid-up members of the Indiana State Medical Association as of May 1, 1959.)

ADAMS COUNTY

Berne

Beaver, Norman E.....165 W. Water St.
Boze, Robert L.....167 N. Jefferson St.
Luginbill, Howard M.....165 S. Jefferson St.

Decatur

Burk, James M.....115 N. Third St.
Carroll, John C.....134 N. First St.
Freeby, C. William.....226 S. Second St.
Girod, Arthur H.....1004 W. Monroe St.
Kohne, Gerald J.....134 S. Third St.
Parrish, Richard K.....238 S. Second St.
Reppert, Roland L.....222 S. Second St.
Rich, Norval.....415 W. Madison St.
Terveer, John B.....222 S. Second St.
Zwick, Harold F.....226 S. Second St.
Hinchman, Clarence P.....Geneva
Schetgen, Joseph V.....Geneva

ALLEN COUNTY

Fort Wayne

A

Adams, E. Wade.....710 W. Wayne
Aiken, Arthur F.....1923 E. State Blvd.
Aiken, Nevin E.....1923 E. State Blvd.
Arata, Justin E.....304 Medical Center Bldg.

B

Bahr, Robert E.....1834 Calhoun St.
Bailey, Paul P.....206 Medical Center Bldg.
Ball, John R.....320 Medical Center Bldg.
Ball, Margaret J.....1414 Park Ave.
Baltes, Joseph H.....821 Broadway
Barch, John W.....1301 S. Harrison St.
Bash, Wallace E.....2424 Fairfield Ave.
Beams, Ralph H.....715 Medical Center Bldg.
Beierlein, Karl M.....446 W. Pontiac
Benninghoff, Daniel R. (S)
208 Medical Center Bldg.
Bergendahl, Emil H.
102 Medical Center Bldg.
Berghoff, James R.....306 E. Jefferson St.
Berghoff, Raymond J.....306 E. Jefferson St.
Beutler, Theodore V.....527 W. Berry St.
Blichert, Peter A.....334 Medical Center Bldg.
Blosser, Howard V. (S)
1122 W. Washington Blvd.
Bolman, Ralph M.....717 Broadway
Borders, Theodore R.....1147 S. Lafayette St.
Bossard, John W.....115 Medical Center Bldg.
Bowers, Gah T.....1417 N. Anthony Blvd.
Bowers, Jesse W. (S).....418 Gettle Bldg.
Bridges, William L.....520 Medical Center Bldg.
Bromley, Luman W.....2730 E. State St.
Brosius, Robert H. W.....1603 Wells St.
Brown, Frederic W.....2609 Fairfield Ave.
Bryan, Franklin A.....512 Medical Center Bldg.
Buckner, George D.....533 W. Washington Blvd.

C

Calvin, Jessie C. (S).....312 W. Wayne St.
Carlo, Ernest R.....2902 Fairfield Ave.
Cartwright, Emor L. (S).....3718 Hiawatha Blvd.
Chambers, Alan R.....601 W. Wayne St.
Clark, William R.....3622 S. Calhoun St.
Cochran, Harry A., Jr.....1301 S. Harrison St.
Conley, John E.....620 W. Berry St.
Connelly, Richard D.....810 Lake Ave.
Cooney, Charles J.....527 W. Berry St.
Craig, Richard M.....3024 Fairfield Ave.
Culp, John E.....2902 Fairfield Ave.

D

Dancer, Charles R. (S).....905 Columbia Ave.
Datzman, Richard C.....525 Medical Center Bldg.
Dieter, William J.....1002 Somerset Lane
Ditton, Irvin W. (S).....1214 E. Wayne St.
Duemling, Arnold H.....Weyrick Bldg.
Dunstone, Harry C.....502 Medical Center Bldg.

E

Edlavitch, Baruch M. (S).....716 Rockhill
Elston, Lynn W.....604 Medical Center Bldg.
Elston, Ralph W.....604 Medical Center Bldg.
Emenhiser, John L.....1411 Reed Rd.

F

Ferguson, Arthur N.....2902 Fairfield Ave.
Fichman, Abraham M.....323 W. Berry St.
Foy, Hayward W.....1747 Wells St.
Franke, Gordon R.....1202 E. State Blvd.
Frankhouser, Charles M. A.
520 Medical Center Bldg.
Fullam, Richard G.....234 Medical Center Bldg.

G

Garton, Harry W.....1635 Broadway
Gastineau, David C.....520 Medical Center Bldg.
Gerding, William J.....2638½ S. Calhoun
Gladstone, Naf H.....335 W. Berry St.
Glassey, Stephen H.....1927 E. State St.
Glock, Homer E. (S).....324 Medical Center Bldg.
Glock, Maurice E.....312 W. Wayne St.
Glock, Wayne R.....2521 Fairfield Ave.
Goebel, Carl W.....327 W. Creighton
Graham, George M.....1301 S. Harrison St.
Graham, James C.....805 E. Creighton Ave.
Greenlee, Robert L.....1110 W. Washington Blvd.
Greist, Walter D.....3024 Fairfield Ave.
Griffith, Harold R.....520 Medical Center Bldg.

H

Hackett, Walter G.....2701 S. Anthony
Haffner; Herman G.....202 E. Jefferson St.
Haley, Alvin J.....533 W. Washington Blvd.
Haller, Robert L.....604 W. Wayne St.
Hamilton, Emory D.....228 Medical Center Bldg.
Harshman, Louis P.....Veterans Hospital
Harvey, Harry C.....406 W. Berry St.
Hasewinkle, August M.....1129 E. State St.
Hastings, Warren C.....111 Medical Center Bldg.
Hattendorf, Anton P.....725 Medical Center Bldg.
Havens, Russell E.....228 Medical Center Bldg.
Hershberger, Philip.....2609 Fairfield Ave.
Hickman, Donald.....3408 N. Anthony
Higgins, Kenneth E.....801 E. State St.
Hipskind, Richard E.....332 E. Pontiac
Hoffman, Arthur F.....519 Medical Center Bldg.
Holsinger, Robert E.....115 Medical Center Bldg.
Horning, Richard R.....416 Medical Center Bldg.
Howe, Fordyce L.....1525 Oxford St.
Humphreys, John L.....1301 S. Harrison St.

J

Jackson, John F. 519 Medical Center Bldg.
Johnston, Richard M. 519 Medical Center Bldg.
Juergens, Richard B. R. R. #2
Jurgensen, Walter T. 3415 Fairfield Ave.

K

Karol, Herbert J. 324 Medical Center Bldg.
Kaufman, Julian 229 W. Berry St.
Keck, Carleton A. 2902 Fairfield Ave.
Kent, Richard N. 731 Medical Center Bldg.
Keyes, Robert C. 3714 S. Calhoun
Kidder, Orva T. Irene Byron Hospital
Kimbrough, Robert F. 2730 E. State St.
Kleifgen, William A. 617 W. Washington Blvd.
Klooze, Kenneth W. 2156 Fairfield Ave.
Knight, Lewis W. 446 W. Pontiac
Krueger, John E. 204 E. Suttenfield
Kruse, Edward H. (S) 705 Lincoln Tower
Kruse, Walter E. 410 McKinnie

L

Ladig, Donald S. 337 W. Berry St.
Lampe, Elfred H. 2902 Fairfield Ave.
Land, Francis L. 116 W. Rudisill Blvd.
Laycock, Richard M. 6642 St. Joe Road
Leming, Ben L. 2902 Fairfield Ave.
Lenk, George G. 1805 E. Washington
Lloyd, Robert P. 717 Broadway
Lohman, Robert M. 4017 S. Wayne St.
Lorman, James G. 520 Medical Center Bldg.
Loudermilk, Jack L. 520 Medical Center Bldg.
Lyon, William C. 710 W. Wayne St.

M

Mackel, Frederick O. 2521 Fairfield Ave.
Manning, George 111 Medical Center Bldg.
Marshall. Caesar L. 438 E. Lewis St.
Mayes, Warren E. 116 W. Rudisill Blvd.
McArdle, Edward G. 2201 S. Calhoun St.
McCallister, John W. 424 Medical Center Bldg.
McCoy, Roy R. 3701 S. Harrison St.
McDowell, George A. 215 Medical Center Bldg.
McEachern, Cecil G. 2424 Fairfield Ave.
McKeeman, Donald H. 633 W. Wayne St.
McKeeman, Leland S. 302 Medical Center Bldg.
Mensch, James R. 2230 Alabama Ave.
Mercer, Samuel R. 710 Medical Center Bldg.
Meyer, Hans 801 E. State St.
Meyer, Herman A. 1030 W. Wayne St.
Meyer, Theodore O. 228 Medical Center Bldg.
Michaelis, Stephen C. 2154 Fairfield Ave.
Miller, Edward D. 1117 E. State Blvd.
Miller, H. Paul 2715 Broadway
Miller, Mahlon F. 222 Medical Center Bldg.
Miller, Orval J. 324 W. Berry St.
Miller, Richard H. 511 Medical Center Bldg.
Miller, Robert B. 412 Medical Center Bldg.
Miller, William J. 2902 Fairfield Ave.
Moats, Carl F. 4007 S. Wayne St.
Moats, George E. (S) 615 E. Washington Blvd.
Moeller, Victor C. 2424 Fairfield Ave.
Moravec, Arthur E. 705 Lincoln Tower
Mortenson, Leland J. 214 Medical Center Bldg.
Mueller, Lawrence W.
533 W. Washington Blvd.
Murdock, Harvey L. 417 Medical Center Bldg.

N-O

Nill, John H. 204 E. Suttenfield St.
Nolan, Gerald R. 1626 Oxford St.
O'Brian, John F. 1807 E. Washington Blvd.
O'Rourke, Carroll 604 W. Berry St.
Oyer, John H. 2609 Fairfield Ave.

P

Painter, Donald S. 222 Medical Center Bldg.
Parker, Carey B. 1105 S. Harrison St.
Parrot, Donald J. 1706 Sherman
Pauly, Leonard R. 730 W. Berry St.
Pearson, Huey L. 1801 S. Hanna
Perrin, Kermit F. 2701 S. Anthony Blvd.
Perry, Frederic G. 2902 Fairfield Ave.
Philbert, Richard N. 4349 S. Anthony Blvd.
Pickett, Merle E. 228 Medical Center Bldg.
Ponczek, Edward 3418 S. Hanna
Popp, Milton F. 606 Medical Center Bldg.
Powell, M. Jack 730 W. Berry St.
Priddy, Marvin E. 5010 Rivieria Court

Q-R

Rawles, Lyman T. (S) 3131 Fairfield Ave.
Ray, Herbert A. (S) 402 Medical Center Bldg.
Rice, Wilkie B. (S) 1101 E. Pontiac
Rissing, Walter J. 229 W. Berry St.
Rockey, Noah A. 1224 E. State
Rodriguez, Juan 2902 Fairfield Ave.
Roser, Arthur J. 617 W. Washington Blvd.
Rossiter, Dudley L. 3629 S. Harrison
Rothberg, Maurice 625 W. Berry St.
Rothschild, Charles J. (S)
319 Medical Center Bldg.
Rousseau, John W. 446 W. Pontiac

S

Sahlmann, Hans 3418 S. Hanna
Salon, Harry W. 535 W. Berry
Salon, Joel W. 604 W. Wayne St.
Salon, Nathan L. 604 W. Wayne St.
Sarver, Francis E. 320 Medical Center Bldg.
Savage, Arthur R. 302 W. Berry St.
Saylors, Rodger D. R. R. #2
Schellhouse, Earl M. 1240 W. Main St.
Schlademan, Karl R. 510 Medical Center Bldg.
Schmidt, Eugene E. 228 Medical Center Bldg.
Schmoll, Robert J. 515 W. Wayne St.
Schneider, Louis A. 730 W. Berry St.
Schoen, Frederic L. 902 W. Wayne St.
Schubert, Jerome C. 1320 Broadway
Scoins, William H. 1301 S. Harrison St.
Scott, H. Vaughn 2902 Fairfield Ave.
Senseny, Eugene F. 2902 Fairfield Ave.
Shaw, James E. 3103 Bowser Ave.
Sherwood, Clarence E. Irene Byron Hospital
Sherwood, J. Vincent Irene Byron Hospital
Shinabery, Lawerence 1850 Broadway
Short, John T. 2902 Fairfield Ave.
Singer, Elmer C. 825 Oakdale Dr.
Smith, Philip L. 2902 Fairfield Ave.
Smith, Richard B. 629 Medical Center Bldg.
Smith, Roger C. 711 Medical Center Bldg.
Snyderman, Sanford C.
102 Medical Center Bldg.
Somers, Gerald H. 2506 Lower Huntington Rd.
Spencer, C. Herbert. 519 Medical Center Bldg.
Stanley, Robert G. 3415 S. Fairfield Ave.
Stauffer, Richard C. 2730 E. State St.
Steigmeyer, David J. 1411 N. Anthony Blvd.
Stellner, Howard A. 324 W. Berry St.
Stier, Paul L. 721 Broadway
Stuckey, Jerry L. 5010 Riviera Court
Sullivan, Robert E. 2424 Fairfield Ave

T

Taylor, Robert G. 2902 Fairfield Ave.
Tennant, David L. 1832 S. Calhoun
Terrill, Richard W. 446 W. Pontiac
Thimlar, James W. (S) 602 E. Lewis
Thompson, Holland Irene Byron Hospital
Thornton, Walter E. (S) 601 W. Oakdale Dr.

V-W

Vogel, Lloyd A., Jr. 116 W. Rudisill
Walker, Floyd B. 3505 S. Monroe
Ward, Gerald F. 206 Medical Center Bldg.
Ward, Paula B. 2014 Curdes Ave.
Warfield, Chester H. 730 W. Berry St.
Weber, John R. 710 W. Wayne St.
Welty, Scudder, G. 2423 S. Calhoun St.
Williams, A. Berniece 3526 N. Washington Rd.
Williams, Aubrey H. 2902 Fairfield Ave.
Wilson, Leslie Veterans Hospital
Wilson, Roland B. 1207 S. Lafayette
Worley, Ansel C. 317 Medical Center Bldg.
Wright, William C. 621 Medical Center Bldg.
Wyatt, James L., III 310 E. Washington St.
Wyatt, James L., II 233 E. Jefferson

X-Y-Z

Zehr, Noah (S) 301 W. Creighton
Zweig, Elmer S. 344 W. Berry St.

Emme, Richard W. Harlan
Cutshaw, James A. Monroeville
Harless, Fred Monroeville
Dahling, Clemens W. 910 Summit, New Haven
Emenhiser, Donald C. .. 608 State St., New Haven
Hoetzer, Eldore M. New Haven
Stumpf, Edwin E. 716 Broadway, New Haven
Wade, Reynolds W. Dahling Bldg., New Haven
Moser, Edward (S) Woodburn

Baumgartner, Jeraldine C. Gateway House, Smith College, Northhampton, Mass.
Bichacoff, Billie D. 341 Webster Springs, W. Va.
Draper, Merlin H. (S) 59 Dolphin Dr., St. Petersburg, Fla. (6)
Geyer, C. Norman 1206 Freeman St., Carbondale, Illinois
Havice, Jay F. Box 56, Lake Lure, N. Carolina
McFall, J. S. R. 608 Cadagua Ave., Coral Gables, Fla.
Prentiss, Nelson H. V. A. Hospital, Oteen, N. C.

BARTHOLOMEW-BROWN COUNTIES

Columbus

Adler, David L. Bartholomew County Hospital
Beggs, Lowell F. 832 Washington St.
Clay, Eleanor 911 Washington St.
Davis, Marvin R. 2300 Washington St.
Echsner, Herman J. 1815 25th St.
Elkouri, Harvey D. Bakalar Air Force Base
Fisher, Walter S. 422 Ninth St.
Hart, Robert B. 712 Washington St.
Hawes, James K. (S) P. O. Box 308
Hawes, Marvin E. 522 Seventh St.
Henry, Alvin L. 621 Franklin St.
Knotts, Slater Bartholomew County Hospital
Krueger, Robert B. 814 Washington St.
Longo, Amerigo V. Bakalar Air Force Base
Macy, George W. 718 Washington St.
Marr, Griffith 741 Washington St.
McCullough, Henry G. Old Indianapolis Rd.
Mohler, Floyd W. 726 Seventh St.
Norton, Harold J. 909 Pearl St.
O'Bryan, Richard B. 503 California St.
Overshiner, Lyman (S) 1001 N. Fifth St.
Reid, Robert M. 2225 Central Ave.
Rothring, Howard E. 2120 Washington St.
Ryan, William J. 911 Washington St.
Schmitt, Richard K. 423 Ninth St.
Sigmund, William B. 2355 Central Ave.
Smith, Don C. 911 Washington St.
Teal, Dorothy D. 728 Franklin St.
Walters, Richard E. Fifth and Union Sts.
Williams, Everett W. 2225 Central Ave.
Wissman, William L. 2225 Central Ave.
Wood, Elmer U. (S) 2012 Washington St.
Yoder, Dewey D. 415½ Seventh St.
Zaring, Byron K. 718 Washington St.

Dudding, Joseph E. Hope
Jacobs, E. Robert Hope
Schneider, Kenneth D. Nashville
Seibel, Robert Nashville

BENTON COUNTY

Leak, Robert H. Boswell
Coddens, Avery L. Earl Park
Altier, William H. Fowler
Miller, Dan T. (S) Fowler
Turley, Verne L. Fowler
McCabe, James E. (S) Otterbein
Rutherford, Charles E. Otterbein
Scheurich, Virgil Oxford

BLACKFORD COUNTY

(See Delaware-Blackford)

BOONE COUNTY

Riley, Frank H. (S) Jamestown
Schaaf, Alvin D. Jamestown

Lebanon

Beck, Herma A. (S) Boone County Bank Bldg.
Coons, John D. Boone County Bank Bldg.
Coons, Ritchie 303 W. Washington St.
Grigsby, Hardin B. 916 N. East St.
Headley, Lloyd M. 1111 N. Lebanon St.
Honan, Paul R. 1726 N. Lebanon St.
Kern, Clarence G. 1726 N. Lebanon St.
Lenox, Jack 303 W. Washington St.
Porter, Jack 209 W. North St.
Rainey, Everett A. (S) 912 N. Meridian St.
Weddle, Charles O. 905 N. Lebanon St.
Wiseheart, Robert H. 905 N. Lebanon St.

Bassett, Clancy (S) Thorntown
Bassett, Margaret A. Thorntown
Gregg, Edwin E. Thorntown
Bailey, Lawrence S. Zionsville
Harvey, Ralph J. Zionsville
Lovett, Harvey D. Whitestown

BROWN COUNTY

(See Bartholomew-Brown)

CARROLL COUNTY

Van Kirk, John R. Burlington
Kennedy, Eva N. (S) Camden
Lemon, Herbert K. (S) R. 1, Camden
Wise, Charles L. Camden

Delphi

Baker, Eldon E. 816 S. Hamilton
Crampton, Charles C. (S) 115 E. Main St.
Petry, T. Neal 111 E. Franklin St.
Seese, Robert M. 101 W. North St.
Wagoner, George W. Front & Union Sts.

Adams, Max R. Flora
McLaughlin, James R. Flora

CASS COUNTY

Dutchess, C. Toney Galveston

Logansport

Adamski, Michael....408 North St.
Bailey, Earl W....212 Fifth St.
Ballard, Charles A (S)....325½ E. Market St.
Bean, Joseph S....Memorial Hospital
Burnett, Paul C....Logansport State Hosp.
Chu, Johnson C. S....Logansport State Hosp.
Cobb, Clarence M....Memorial Hosp.
Davis, John C. (S)....Masonic Temple
Eckert, Russell A....1101 Michigan Ave.
Fitzgerald, Brice E....126 Fourth St.
Fogel, Ernest....Logansport State Hosp.
Gatzimos, Christos D....1101 Michigan Ave.
Glendening, Richard L....422 North St.
Hall, Bernard R....415 North St.
Harrington, James F....1001 E. Broadway
Hedde, Eugene L....211 S. Third St.
Hillis, Lowell J....203 S. Third St.
Hochhalter, Marian....86 9th St.
Hogle, Frank D....Logansport State Hosp.
Holloway, William A. (S)....201 S. Third St.
Jewell, Earl B. (S)....3019 S. Pennsylvania St.
Jones, J. Carl....R. R. 3
Killian, E. Camille....211 S. Third St.
King, Jay M....201 S. Third St.
Maschmeyer, Robert H....Logansport State Hosp.
Matheu, Heracleo....Logansport State Hosp.
Mikan, V. Robert....216 9th St.
Morrical, Russell J....212 Fifth St.
Pfuetze, Max....408 North St.
Schenck, Foss (S)....Logansport State Hosp.
Sheller, Tom G....Logansport State Hosp.
Shultz, Henry M. (S)....412 Fourth St.
Stanton, James J. (S)....220 S. Sixth St.
Stewart, Milton B. (S)....1515 Broadway
Viney, Charles L....Masonic Temple
Wilson, Paul H....422 North St.
Winter, Donald K....422 North St.

Newcomb, William K....Royal Center
Flanangan, Estle P. (S)....Walton
Lybrook, Daniel E. (S)....Young America
Travis, Mary F....55 Chickasaw Ct., Corte Madera, Calif.

CLARK COUNTY

Goodman, Eli S....Charlestown
Jones, David H....Charlestown
Lehman, Harold....Charlestown
Shina, Heskel S....Charlestown
Willner, Alan....Clarksville
Wolverton, George M....Clarksville
Carr, Joseph H....Henryville
Greene, William R....Henryville

Jeffersonville

Adair, Samuel....201 E. Market
Buehler, George M....414 Wall St.
Bruner, Ralph W....437 Spring St.
Carlberg, Dale L....226 E. Maple
Carney, Joel T....347 Spring St.
Clark, William B., Jr....437 Spring St.
Dare, Lee A....209 E. Maple St.
Forsee, Norman E....437 Wall St.
Havens, A. Lyle....432 Wall St.
Havens, Thomas R....432 Wall St.
Huoni, John S....1405 Youngstown Shopping Center
Isler, Nathaniel C....519 Spring St.
Reed, Edsel S....Clark Co. Memorial Hosp.
Roby, Alma L....201 E. Market St.
Shaw, Houston W....430 Wall St.
Thompson, Walter....437 E. Spring St.
Weems, Mallory P....404 Spring St.
Witt, William R....Medical Center

Regan, George L....Sellersburg
Sturgis, Donald G....Sellersburg

CLAY COUNTY

Brazil

Garvin, Donald B....111 N. Walnut St.
Maurer, J. Frank....111 N. Walnut St.
Maurer, Robert M....111 N. Walnut St.
McCormick, Wilbur C....R. R. 2
Mehne, Richard G....1½ E. National Ave.
Shattuck, John C....1½ E. National Ave.
Weaver, Timothy M. (S)....Brazil Trust Bldg.
Webster, Robert K....28 N. Franklin St.
Wood, Opal L....111 N. Walnut St.

Moon, Charles E....Center Point
Bond, Walter C....Clay City
Glosson, Jack R....Clay City
Rentschler, Lewis C. (S)....Clay City

CLINTON COUNTY

Waits, Chester L....Colfax

Frankfort

Applegate, Albert E....51 E. Walnut St.
Beardsley, Frank A....51 S. Jackson St.
Carrel, Francis E....214 Ross Bldg.
Dykhuizen, Theodore A....59 S. Main St.
Erdel, Milton W....2 E. White St.
Flora, Fred W....59 S. Main St.
Hammersley, George K....361 E. Clinton St.
Hedgcock, Robert A....259 E. Clinton St.
Holmes, Claude D. (S)....9½ W. Clinton St.
Mather, Robert L....4 E. White St.
Stout, Harry T....361 E. Clinton St.
Van Kirk, Paul P....204 W. Washington St.
Work, Bruce A....47½ S. Jackson St.

Bush, Charles E....Kirklin
Carlyle, Ivan E. (S)....Michigantown
Lind, Jaap J....Mulberry
Holmes, John L....510 Moss St., Columbia, Mo.
Reed, John D....869 Pallister, Detroit, Mich.
Tedford, John H....4161st USAF Hosp., Tucson, Ariz.

CRAWFORD COUNTY

(See **Harrison-Crawford**)

DAVIESS-MARTIN COUNTIES

Rohrer, James R....Elnora

Loogootee

Chattin, Robert E....102 Wood
Gootee, Francis H....206 W. Main St.
Lett, Emory B....408 E. Main

Sears, Don....Odon
Gilkison, John S. (S)....Shoals

Washington

Arthur, Nora M. (S)....R. R. 4
Blazey, Arthur G....7 E. Walnut St.
Chattin, Vance J....514 E. Main St.
Farris, John J....514 E. Main St.
Fox, C. Philip....305 Peoples Bank Bldg.
Lindsay, Hamlin B....511 E. Main St.
Lloyd, Claude A....107 N. E. Second St.
McKittrick, Jack....Peoples Bank Bldg.
McNaughton, Lawrence M....400 E. Hefron St.
Norton, Horace....511 E. Hefron St.
Rang, A. A. (S)....211 N. E. 9th St.
Rang, Robert H....1312 Bedford Rd.
Ross, Glenn E....1210 Bedford Road
Schafer, William C....1312 Bedford Rd.

Schroeder, Henry R. 101 N. E. First St.
Seat, Marshall H. Williams Bldg.
Smoot, Emory B. 507 E. Main St.

DEARBORN-OHIO COUNTIES

Aurora

Baker, Leslie M. 223 Mechanic St.
Jackson, John K. 223 Mechanic St.
Olcott, Charles W. 203 Main St.
Treon, James F. (S) 505 Fifth St.

McNeely, Matthew J. Dillsboro
Elliott, John C. (S) Guilford

Lawrenceburg

Aldred, A. W. 370 Bielby Road
Conrad, Henry 370 Bielby Road
Fagaly, William J. 238 Short St.
Frable, Frank L. 370 Bielby Road
Houston, Fred D. 300 Walnut
Hunter, Lowell G. 370 Bielby Road
Morrison, George G. 209 Fourth St.
Pfeifer, James M. 319 Front St.
Streck, Francis A. 326 Walnut St.
Vail, George A. 28 Oakey Ave.

Fessler, Gordon S. Rising Sun

DECATUR COUNTY

Tremain, Milton A. (S) Adams

Greensburg

Acher, Robert P. 221 E. Washington St.
Callaghan, Winship C. 304 Bates Bldg.
Dickson, Dale D. Bates Bldg.
Miller, James C. 205 Bates Bldg.
Morrison, James T. 207 N. Franklin
Overpeck, Charles Murphy Bldg.
Sallee, William T. Bates Bldg.
Shaffer, William R. 214 N. Franklin
Walker, Louis 215 N. Franklin

Harkcom, Harry E. St. Paul
Porter, Edward A. Westport
Porter, Robert A. Westport

DE KALB COUNTY

Auburn

Covell, Harry M. 127 W. Seventh St.
Geisinger, Lewis N. (S) Auburn
Hines, Archie V. Auburn
Hines, John H. 403 S. Main St.
Hippensteel, Harland V. 208 W. Seventh St.
Nugen, Harold 223 W. Seventh St.
Rogers, Evered E. 212 W. Sixth St.
Sanders, Jesse A. (S) Auburn
Souder, Bonnell M. Auburn
Wills, Max 127 W. Seventh St.

Hathaway, Clayton B. Butler
Weirich, Charles I. Butler

Garrett

Carpenter, Ramesh S. 514 S. Randolph
Jinnings, Loren E. 200 S. Randolph
Kantzer, Floyd B. 200 S. Randolph
Nason, Robert A. 123 E. King
Novy, Charles A. 200 S. Randolph
Reynolds, Russell P. 215 S. Randolph

Coleman, Floyd B. Waterloo
Showalter, John P. Waterloo
Van Nest, Willard A.
501 Magnolia St., New Smyrna Beach, Fla.

DELAWARE-BLACKFORD COUNTIES

Brown, Stewart D. Albany
Puterbaugh, Karl E. Albany
Hurley, John R. Daleville
Tucker, Oral A. Daleville
Lutz, Robert J. Eaton
Downard, Leland F. Gaston
Ko, Richard C. B. Gaston

Hartford City

Dodds, James U. 227 W. Main St.
Dudgeon, Charles A. 720 N. Spring
Jackson, Dean B. 401 W. Washington St.
Owsley, Guy A. 214 N. High St.
Parks, George 302 N. High St.
Weldy, Bryce P. 227 W. Franklin St.
Werry, Leslie E. 218 W. Washington St.
Wierzalis, Edward F. Rural Loan Bldg.

Burns, Paul E. Montpelier
Douglas, William T. Montpelier

Muncie

Adams, Julia L. R. R. 6
Adams, William B. Ball Memorial Hosp.
Alvey, Charles R. 217 S. Cherry St.
Ball, Clay A. (S) 303 W. Adams St.
Ball, Phillip 420 W. Washington St.
Benken, Lawrence D. 2423 W. Jackson
Bergwall, Warren L. 223 Tillotson Ave.
Bibler, Henry E. 311 W. Adams St.
Botkin, Charles (S) 508 W. Jackson St.
Botkin, Clyde G. 508 W. Jackson St.
Botkin, Thomas 400 White River Blvd.
Brown, Leland G. 412 White River Blvd.
Brown, Thomas M. 412 White River Blvd.
Burwell, Stanley W. 424 W. Jackson St.
Butterfield, Robert M. 315 W. Jackson St.
Butz, Ralph O. 408 Western Reserve Bldg.
Christie, Robert W. 321 N. Manning Ave.
Clark, Robert M. 115 N. Cherry St.
Clauser, Eldo H. M. 315 S. Jefferson St.
Clevenger, Joseph H. 424 W. Jackson St.
Cochran, Robert B. 420 W. Washington St.
Covalt, Wendell E. 305 Western Reserve Bldg.
Cure, Elmer T. 122 W. Jackson St.
Davis, Edgar C. 107 Plaza Bldg.
Deutsch, William 406 White River Blvd.
Dunn, Ferrell W. (S) 2210 Janney Ave.
Dunning, Thomas W. 2327 S. Madison
Eissman, Robert C. 211 Alden Rd.
Fair, Herbert D. (S) 201 Alameda Ave.
Funk, John W. 217 W. Charles St.
Galliher, Marjorie J. 410 White River Blvd.
Garling, Luvern C. 420 W. Washington St.
Geckler, Charles E. 203 Western Reserve Bldg.
Gill, Thomas A. 808 W. Jackson St.
Greiber, Marvin F. 420 W. Washington St.
Gustafson, Milton 808 W. Jackson St.
Hall, Orville A. 514 Wysor Bldg.
Hall, Robert S. 514 Wysor Bldg.
Hayes, Theodore R. 210 S. High St.
Heinrichs, Harry H. (S) 214 Cromer St.
Henderson, Ramon A. 806 W. Main St.
High, Ralph L. 420 W. Washington St.
Hill, Howard E. 402 W. Jackson St.
Hostetter, Irwin S. 115 N. Cherry St.
Hurley, Anson G. 1111 W. Jackson St.
Imhof, Joseph D. 206 Western Reserve Bldg.
Kammer, Grace C. 1005 W. Parkway Dr.
Kammer, Walter F. 420 W. Washington St.
Kern, Charles B. (S) 31 Mann
Kirshman, Forrest E. 211 S. High St.
Koss, K. William 1600 W. Jackson St.
LaDuron, Jules F. 615 S. Liberty St.
McClintock, James A. 316 W. Adams St.
McCoy, George E. 806 W. Jackson St.
McDowell, Fletcher W. 315 S. Jefferson St.

Mathewson, Russell C.....420 W. Washington St.
Molloy, William J. (S).....619 E. Charles St.
Montgomery, Lall G.....Ball Memorial Hosp.
Moore, Thomas C.....100 N. Cherry St.
Moore, Will C.....110 N. Cherry St.
Morris, Jean W.....247 Johnson Bldg.
Nelson, Harold E.....424 W. Jackson St.
Owens, Richard R.....406 Western Reserve Bldg.
Owens, Thomas R.....202 Western Reserve Bldg.
Peacock, Robert C.....124 S. High St.
Pippenger, Wayne G...Ball State Teachers College
Quick, William J.....314 E. Washington St.
Rathkey, Arthur S.....420 W. Washington St.
Rettig, Arthur C.....314 W. Jackson St.
Rivers, Glynn A.....625 W. Adams St.
Saperstein, Morris.....2327 S. Madison St.
Schulhof, Maurice G.....420 W. Washington St.
Smith, James S.....501 Kirby
Speck, Carlson R.....Ball Memorial Hospital
Stanley, John R.....310 W. Jackson St.
Starks, William O.....420 W. Washington St.
Steele, Frank M.....420 W. Washington St.
Stibbens, Warren.....2210 Janney St.
Stout, Francis E.....2423 W. Jackson St.
Taylor, Donald R.....Ball Memorial Hosp.
Taylor, James A.....Delco Remy Plant
Tomlin, Hugh M.....420 W. Washington St.
Venis, Kemper N.....108 N. Liberty St.
Vlaskamp, Elaine M.....401 W. Main St.
Walker, Jack M.....412 White River Blvd.
Ware, Herbert E.....514 Wysor Bldg.
Young, Gerald S.....316 W. Jackson St.

Jump, Charles A. (S).....Selma
Hill, Robert E.....Yorktown
Moss, Mavor J.....Yorktown

DUBOIS COUNTY

Backer, Henry G.....Ferdinand

Huntingburg

Amini, Sohrab.....521 Fourth St.
Bretz, John M.....302 Fourth St.
Heaton, Elton.....215 Walnut St.
Scales, Alfred B.....409 Van Buren
Scales, Allen D.....409 Van Buren
Steinkamp, Emil F. (S).....302 Walnut St.
Stork, Harvey K.....532 Fourth St.
Williams, Fielding P.....215 W. Walnut St.

Jasper

Beaven, John B.....111 Central Bldg.
Blessinger, Paul J.....325 E. Sixth St.
Gootee, Thomas H.....101-4 Central Bldg.
Heck, Martin C.....801 Newton
Held, George A.....716 W. Ninth St.
Klamer, Charles H.....Metzger Bldg.
Lukemeyer, St. John.....109 W. 12th St.
Ploetner, Edward J.....Sixth & Newton Sts.
Salb, John P.....Jasper
Salb, Leo A. (S).....301 E. Sixth St.
Singer, Paul J.....116 E. Seventh St.
Wagner, Arthur L.....801 Newton St.

ELKHART COUNTY

Horswell, Richard G.....Bristol
Neidballa, Edward G.....Bristol

Elkhart

Arlook, Theodore D.....912 W. Franklin St.
Bender, Robert L.....411 S. Third St.
Benson, James E.....405 S. Second St.
Billings, Elmer R.....405 S. Third St.
Bloom, George R.....506 S. Second St.
Bowdoin, George E.....515 S. Second St.
Campbell, Patrick B.....605 Oakland Ave.
Classen, Pete R. C.....4112 S. Main St.
Compton, Walter A.....1127 Myrtle St.
Cormican, Herbert L.....316 S. Fourth St.
Crandall, Lathan A.
Miles-Ames Research Laboratory
DeDario, Leonard M.....123 W. Marion St.
Dovey, Edward G.....Equity Bldg.
Elliott, Lloyd A. (S).....405 S. Second St.
Elliott, Thomas A.....405 S. Second St.
Fleming, Claude F. (S).....217 W. Jefferson St.
Futterknecht, James O.....405 S. Second St.
Gattman, George B.....427 S. Second St.
Graber, Virgil R.....413 W. Franklin St.
Hannah, Jack W.....1906 E. Jackson Blvd.
Heminway, Norman L..Miles-Ames Research Labs.
Hull, Arthur W.....221 Jefferson
Hurley, James W.....405 S. Second St.
Ivy, John H.....405 S. Second St.
Keating, John U.....215½ W. Lexington
Kintner, Burton E.....506 S. Second St.
Kistner, Arthur W.....400 Equity Bldg.
Koehler, Elmer G.....416 W. Lexington Ave.
Leasure, Kenneth.....1000 W. Marion St.
Lundt, Milo O.....521 S. Second St.
Markel, Ivan J.....215 W. Franklin St.
McArt, Bruce A.....123 W. Marion St.
Martin, Paul H.....202 Harrison St.
Mendez, Carlos.....116 W. Marion St.
Middleton, Ramona J.....209 S. Second St.
Miller, Galen R.....903 W. Franklin St.
Miller, Hugh A.....417 Prospect
Miller, Samuel T. (S).....506 S. Second St.
Mininger, Edward P.....1118 E. Jackson Blvd.
Mishkin, Irving.....209 S. Second St.
Norris, Allen A. (S).....401 W. Marion St.
Paff, William A.....115 S. Third St.
Paine, George E.....329 Meisner Ave.
Pancost, Vernon K.....200 Equity Bldg.
Parshall, Dale B.....133 W. Lusher Ave.
Patrick, Glenn B.....427 S. Second St.
Rouen, Robert.....114 Monger Bldg.
Rupe, Lloyd O.....209 Equity Bldg.
Schlosser, Herbert C.....116 W. Marion St.
Sears, Murray M. (S).....304 Equity Bldg.
Sobol, Z. W.....405 S. Second St.
Spray, Page E.....316 Fourth St.
Stauffer, Walter A. (S).....701 Strong Ave.
Stout, Richard B.....1501 Greenleaf Blvd.
Stubbins, William M.....412 S. Second St.
Swihart, Danny D.....506 S. Second St.
Swihart, Homer R.....124 W. Marion St.
Swihart, Leonard F.....214 W. Marion St.
Wilson, Orley E.....217 N. Main St.
Work, James A., Jr. (S).....133 Monger Bldg.
Yoder, C. Richard.....603 Oakland

Goshen

Amstutz, Henry C.....112 W. High Park
Bartholomew, Mary L.....317 E. Lincoln
Bender, Cecil K.....320 S. Fifth St.
Bigler, Frederick W.....314 S. Fifth St.
Bosler, Howard A....Waterford Mills, mail Goshen
Bowser, Philip G.....107 S. Fifth St.
Chandler, Leon H.....Shoots Bldg.
Hostetler, Carl M.....304 E. Lincoln
Krabill, Willard S.....112 W. High St.
Martin, Floyd S.....127 E. Lincoln
Quilty, Thomas J.....112 E. Madison St.
Simmons, Lloyd H.....208 E. Lincoln
Troyer, Dana.....122 E. Clinton St.
Turner, John P.....115 E. Washington St.
Wagner, David G.....307 S. Seventh St.
Westfall, George S.....214 E. Lincoln St.
Yoder, Albert C. (S).....113 S. Fifth St.
Yoder, Jonathan G.....314 E. Lincoln
Young, Ralph H.....113 E. Madison

Massanari, Walter.....Millersburg
Miller, Donald G.....Middlebury
Teters, Melvin S.....Middlebury

Nappanee

Fleetwood, Raymond A. 357 N. Nappanee
Kendall, Forest M. 252 W. Market St.
Price, Douglas W. 162 E. Market St.
Roose, Lisle W. 357 N. Nappanee
Slabaugh, Jancy S. (S) 111 N. Main St.

De Fries, John J. New Paris
Abel, Robert Wakarusa
Guttman, John B. Wakarusa
Todd, David D. (S)
5835 Beaumont Ave., La Jolla, Calif.

FAYETTE-FRANKLIN COUNTIES

Brookville

Foreman, Walter A. 617 Main St.
Peters, Elmer E. 830 Main St.
Seal, Perry F. 901 N. Main St.
Smith, Herbert N. 812 Main St.
Truman, E. Michael 814 Main St.

Connersville

Dale, Maxwell H. 818 Grand
Ellis, George M. 108 E. 10th St.
Entner, Charles L. 716 Grand Ave.
Gregg, Albert F. 124 E. Sixth St.
Hudson, Arlington M. 20th at Indiana
Kemp, William A. 122 W. Seventh St.
Kerrigan, William F. 718 Central Ave.
Lockhart, Jack M. 520 Eastern Ave.
Mountain, Francis B. 930 Central Ave.
Neukamp, Frank H. 621 Central Ave.
Sanders, Bertram W. 1533 Virginia Ave.
Smelser, Herman W. 823 Central Ave.
Steinem, Joseph L. 812 Grand Ave.
Watterson, Gerald T. 1910 Virginia Ave.

Poston, Clement L. R. R. 2, Laurel

FLOYD COUNTY

Engleman, Harry K. (S) Georgetown

New Albany

Baker, Avey M. 811 E. Spring St.
Baxter, Samuel M. 1201 E. Spring St.
Briscoe, Clarence E. (S) 1413 E. Spring St.
Brown, Kenneth H. 410 E. Spring St.
Byrn, Howard W. (S) 415 Elsby Bldg.
Cannon, Daniel H. 1203 E. Spring St.
Davis, Parvin M. 601 E. Spring St.
Edwards, William F. Floyd County Bank Bldg.
Garner, William H. Jr. 919 E. Spring St.
Garner, William H. 919 E. Spring St.
Gentile, John P. 101 Adams St.
Geyer, Joseph Silvercrest Sanitarium
Harris, Robert W. 2652 Charlestown Rd.
Hauss, Augustus P. (S) 212 Elsby Bldg.
Hess, Paul P. Floyd Co. Bank Bldg.
Higgins, John R. 700 E. Spring St.
LaFollette, Donald 1000 E. Spring St.
LaFollette, Robert E. 1000 E. Spring St.
McCullough, James Y. 624 E. Spring St.
May, William D. Silvercrest Sanitarium
Paris, John M. 602 E. Spring St.
Pierce, Gene S. 1696 Garretson Lane
Robertson, Addis N. 820 E. Spring St.
Ruoff, William 1706 DePauw
Shelton, Clyde F. 601 E. Spring St.
Sloan, Herbert P. 1207 E. Spring St.
Sonne, Irvin S., Jr. 703 E. Spring St.
Streepey, Jefferson I. 1102 E. Spring St.
Tyler, Frank T. (S) Hausfeldt Lane
Voyles, Harry E. 213 Elsby Bldg.
Wallace, Elmer L. 1516 State St.
Weaver, William W. 1104 E. Spring St.
Wohlfeld, Gerald Silvercrest Sanitarium
Wolfe, Nelson 1117 E. Spring St.
Worley, Henry L. 1104 E. Spring St.

FOUNTAIN-WARREN COUNTIES

Attica

Fisher, John E. 217 S. Perry St.
Maris, Lee J. 201 Brady
Petrich, Peter R. 401 S. Perry St.
Raymundo, Vivencio F. 401 S. Perry St.

Hoffman, Max N. Covington
Humphrey, Edward M.
Olin Mathieson Corp., Covington
Stephens, Lowell R. Covington
Suzuki, Tsutomu T. Covington
Smith, Byron J. Kingman
McCord, Carl B. (S) Veedersburg
Person, Theodore C. Veedersburg
Rusk, Hubert M. Wallace
Nelson, Carl A. West Lebanon
Crain, James W. Williamsport
Leo, Renate G. Williamsport
Spinning, A. L. (S)
1563 S. Palm Canyon, Palm Springs, Calif.

FULTON COUNTY

Herrick, Charles L. Akron
Miller, Virgil C. Akron
Dielman, Franklin C. (S) Fulton
Kraning, Kenneth K. Kewanna

Rochester

Glackman, John C. (S) 912 Main St.
Guthrie, James U. 116 W. Ninth St.
Herendeen, Elbie V. 120 W. Ninth St.
Johnson, Frank P. 817 E. 9th St.
Richardson, Charles L. 121 W. Eighth St.
Rowe, Howard H. 705 Jefferson St.
Stinson, Dean K. 816 Main St.

GIBSON COUNTY

Geick, Raymond G. Fort Branch
Marchand, Edwin V. Haubstadt
Petitjean, Harold G. Haubstadt
Dye, William E. Oakland City
Ropp, Eldon R. Oakland City
Wood, Russell W. Oakland City
Geller, Samuel Owensville

Princeton

Brazelton, Osborne T. (S) 222 E. Clark
Carpentier, Harry F. 105 E. Broadway
Folck, John K. 115 N. Prince St.
Graves, Orville M. 117 S. Hart St.
McCarty, Virgil 113 S. Main St.
McElroy, Robert S. 116 S. Main St.
Peck, James F. 218 Broadway
Strickland, Karl S. (S) 230 W. Broadway
Weitzel, Roland 114 S. Hart St.

Chappell, Harold R. 604 Howard A.F.B.
Canal Zone

GRANT COUNTY

Grant, M. Arthur Fairmount
Yale, Charles A. Fairmount
Garrison, Leon J. Gas City
Koontz, William A. Gas City
Baskett, Russell J. Jonesboro

Marion

Abell, Charles F.....321 Marion Nat'l Bank Bldg.
Alderfer, Henry.....131 N. Washington St.
Ansbacher, Stefan (H).....R. R. 1
Ayres, Wendell W.....303 Glass Block
Bailey, Douglas A.....107 E. 31st St.
Bloom, Asa W.....724 W. Third St.
Boyer, Grace B.....605 Locust St.
Braunlin, Robert F...711 Marion Nat'l Bank Bldg.
Braunlin, William H. (S)
709-15 Marion Nat'l Bank Bldg.
Brown, Robert M.....520 Marion Nat'l Bank Bldg.
Comeau, William J.....Marion General Hosp.
Cunningham, Robert D.....510 Glass Block
Daniels, George R. (S).....106 N. E Street
Davis, Joseph B.....131 N. Washington St.
Davis, Merrill S.....131 N. Washington St.
Davis, Richard.....131 N. Washington St.
Diamond, Leo L.....413 Marion Nat'l Bank Bldg.
Dunbar, Fred.....Fisher Body Division
General Motors Corp.
Fisher, Henry.....1502 S. Washington St.
Ganz, Max.....930 S. Adams
Goldsmith, David A.....1225 Jeffras Ave.
Gustafson, Carl J.....Veterans Hospital
Hover, Galen M.....Veterans Hospital
Hummel, Russel M...317 Marion Nat'l Bank Bldg.
Jarrett, John C.....131 N. Washington St.
Lahr, Richard E.....1121 W. Third St.
Langrall, Harrison M. Jr....131 N. Washington St.
Lavengood, Russell W.....225 Glass Block
Long, Max R.....803 S. Boots St.
Lonngren, Dudley H.....131 N. Washington St.
Love, V. Logan.....131 N. Washington St.
Miller, H. Allison.....320 Glass Block
Oatman, Jack G.....131 N. Washington St.
Pattison, John D.....131 N. Washington St.
Powell, J. Paxton.....501 Glass Block
Price, Ambrose M.....309½ Adams St.
Renbarger, Lester L.....1531 W. Second
Rhamy, Arthur P.....506 Glass Block
Rhorer, John G.....201 S. D St.
Schroeder, Robert W.....317 N. Western Ave.
Shoemaker, Richard L.....211 E. South St. A
Simmons, Frederick H.....1009 N. Baldwin
Skomp, Claud E. ...302 Marion Nat'l Bank Bldg.
Smith, Barton T.....131 N. Washington St.
Snowhite, Arthur B.....311 Glass Block
Thompson, B. Jay.....Marion General Hosp.
Warren, Carroll B.....511 Glass Block
Weinberg, Samuel.....104 W. Third St.
Wojcik, Ladislas D.....131 N. Washington St.
Woodbury, John W.....131 N. Washington St.
Young, Robert G.....2927 S. Washington St.

Beck, Thomas A.....Swayzee
Taylor, Everett C.....Upland
Rifner, Eugene S.....Van Buren
Breedlove, Dane.....3308 D. Middlesex, Dr.
Toledo, Ohio

GREENE COUNTY

Bloomfield

Graf, Jerome A.....Bloomfield
Mount, Mathias S.....55 N. Franklin St.
Turner, Harold B.....8 East Main St.
Turner, Jack J.....8 East Main St.
Van Sandt, Frank A. (S).....110½ E. Main St.

Porter, Carl M.....Jasonville
Rotman, Harry G.....Jasonville
Rotman, Sam I.....Jasonville
Bailey, Edwin B.....129 E. Vincennes, Linton
Broshears, Kenneth P...129 E. Vincennes, Linton
Craft, William F. (S).....Linton
Raney, Ben B.....129 E. Vincennes, Linton
Tomak, Milton E.....289 N. Main St., Linton
Woner, John W.....Linton
Hamilton, M. Luther (S).....Newberry
Moses, George E.....Worthington
Moses, Robert E.....Worthington

HAMILTON COUNTY

Karlick, Joseph.....Arcadia
McDaniel, Franklin P. (S).....Atlanta
Donahue, Claude M.....Carmel
Thomas, W. Clayton.....Carmel
Havens, Oscar.....Cicero

Noblesville

Ambrose, Jesse C.....298 N. Ninth Street
Campbell, Sam W.....952 Maple St.
Harris, Robert F.....120 N. 11th St.
Hash, John S.....139 S. 10th St.
Haywood, John G.....120 N. 11th St.
Lanning, R. Adrian.....10th and North Dr.
Lloyd, Joe R.....148 N. 9th St.
Shanks, Ray W.....104 S. 10th St.
Shonk, Harold W.....1084 Clinton St.
Smith, Charles F.....23 N. 10th St.

Griffith, James W.....Sheridan
Newby, Eugene.....Sheridan
Reck, John L. (S).....Sheridan
Waitt, Paul M.....Sheridan
Connoy, Andrew F.....Westfield
Connoy, Leo F.....Westfield

HANCOCK COUNTY

Scott, Robert S.....Charlottesville
Ferrell, Mars B.....Fortville
Manifold, Harold W.....Fortville
Navin, Hugh K.....Fortville

Greenfield

Beeson, Wilbur.....114 N. State St.
Endicott, Wayne.....940 N. State St.
Farrell, John J., Jr.....1001 N. State St.
Gibbs, Charles M. (S).....203 E. North St.
Gill, Dee D.....1001 N. State St.
Henn, R. Anthony.....211 W. Main St.
Hunter, Donn.....10 W. Boyd
Kinneman, Robert E.....114 N. State St.
Kirby, Ted C.....114 N. State St.
Smith, John H.....744 N. State St.
Vingis, Bronie.....746 N. State
Woods, James R., Jr.....11 N. State St.

Cagle, Bob R.....New Palestine
Larrabee, William H. (S).....New Palestine
Pierson, Thomas A.....New Palestine
Kuhn, Robert W.....Wilkinson

HARRISON-CRAWFORD COUNTIES

Corydon

Amy, William E. (S).....120 S. Capitol
Blessinger, Louis H.....738 N. Capitol
Brockman, Wilfred.....439 E. Chestnut St.
Dillman, Carl E.....Beaver & Oak Sts.
Dukes, David J.....439 E. Chestnut St.
Jordan, Richard A.....Harrison Dr.
Martin, Samuel W.....R.R. 1

Baker, Guy D (S).....Crandall
Gobbel, Novy E.....English
Seipel, Stanley.....Lanesville
Benz, Jesse (S).....Marengo
Lynch, Otis R.....Marengo
Mathys, Alfred (S).....Mauckport
Johnson, Jerome M.....Palmyra

HENDRICKS COUNTY

Foltz, Lloyd E. Brownsburg
Scudder, Arthur N. Brownsburg
Ellett, John, Jr. Coatesville

Danville

Hibner, Kermit 25 W. Marion St.
Kirtley, Robert W. 138 W. Marion St.
Koch, Elmer L. 201 E. Columbia St.
Southard, James E. 138 W. Marion St.
Terry, Lloyd 138 W. Marion St.

Ellis, Lyman H. Lizton
Wiseheart, Oscar H. (S) North Salem
Scamahorn, Malcolm O. Pittsboro
Scamahorn, Oscar T. (S) Pittsboro

Plainfield

Aiken, Milo M. 140 N. Center St.
Cohen, Irving 115 E. Main St.
Haggard, David B. 119 S. Carr Road
Johnston, Alan 115 E. Main St.
Stafford, James C. (S) 107 W. Main St.
Stafford, William C. 107 W. Main St.

Frantz, Mount E.
3530th USAF Hosp., Bryan AFB, Texas

HENRY COUNTY

McNabb, Richard C. Knightstown
Wiatt, Leonard Knightstown
Scheetz, Marion R. Lewisville
Arford, Roxford D. (S) Middletown
Hammer, Jay W. Middletown
Stauffer, George E. Mooreland
Marshall, Lloyd C. (S) Mt. Summit

New Castle

Amos, Robert L. 1219½ Race St.
Bledsoe, James G. 319 S. 14th St.
Burnett, Arthur B. 106 N. Main St.
Craig, Alexander F. M R 13, Crescent Dr.
Davies, Robert 1319 Church St.
Dyken, Mark L. New Castle State Hosp.
Fisher, John E. 540A S. Main St.
Foster, Ray T. 1215 Race St.
Grant, Phyllis New Castle State Hosp.
Harrison, Benjamin L. 118 Jennings Bldg.
Heilman, William C. 1319 Church St.
Heilman, William C., Jr. 1319 Church St.
Hill, Kenneth G. 1319 Church St.
Iterman, George E. (S) 1319 Church St.
Kennedy, Walter U. 208 Union Block
Life, Homer L. 101 S. 11th St.
McDonald, Frank C. 527 S. Main St.
McElroy, James S. 1319 Church St.
McGee, Robert R. 527 S. Main St.
McKee, Roy G. 319 S. 14th St.
Murray, William E. New Castle State Hosp.
Saint, William K. 1219½ Race St.
Smith, Mark E. 1319 Church St.
Steussy, Calvin, N. Henry Co. Hospital
Stout, Walter M. 1319 Church St.
Thorne, Charles E. 200 N. 12th St.
Tully, John A. (S) 502 S. Main St.
Vivian, Donald E. Henry County Hospital
Wiggins, Dulania S. (S) 219 S. 12th St.

Robertson, William S. Spiceland
Canaday, Clifford E. (S) ... 453 Meadowcrest Circle
Memphis 17, Tenn.

HOWARD COUNTY

Denton, Larkin D. Greentown
Shoup, Homer B. Greentown

Kokomo

Alward, John H. 321 W. Walnut St.
Artis, Myrle E. 107½ S. Union St.
Ault, Carl H. 421 W. North St.
Behn, Walter M., Jr. 1208 Highland Drive
Boughman, Joe D. 2008 W. Sycamore
Bowers, Copeland C. 210 W. Mulberry St.
Bowers, Garvey B. 210 W. Mulberry St.
Bowers, John A. 210 W. Mulberry St.
Bruegge, Theodore J. 2108 W. Sycamore
Cattell, Lee M. 214 E. Mulberry St.
Clarke, Elton R. 304 W. Taylor St.
Conley, Thomas M. 520 Union Bank Bldg.
Craig, Reuben A. 514 W. Superior St.
Craig, Reuben 514 W. Superior St.
Crawford, Theodore R. 2108 W. Sycamore St.
Earl, Max M. 409 W. Taylor St.
Ferry, Paul W. 406 Union Bank Bldg.
Fretz, Richard C. 215 W. Superior St.
Golper, Marvin N. 1907 W. Sycamore St.
Good, Richard P. 308 Armstrong-Landon Bldg.
Halfast, Richard W. 214 E. Mulberry St.
Hoyt, John M. 1017 S. Delphos
Hutto, William H. 215 W. Superior St.
Jewell, George M. 508 Armstrong-Landon Bldg.
Knepple, LaMarr R. (S) 534 W. Sycamore St.
Kremers, George A. 522 Armstrong-Landon Bldg.
McClure, Warren N. 407 W. Taylor St.
McIndoo, Ralph E. 313 W. Taylor St.
Mendelson, Stanley M. 117 W. Markland
Michael, Robert L. 321 W. Walnut St.
Morrison, William R. 504 Union Bank Bldg.
Murray, Ernest C. 501 N. Washington St.
Paris, Durward W. 614 Armstrong-Landon Bldg.
Perkins, Powell L. 2112 W. Sycamore
Phares, Robert W. 905 W. Mulberry St.
Prather, Philip E. 909 S. Courtland
Ramey, John W. 107½ S. Union St.
Rhorer, Herbert M. 210 W. Mulberry St.
Rudicel, Max 1907 W. Sycamore St.
Schwartz, Frederick C. 2016 W. Sycamore
Shenk, Earl M. 208½ N. Main St.
Smith, Gloster J. 105½ E. Sycamore St.
Sorenson, Raymond 522 Armstrong-Landon Bldg.
Spangler, Jesse S. 215 E. Taylor St.
Taraba, Ralph W. 2520 W. Sycamore St.
Trimble, John G. 116 S. Buckeye St.
Wachob, Tom W., Jr.
406 Armstrong-Landon Bldg.
Wible, James H. 2112 W. Sycamore St.

Miller, Arthur H. (S) Russiaville

HUNTINGTON COUNTY

Huntington

Brubaker, Harold S. 42 W. Park Dr.
Casey, Stanley M. 408 E. Market St.
Clunie, William A. 323 W. Park Dr.
Cope, Stanton E. 1022 N. Jefferson St.
Erehart, Mark G. 232 W. Market St.
Eviston, John B. 34 E. Washington St.
Gray, Paul M. 340 E. Market St.
Grayston, Wallace S. (S) 303 E. Market St.
James, Thomas, Jr. 202 U. B. Publishing Bldg.
Johnston, Robert G. (S) 339 E. Market St.
Marks, Howard H. 248 W. Park Dr.
Meiser, Robert D. 612 N. Jefferson St.
Mitman, Floyd B. 210 W. Park Dr.
Nie, Grover M. (S) 650 Cherry St.
Omstead, Trevalyn W. 231 Vine St.
Thompson, Frank M. 818 W. Park Dr.
Wagner, Richard 1355 Guilford

Woods, Halden C. Markle
Cooper, B. Trent Roanoke
Bennett, J. B. Warren

Eby, Ida L. (S) Methodist Home, Warren
McIlwain, Eleanor E. Methodist Home, Warren
McIlwain, Robert E. Methodist Home, Warren
Webb, Lawrence C. Warren

JACKSON COUNTY

Cummings, David J. (S) Brownstown
Gillespie, Garland R. Brownstown
Shields, Jack E. Brownstown
Adair, William K. (S) Crothersville
Bard, Frank B. Crothersville
Butler, Joe B. Crothersville
Scharbrough, William Medora

Seymour

Baxter, Harry R. 326 N. Walnut St.
Black, Joe M. 502 W. Second St.
Bobb, Kenneth E. 311 Lee Blvd.
Bosch, Ralph 635 W. Second St.
Day, William D. C. 510 W. Sixth St.
Graessle, Harold P. 304 W. Second St.
Martin, Guy 105 N. Walnut St.
Miller, Harold E. Vehslage Bldg.
Osterman, Louis H. 315 S. Second St.
Ripley, John W. 321 Bruce St.
Templeton, Ian S. 402 W. Bruce St.
Wiethoff, Clifford A. 215 W. Second St.

JASPER-NEWTON COUNTIES

Schoonveld, Arthur Brook
Lee, Robert L. De Motte
Parker, John C. Goodland
Kresler, Leon E. Kentland
Yegerlehner, Roscoe S. Kentland
Brady, Kingdon Morocco
Hartsough, Ralph I. Remington
Schantz, Richard Remington
Beaver, Ernest R. Rensselaer
Greene, Robert W. Rensselaer
Johnson, Cecil E. Rensselaer
O'Brien, Francis E. Rensselaer
Ockerman, Kenneth R. Rensselaer
Williams, Earl K. Rensselaer

Gwin, Merle D. (S)
2111 Regatta Ave., Miami Beach, Fla.

JAY COUNTY

Girod, Donald A. Dunkirk
Heller, Nelson L. R. (S) Dunkirk
Shroyer, Herbert Dunkirk
Tate, Elizabeth Dunkirk
Hiestand, Harley J. (S) Pennville
Albert, Harold F. Red Key

Portland

Badders, Ara C. 226 W. Main St.
Cring, George V. (S) 210 W. Walnut St.
Cripe, William 116 W. Walnut St.
Fitzpatrick, James S. 603 W. Arch St.
Gillum, Eugene M. Main and Meridian Sts.
Hammond, Stanley M. Weiler Bldg.
Keeling, Forrest E. 504 W. Arch St.
Lyon, Florence M. 127 E. North St.
Moran, Mark M. (S) Portland
Morrison, George C. Weiler Bldg.
Schenck, Ralph E. 603 W. Arch St.
Spahr, Donald E. 615 W. Race St.
Steffy, Ralph M. 116 W. Walnut St.

JEFFERSON-SWITZERLAND COUNTIES

Madison

Alcorn, Merritt O., Jr. 428 E. Main St.
Beetem, Luther F. 425 W. Main St.
Childs, A. G. W. (S) 412 E. Main St.
Childs, Wallace E. 412 E. Main St.
Davis, Lloyd H. Madison State Hospital
Fong, Theodore C. C. Madison State Hospital
Haney, William 104 E. Third St.
Hare, Francis W., Jr. 722 W. Main St.
Jolly, Lewis E. 722 W. Main St.
King, Peter D. Madison State Hospital
May, George A. 426 E. Main St.
McAtee, Ott B. Madison State Hospital
Modisett, Jackson W. 722 W. Main St.
Modisett, Marcella S. 722 W. Main St.
Moore, Martha Madison State Hospital
Pratt, Ralph M., Jr. 806 W. Main St.
Prenatt, Francis Madison State Hospital
Shuck, William A. Odd Fellows Bldg.
Sloan, W. Keith 428 E. Main St.
Turner, Anna Goss 104 E. Third St.
Turner, Oscar A. (S) 602 E. Second St.
Whitsitt, Schuyler A. (S) 722 W. Main St.
Zink, Robert O. 722 W. Main St.

Bear, Lowery H. (S) Vevay
Graves, Noel S. Vevay
Hamilton, Antha A. Vevay
Hamilton, Guy W. (S) Box 144, Durati, Calif.

JENNINGS COUNTY

Dagley, H. R. Box 370, Butlerville
Easter, James N.
Muscatatuck State School, Butlerville
Guthrie, William H. Box 30, Butlerville
Hingeley, John E.
Muscatatuck State School, Butlerville

North Vernon

Berkshire, Shaffer B. Medical Center
Calli, Louis 408 S. State St.
Green, John H. (S) 202 E. Walnut St.
Johnson, William A. 45 N. Madison Ave.
Matthews, Dennis W. (S) North Vernon
Thayer, Benet W. 25 S. Jackson St.

JOHNSON COUNTY

Gammell, Lindley L. .. 118 S. Holland St., Edinburg
Libbert, Edwin L. 118 S. Holland St., Edinburg
Lutes, David L. (S) .. 303 S. Walnut St., Edinburg

Franklin

Andrews, Hugh K. 176 E. Jefferson St.
Bullers, Robert C. 551 Center St.
Bullington, George E. 251 E. Jefferson St.
Deppe, Charles F. 301 E. Jefferson St.
Ferrara, Joseph F. 25 E. Madison St.
Foster, Robert 301 E. Jefferson St.
Jones, Charles A. 251 E. Jefferson St.
Mock, Harry E. Jr. 201 E. Monroe St.
Murphy, Harry E. 150 N. Main St.
Portteus, Walter L. 1551 N. Main St.
Province, Oran A. 100 N. Main St.
Province, William D. 100 N. Main St.
Records, Arthur W. 198 E. Jefferson St.
Ritteman, George W. .. Johnson Co. Memorial Hosp.
Stogsdill, Willis W. 176 E. Jefferson St.
Walters, Jack 1551 N. Main St.
Waymire, William 1551 N. Main St.

Greenwood

Barnes, Helen Beall 201½ W. Pearl St.
Brown, George E. 400 S. Madison Ave.
Chambers, Pauline D. 360 S. Madison Ave.
Onyett, Harold R. Smith Valley Rd.

Sheek, Kenneth I. 188 Madison Ave.
Snodgrass, Robert E. 360 S. Madison Ave.
Tiley, George A. 41 N. Madison Ave.
Woodcock, Charles E. (S) 224 S. Madison Ave.

Machledt, John H. Whiteland

KNOX COUNTY

Bicknell

Byrne, Robert J. 517 N. Main St.
Meade, Walter W. 403 N. Main St.
Shanklin, Jack L. 417 N. Main St.
Wilson, Guy H. 120 W. Third St.

Springstun, George H. Oaktown

Vincennes

Anderson, John B. 301 LaPlante Bldg.
Anderson, Richard M. 301 LaPlante Bldg.
Arbogast, Paul B. 915 Main St.
Barrett, Thomas L. 1019 Dubois St.
Bartlett, Donald T. 429 S. Sixth St.
Beckes, Ellsworth W. 220 N. Fifth St.
Black, Boyd K. Good Samaritan Hospital
Chattin, Herbert O. 729 Main St.
Coffel, Melvin H. 424 LaPlante Bldg.
Corsentino, Bart Good Samaritan Hospital
Curtner, Myron L. 222 N. Sixth St.
Edwards, Edward T., Jr. 1045 Washington Ave.
Ewing, Nathaniel D. 14 N. Third St.
Green, Carl L. 1004 Main St.
Hendrix, Charles E. 603 Busseron
Hoffman, Doris 720 Perry St.
Humphreys, Joe E. 1516 N. Second St.
Jones, John G. (S) 210 N. Third St.
McCormick, Hubert D. (S) 325 LaPlante Bldg.
McDowell, Mordecai M. 611 Dubois St.
McMahan, Virgil C. 609 Dubois St.
Moore, Robert G. 21 N. Third St.
Nichols, Robert J. 605 Busseron St.
Reilly, James F. 401 Buntin St.
Richards, David H. (S) 904 Busseron
Schulze, William 810 Buntin St.
Shaffer, Kenneth L. 404 LaPlante Bldg.
Smith, Ralph O. 603 Busseron
Smith, S. Joseph 301 LaPlante Bldg.
Spencer, Frederic 429 S. Sixth St.
Stein, Richard H. 1304 E. St. Clair St.
Stewart, J. Frank W. Hillcrest Hospital
Sullenger, Adron A. 605 Busseron
Vaughn, Walter R. 615 Dubois St.
von der Lieth, William C. 14 N. Third St.
Welch, Norbert M. 615 Dubois St.

KOSCIUSKO COUNTY

Murphy, Harold O. Claypool
Bahler, Dean R. Leesburg
Urschel, Dan L. Mentone
Wilson, Wymond B. Mentone
Hursey, Virgil G. Milford
Rheinheimer, Floyd L. Milford
Stalter, Gaylord W. North Webster
Mishler, Joseph B. Pierceton
Pierson, Pearl H. Silver Lake
Craig, Robert A. Syracuse
Fosbrink, Ephraim L. Syracuse

Warsaw

Arford, John E. 1319 E. Center St.
Bibler, Richard H. 600 E. Winona Ave.
Cron, William J. 215 S. High St.
Dormire, Robert D. 600 E. Winona Ave.
DuBois, Charles C. (S) 800 E. Center St.
Hashemi, Hossein Murphy Medical Center
Hillery, John 212 S. Indiana
Johnson, John J. Court House
Richer, Orville H. 212 E. Market St.
Schlemmer, George H. Murphy Medical Center
Shrader, Carl E. 600 E. Winona Ave.
Thomas, Everett W. 212 S. Indiana

LAGRANGE COUNTY

Wade, Alfred A. (S) Howe
Yunker, Philip E. Howe

LaGrange

Benedict, Charles D. 203 W. Wayne St.
Flannigan, Harley F. 213 W. Lafayette
Studebaker, Lloyd R. 219 S. Sherman
Weir, Dale 220 S. Poplar

Williams, John H. Shipshewana
Lehman, Kenneth M. Topeka

LAKE COUNTY

King, Robert W. Cedar Lake
Miller, Donald C. Cedar Lake
Misch, William Cedar Lake

Crown Point

Amico, Pasquale J. Lake County Tuberculosis San.
Becker, Philip H. Lake County Tuberculosis San.
Bernoske, Daniel G. Co. Health Department
Birdzell, John P. 124 N. Main St.
Carroll, Mary E. 124 N. Main St.
Dhein, Donald T. R.R. 5, Box 495
Doherty, Raymond J. R. R. 5, Box 495
DuSold, Donald D. 306 E. Joliet
Gray, Daniel E. 182 W. North St.
Gutierrez, Peter E. 123 N. Court St.
Horst, William N. 123 N. Court St.
Martirez, Napoleon A.
Lake County Tuberculosis Sanitarium
Russo, Andrew E. 224 S. Court St.
Steele, Everett B. 124 N. Main St.
Troutwine, William R. 224 S. Court

Theobald, Sterling 212 Joliet St., Dyer

East Chicago

Angel, Virgil E. 4712 Magoun
Bacevich, Andrew J. 3406 Guthrie St.
Balingit, Bienvenido L. Inland Steel Co.
Barron, Elmer A. 3406 Guthrie St.
Beam, Vernon B. 5215 Kennedy Ave.
Beilke, Clifford A. 815 W. Chicago Ave.
Benchik, Frank A. 4712 Magoun Ave.
Bonaventura, Angelo P. 3701 Main St.
Boyd, Charles S. 4739 Melville Ave.
Boys, Fay F. 4712 Magoun Ave.
Braun, Benjamin D. St. Catherine's Hospital
Broomes, Edward L. C. 2301 Broadway
Bryant, Edward G. 2220 Broadway
Callahan, Richard H. 3704 Main St.
Campagna, Ettro A. 3406 Guthrie St.
Claybourn, Norman L. 3210 Watling St.
Dainko, Alfred J. 823 W. Chicago Ave.
De Bois, Elon 2220 Broadway
Fadul, Armand 4035 Elm
Fleischer, Jacob C. 4035 Elm St.
Gardiner, H. Glenn 3210 Watling
Geronimo, Manuel M. 3502 Main St.
Geronimo, Rita R. V. 3502 Main St.
Govorchin, Alexander 724 W. Chicago Ave.
Grosso, William G. 1919 E. Columbus Dr.
Hayes, Frank W. 4742 Melville Ave.
Hayes, Jesse D. 4804 Alexander
Hernandez, I. C. 3701 Main St.
Irish, Wilbur J. 806 W. Chicago Ave.
Johns, David R. (S) 1211 Beacon St.
Kamen, Jack M. 3406 Guthrie St.
Kmak, Chester 3701 Main St.
Komoroske, John E. 823 W. Chicago Ave.
Kopanko, Bernard F. 823 W. Chicago Ave.
Levin, Eli 4105 Grand Blvd.

Llamas, Dominardor F. 2501 Deodar Ave.
McGauvran, Theodore 3406 Guthrie
McGuire, Desmond F. (S) 3429 Michigan Ave.
Madlang, R. M. 3406 Guthrie
Marks, Ora L. 815 W. Chicago Ave.
Marquinez, Adoracin A. St. Catherine's Hospital
Nicosia, John B. 3701 Main St.
Payne, Arthur C. 2020 Broadway
Sazama, Francis J. Inland Steel Co.
Shapiro, Joseph 3738 Main St.
Shapiro, Seymour W. 3738 Main St.
Shulruff, Harry I. 3701 Main St.
Teegarden, Joseph A., Jr. 1919 E. Columbus Dr.
Teegarden, Joseph A. (S) 1919 E. Columbus Dr.
Teplinsky, Louis L. 3701 Main St.
Thegze, George A. 4712 Magoun Ave.
Trepagnier, Francis B. 3700 Main St.
Vore, Hugh A. Inland Steel Co.
Walker, William G. 3406 E. Guthrie St.
Zallen, Stanley G. 720 W. Chicago Ave.
Zivich, J. M. 3701 Main St.

Gary

Abramson, Allan L. 3290 Grant St.
Agana, Adriano 746 Harrison
Alfano, Paul A. 2717 Wabash
Almquist, Carl O. 504 Broadway
Angeles, Uldarico A. 504 Broadway
Armalavage, Leon J. 2620 W. Fifth Ave.
Atienza, Rizalino T. Mercy Hospital
Baitinger, Herbert M. 504 Broadway
Barton, Reginald R. 427 S. Lake
Behn, Walter M. 504 Broadway
Bendler, Carl H. 3290 Grant St.
Bergal, Milton B. 757 Broadway
Bernard, Marvin R. 2717 Wabash St.
Bills, Robert N. 504 Broadway
Bisgyer, Jay L. 400 Broadway
Black, Charles E. 2620 W. Fifth Ave.
Boardman, Carl (S) 630 Buchanan St.
Borak, Walter J. 6151 W. 25th Ave.
Borenstein, Herschel 3290 Grant
Brady, Samuel G. 757 Broadway
Brandman, Harry 504 Broadway
Brauer, Abraham B. 8124 Locust St.
Brincko, John 504 Broadway
Brink, Calvin C. (S) 504 Broadway
Bringas, Irineo B. 858 Broadway
Brown, David B. 504 Broadway
Brown, Jesse F. Methodist Hospital
Brown, Leo R. 4645 Broadway
Bullard, Mattie J. 620 E. Tenth Place
Burcham, James B. 738 Broadway
Burger, Robert A. Methodist Hospital
Carberry, George A. 3656 Grant St.
Carbone, Joseph A. 504 Broadway
Carey, J. Albert 1901 Broadway
Carmody, Raymond F. 504 Broadway
Chevigny, Julius J. 504 Broadway
Chube, David D. 1649 Broadway
Collins, Le Roy 2287 W. 15th St.
Cooper, Leo K. 504 Broadway
Corrao, Gaetano 2471 Colfax
Danieleski, Ladislaus J. 738 Broadway
Darling, Dorothy 1600 W. Sixth Ave.
Davis, Neal 1600 W. Sixth Ave.
Dian, August J. 504 Broadway
Dian, Julia K. 584 Garfield
Dierolf, Edward J. 504 Broadway
Donchess, Joseph C. 215 Broadway
Doneff, Ronald H. Mercy Hospital
Duncan, John S. 2165 W. 11th St.
Elliott, Ralph A. 504 Broadway
English, Hubert M. 673 Broadway
Espy, Theodore R. 1901 Broadway
Fadell, Matthew J. 4655 Broadway
Franklin, Philip L. 936 W. 5th Ave.
Fukumoto, Richard I. Methodist Hospital
Galante, Vincent J. St. Mary Mercy Hospital
Gallinatti, John J. 401 S. Lake St.
Gannon, George W. (S) 602 Broadway
Glover, William J. 504 Broadway
Goldberg, Harold B. 3656 Grant
Golding, Robert F. Mercy Hospital
Goldstone, Adolph 3229 Broadway
Goldstone, Joseph 3229 Broadway
Goldstone, Sidney R. 3233 Broadway
Grant, Benjamin F. 1706 Broadway
Gregoline, Amadeo F. 729 Broadway
Griem, Sylvia F. 504 Broadway
Griffin, Joseph P. 504 Broadway
Harper, James W. 2301 Broadway
Hayes, J. D., Jr. 633 East 21st St.
Hedrick, James T. 1649 Washington St.
Hodurski, Zigfield 4319 Broadway
Hoit, Leonard 504 Broadway
Jahns, Albin A. 504 Broadway
Jannasch, Maurice C. 2717 Wabash Ave.
Johnson, Arnold L. 1903 Broadway
Johnson, Lonnie B. 123 W. 21st St.
Jordan, Stanley Y. 3807 Washington St.
Kendrick, Frank J. 504 Broadway
Khaton, Odessa M. 1649 Broadway
Kobrin, Meyer W. 3229 Broadway
Kolettis, John G. 708 Broadway
Kopcha, Joseph E. 504 Broadway
Korn, Jerome M. 3290 Grant St.
Kyle, Michael A. Methodist Hospital
Lazo, Vicente R. 756 Broadway
Lebioda, Henry S. 4655 Broadway
Lewis, George N. 504 Broadway
Lipschutz, Harold 504 Broadway
Lipsey, Alfred J. 504 Broadway
Loh, Hwei Ya (Chang) Methodist Hospital
Loh, Wei-Ping 1600 W. Sixth Ave.
Lorenty, Thaddeus B. 504 Broadway
Lovell, Martin H. 1606 Broadway
Lutz, Georgianna 504 Broadway
McMath, Samuel B. 1649 Broadway
Majsterek, Stanley L. 1034 Aetna St.
Manalo, Francisco M. Mercy Hospital
Mangan, Frank P. 3807 Washington
Marcus, Morris C. 3229 Broadway
Marshall, Millard R. 504 Broadway
Mather, J. Winford 2250 Ripley St., East Gary
May, Richard M. 583 Broadway
Miller, Kenneth D. Methodist Hospital
Milos, Robert J. 504 Broadway
Minczewski, Richard C. 517 Marshall St.
Molengraft, Cornelius J. 504 Broadway
Moore, E. Gregory 2367 Madison
Moore, Edwin G. 1606 Broadway
Morris, Hyman 504 Broadway
Moswin, Jack A. 504 Broadway
Nelson, Walfred A. 559 S. Lake St.
Nilges, Richard G. 2717 Wabash Ave.
Ornelas, Joseph P. 3656 Grant St.
Palmer, Russell H. 2006 W. 4th Place
Pappas, Eddie T. 2717 Wabash Ave.
Parratt, Louis W. 708 Broadway
Penn, Robert A. 3792 Central Ave., East Gary
Poracky, Bernard F. 504 Broadway
Pruitt, J. Edward 4119 Broadway
Ranck, Benjamin 5313 E. 11th St.
Rau, Charles A. Methodist Hospital
Reynolds, James S. 504 Broadway
Rhamy, Donald 5248 E. 11th St.
Richter, Samuel 504 Broadway
Robinson, Walter K. 504 Broadway
Rohrer, Bryce B. Methodist Hospital
Rosenbloom, Philip J. 571 Lincoln St.
Roth, Leo 7033 E. First Ave.
Roth, Melvin I. 757 Broadway
Rubin, Simon S. 504 Broadway
Ryan, Hubert J. 504 Broadway
Sala, Joseph J. 2705 Wabash
Sala, Walter R. 2705 Wabash
Schulz, Kurt J. 4655 Broadway
Scully, John T. 504 Broadway

Senese, Thomas J. 504 Broadway
Shellhouse, Michael 3811 Washington St.
Shevick, Alexander 504 Broadway
Slama, George F. 4481 Broadway
Slama, John T. 4481 Broadway
Spellman, Frank W. 401 S. Lake
Spivack, Mary 504 Broadway
Sponder, Joseph (S) 1512 Broadway
Stimson, Harry R. 504 Broadway
Stoycoff, Christ M. (S) 844 Broadway
Thomas, Daniel D. 3290 Grant St.
Thomas, Gerald J. 504 Broadway
Trinosky, Frank G. 504 Broadway
Turgi, Robert W. 504 Broadway
Valencia, M. M. 2421 Walnut St., East Gary
Verplank, Grover L. (S) 527 Broadway
Voorhies, McKinley 1606 Broadway
Vye, James P. 607 Broadway
Walters, Eleanore 9 W. 6th Ave.
Washington, G. Kenneth 1649 Broadway
Weiskopf, Henry S. 504 Broadway
Wharton, Russell O. (S) 6559 Ash Place
Williams, Alexander S. 436 W. 25th St.
Williams, Edwin D. 436 W. 25th St.
Williams, Fred 809 W. 25th Avenue
Wimmer, Robert N. (S) 9 W. Sixth St.
Woodall, Robert Methodist Hospital
Yast, Charles J. 504 Broadway
Yocum, Paul S., Jr. 757 Broadway
Yocum, Paul S. 757 Broadway
Yocum, William S. 790 Broadway
Young, George M. 3656 Grant St.
Young, Robert L. 504 Broadway
Zucker, Edward 504 Broadway

Griffith

Hazinski, Robert T. 401 N. Broad
Lundeberg, Ralph A. 109 N. Broad
Purcell, Richard J. 145 N. Griffith
Siekierski, Joseph M. 145 N. Griffith

Hammond

Allegretti, Michael L. 6850 Hohman Ave.
Arbeiter, Herbert I. 5231 Hohman Ave.
Arrowsmith, James L. 5231 Hohman Ave.
Bakos, Edward R. 7016 Indianapolis Blvd.
Beconovich, Robert 6850 Hohman Ave.
Bethea, Dennis A. (S) 1021 Fields St.
Bombar, Leslie E. 6850 Hohman Ave.
Chael, Thomas C. 6850 Hohman Ave.
Chidlaw, Benjamin W. (S) 29 Wildwood Rd.
Clancy, James F. 6219 Hohman Ave.
Costello, Albert J. 30 Douglas St.
Cotter, Edward R. 2415 169th St.
Davis, Alice Hall (S) 264 Highland St.
Davis, Thomas N. III 5246 Hohman Ave.
Eggers, Ernest L. (S) 5141 Hohman Ave.
Eggers, Henry W. 30 Douglas St.
Egnatz, Nicholas 820 Highland
Elledge, Ray 6415 Forest Ave.
Fischer, Burnell 5217 Hohman Ave.
Fitzpatrick, William J. 30 Douglas St.
Foster, Douglas L. 236 169th St.
Fox, Jack 1130 Conkey St.
Friedman, Isadore E. 7217 Indianapolis Blvd.
Gevirtz, Milton B. 6850 Hohman Ave.
Hickman, A. Lee 7127 Indianapolis Blvd.
Hofmann, Andrew (S) 445 State St.
Hopkins, Joseph R. 5231 Hohman Ave.
Howard, William Harry 5231 Hohman Ave.
Husted, Robert G. 6850 Hohman Ave.
Johnston, John M. 6429 Kennedy
Jones, Eli S. 30 Douglas St.
Kenney, Francis D. 30 Douglas St.
Kolanko, Leon A. 30 Douglas St.
Koransky, David S. 7217 Indianapolis Blvd.
Kuhn, Arthur J. 112 Rimbach St.
Kuhn, Hedwig S. 112 Rimbach St.
LaFollette, Forrest R. 7016 Indianapolis Blvd.
Larrabee, James F. St. Margaret's Hospital
Lautz, Herbert A. 112 Rimbach St.
Long, Keith 30 Douglas St.
McVey, Clarence A. 5231 Hohman Ave.
Mansueto, Mario D. 5231 Hohman Ave.
Marcus, Emanuel 7127 Indianapolis Blvd.
Marks, Salvo P. 30 Douglas St.
Mason, Richard L. 132 Rimbach St.
Matthews, Charles B. (S) 6416 Forrest Ave.
Mintz, Alfred M. 5217 Hohman Ave.
Modjeski, Joseph R. 5451½ Hohman Ave.
Morrison, Lindsey (S) 109 Rimbach St.
Neal, Leonard W. 6850 Hohman Ave.
Nodinger, Louis 540 165th St.
Panares, Solomon V. 5434 Hohman Ave.
Peck, Edward A. 430 Conkey St.
Peiffer, Geraldine M. 421 Hoffman St.
Pilot, Jean 5231 Hohman Ave.
Premuda, Franklin F. 6727 Kennedy Ave.
Ramker, Daniel T. 7040 Kennedy Ave.
Rasch, George C., Jr. 8148 Calumet
Rawlins, Carolyn M. 6223 Hohman Ave.
Remich, Antone C. 30 Douglas St.
Rendel, Donald T. 5231 Hohman Ave.
Rhind, Alexander W. 5145 Hohman Ave.
Rosenthal, Carl St. Margaret's Hospital
Rosevear, Henry J. 30 Douglas St.
Row, Perrie Q. 7217 Indianapolis Blvd.
Rubright, Robert L. 6850 Hohman Ave.
Rudolph, Franklin G. 5231 Hohman Ave.
Santare, Vincent J. 5231 Hohman Ave.
Santiago, Carmen 5217 Hohman Ave.
Sargent, Wallace B. 112 Rimbach
Schlesinger, Daniel J. 6850 Hohman Ave.
Schulfer, Richard J. 7134 Calumet Ave.
Scott, Mildred E. 5935 Hohman Ave.
Skrentny, Stanley H. 5231 Hohman Ave.
Solis, Roger V. 422 Conkey
Sroka, Alexander G. 5305 Hohman Ave.
Stasick, Murray 837 169th St.
Stern, Samuel L. 5231 Hohman Ave.
Stevens, Edwin W. 6850 Hohman Ave.
Tilka, Edward C. 7134 Calumet
Trachtenberg, Lee 112 Rimbach
Weissman, Charles G. 5246 Hohman Ave.
Westhaysen, Peter 6223 Hohman Ave.
White, Gilbert H., Jr. 6429 Kennedy Ave.
Wong, Samuel N. 7127 Indianapolis Blvd.

Highland

Sroka, Stanley J. 2942 Highway Ave.

Hobart

Bjorklund, C. Ray 295 S. Wisconsin St.
Bradley, Charles F. 201 Main St.
Carter, John O. 295 S. Wisconsin St.
Faulkner, Donald J. 295 S. Wisconsin St.
Klos, Stanley J. 10 N. Michigan Ave.
Markle, Joseph G. 201 Main St.
Parker, Harry C. (S) 831 Garfield St.
Pike, Warren H. 108 E. Third St.
Reed, John 10 N. Michigan Ave.
Weiss, John T. 295 S. Wisconsin St.

Lowell

Mirro, John A. E. Commercial
Templin, David B. E. Commercial

Munster

Espino, Jose C. 8144 Calumet Ave.
Lanman, John U. 8146 Calumet Ave.
McLean, James S. 1836 Ridge Road
Walker, Adolph P. 1504 Park Dr.

Whiting

Becker, Samuel W. 1900 Indianapolis Blvd.
Best, Robert C. 1900 Indianapolis Blvd.
Ferry, John L. 1902 Indianapolis Blvd.
Frankowski, Clementine E. 1907 New York Ave.

Greisen, Jack G. 1902 Indianapolis Blvd.
Gustaitis, John W. 1900 Indianapolis Blvd.
Kaiser, George D. 1900 Indianapolis Blvd.
Kudele, Louis T. 1321 119th St.
McCarthy, Jeremiah A. 1341 119th St.
Navarre, Vincent J. 1900 Indianapolis Blvd.
Rudser, Donald H. 1902 Indianapolis Blvd.
Silvian, Harry A. 1400 119th St.
Smith, Theodore J. 1902 Indianapolis Blvd.
Sokol, Allen B. 1900 Indianapolis Blvd.
Stecy, Peter 1902 Indianapolis Blvd.
Steen, Lowell H. 1900 Indianapolis Blvd.
Troy, Jack M. 1900 Indianapolis Blvd.
Weinberg, Benjamin A. 1346 119th St.

Bolin, John T. (S) Mountain Home, Arkansas
Callaghan, Patrick E.
3201st USAF Hosp., Eglin AFB, Florida
Cook, George M. Lake Worth, Florida
Daniel, Robert A.
Akron Children's Hospital, Akron, Ohio
Detrick, Herbert W. (S)
4845 Northwood Avenue, Sarasota, Fla.
Gill, John R. St. Luke's Hosp., Denver, Colo.
Justen, Jerome W.
668 Fairmont Ave., Glendale, Calif.
McMichael, Frank J. (S)
Box 227, Hernando, Florida
Monroe, F. Bruce VA Hospital, Hines, Illinois
Murphy, Joseph F. ... 3508 Ridge Rd., Lansing, Ill.
Nixon, Richard R. Gunter AFB, Gunter, Ala.
Polite, Nicholas L.
Cook Co. Hospital, Chicago, Illinois
Seyler, Anna G.
2780 Hillcrest Dr., LaVerne, Calif.
Shafer, Sid J.
55 E. Washington St., Chicago, Ill.
Tyrrell, Joseph J. V. A. Hosp., West Side Hosp., 820 Damen, Chicago, Ill.
Tyrrell, Thomas C.
800 State Line, Calumet City, Ill.

LA PORTE COUNTY

Oak, David, Jr. Hanna
Oak, David D. (S) LaCrosse

La Porte

Backer, George P. 806 Maple Ave.
Carter, Fred S. 912 Indiana Ave.
Cartwright, Jack D. 1003 Indiana Ave.
Durham, Lowell J. 1012 Harrison St.
Elshout, Clem H. 1004 Indiana Ave.
Fargher, Robert A. 811 Jefferson Ave.
Farnsworth, Samuel A. 1012 Michigan Ave.
Feinn, Harry S. 1013 Indiana Ave.
Fischer, Carlton N. 1001 Maple Ave.
Hinshaw, Horace D. 808 Maple Ave.
Jones, Robert B. (S) 1515 Indiana Ave.
Kelsey, Robert M. 702 Maple Ave.
Kepler, Robert W. 708 Harrison St.
Kistler, James J. 911 Maple Ave.
Larson, Goyt O. 1110 Indiana Ave.
Mead, Frank E. 801 Madison St.
Mueller, Edwin C. 905 Indiana Ave.
Muhleman, Charles E. 901 Indiana Ave.
Philbrook, Seth S. 705 Harrison St.
Predd, Adolph C. 909 Madison St.
Richter, John C. 1110 Indiana Ave.
Scott, John S. 806 Maple Ave.
Tabaka, Francis B. 1201 Michigan Ave.
Von Asch, George 912 Monroe St.
Wolf, William E. 102 Lincoln Way

Michigan City

Armstrong, Thomas D. 120 W. Ninth St.
Arney, Amos 125 E. Fifth St.
Baker, Warren 427 Warren Bldg.
Bankoff, Milton L. 125 E. Fifth St.
Bergan, Joseph A. Warren Bldg.
Berkson, Myron E. 801 Washington St.
Brooks, Harry L. 100 Beverly Court
Burris, Floyd L. 731 Spring St.
Carlson, Norman R. 912 Wabash St.
Cleveland, John B. 117 W. Seventh St.
Fargher, Francis M. 907 Washington St.
Flaherty, Walter T. 1016 Washington St.
Frost, Robert J. 817 Pine St.
Gardner, Melvin D. 801 Washington St.
Gardner, Russell A. 801 Washington St.
Gilmore, Robert W. 304 Warren Bldg.
Gilmore, Russell A. 304 Warren Bldg.
Grotts, Bruce F. 2110 Oriole Trail, Long Beach
Henderson, Norman C. 131 E. Eighth St.
Hillenbrand, Charles 128 W. 10th St.
Jones, King S. 328½ Franklin St.
Kemp, John T. 122 E. Seventh St.
Kerr, John E. 507 Warren Bldg.
Kerrigan, John F. 916 Washington St.
Kerrigan, Robert L. 916 Washington St.
Kubik, Francis J. 902 Pine St.
Liddell, Charles K. 916 Washington St.
Marske, Robert L. 311-13 Warren Bldg.
Meyer, Milo G. 801 Washington St.
Milne, Walter S. 916 Washington St.
Olson, William H. P. O. Box 41
Paul, Leonard G. 125 E. Fifth St.
Phillips, John H. 120 W. Ninth St.
Piazza, Leonard F. 907 Washington St.
Pilecki, Peter J. 125 E. Fifth St.
Plank, C. Robert 732 E. Pine St.
Reed, Nelle C. (S) 3210 Tilden Ave.
Schmitt, Robert J. 217 W. Eighth St.
Stumer, Myer 811 Pine St.
Taub, Robert G. 125 E. Fifth St.
Walters, William H. Warren Bldg.
Warren, Lewis T. 2936 Belle Plaine
Weeks, Patrick H. (S) 119 E. Sixth St.
Weiss, Albert E. 125 E. Fifth St.
Zalac, Donald A. 723 Pine St.
Zullo, Robert S. Warren Bldg.

Weinstock, Adolph Rolling Prairie
Moosey, Louis Union Mills
Benz, Owen F. Wanatah

Westville

Caplin, Samuel S. Beatty Memorial Hospital
Hetman, Mitchell J. Westville
Johnston, Donald D. Beatty Memorial Hospital
Morton, David P. Beatty Memorial Hospital
Oster, Jack H. Beatty Memorial Hospital
Schulze, Hans A. Beatty Memorial Hospital
Sennett, Cecil M. Beatty Memorial Hospital
Smith, William M. Beatty Memorial Hospital
Syler, Robert W. Beatty Memorial Hospital
Tasher, Dean C. Beatty Memorial Hospital
Tobin, Walter W. Beatty Memorial Hospital
Wygant, Marion D. Beatty Memorial Hospital

LAWRENCE COUNTY

Bedford

Allen, L. Howard 1622 24th St.
Austin, Richard P. ... 209 Citizens Nat'l Bank Bldg.
Benham, Lawrence E. ... 310 Stone City Bank Bldg.
Bridwell, Edgar 1317 L St.
Campbell, William T. ... Citizens Nat'l Bank Bldg.
Duncan, Raymond 1317 L St.
Dusard, Joseph C. ... 304 Citizens Nat'l Bank Bldg.
Edmonds, Kendrick 1303 15th St.
Emery, Charles B. 1027 15th St.
Fountaine, Thomas J. 1501 J St.
Hammel, Howard T. 1501½ J St.
Hawkins, Richard D. Box 286
Kasting, Gerald 206 Citizens Nat'l Bank Bldg.
Kerr, Donald M. 1317 L St.

Morrow, Robert J. 1317 L St.
Newland, Arthur E. Masonic Temple
Noe, William R. 1317 L St.
Scherschel, John P. 1711 H St.
Waldo, Guy H. 2218 I St.
Wohlfeld, Julius B. 1222 15th St.
Woolery, Richard H. 1310 W. 16th St.
Wynne, Roland E. (S)
301 Citizens Nat'l Bank Bldg.

Hamilton, James R. Mitchell
Oswalt, James T. Mitchell
Robinson, William H. Mitchell
Dollens, Claude (S) Oolitic

MADISON COUNTY

Alexandria

Carpenter, John L. 313 N. Harrison St.
Gaunt, Everett W. 214 E. John
Leroy, Alvin G. 1309 N. Harrison St.
McClelland, Harry N. 118 E. Church St.
Overpeck, George H. 313 N. Harrison St.
Shafer, Richard H. 111 S. Harrison St.

Anderson

Aagesen, Walter J. 702 Citizens Bank Bldg.
Armington, Charles L. 655 Anderson Bank Bldg.
Armington, Robert L. 1504 Broadway
Austin, Charles E. 1612 Westwood Ave.
Ayres, Kenneth D. 2210 Meridian St.
Baughn, William L. Guide Lamp
Beeler, Franklin K. 1931 Brown St.
Benoit, Merrill P. Delco Remy
Bixler, Donald P. 1931 Brown St.
Blassaras, Chris 2005 Broadway
Bowers, Charles R. 207 Anderson Loan Bldg.
Brauchla, Carl H. (S) 117 W. 17th St.
Bridges, Alvin 1302 Madison Ave.
Brock, Earl E. (S) 931 Meridian St.
Brown, James M. 12 W. 29th St.
Buckles, David L. St. John's Hospital
Dixon, Rex W. 934 W. 8th St.
Doenges, James L. 1931 Brown St.
Donaldson, Frank C. 1931 Brown St.
Drake, John C. 604 Anderson Bank Bldg.
Drennen, Robert V. 1424 E. 8th St.
Dulin, Basil B. St. John's Hospital
Ellis, Seth W. 717 Anderson Bank Bldg.
Elsten, Aubrey W. 704 Anderson Bank Bldg.
Erehart, Archie D. 1221 Irving Way
Faust, Howard M., Jr. 315 Anderson Bank Bldg.
Ferguson, Donald H. 402 Anderson Bank Bldg.
Fischer, Warren E. 119 W. 19th St.
Gante, Henry W. (S) 2005 Nichol Ave.
Hart, William D. 126 W. 12th St.
Hensler, Benton M. 1709 Nichol Ave.
Irwin, Seth (S) 2209 Cedar St.
Jarrett, Paul E. 315 Citizens Bank Bldg.
Jones, Albert T. 530 Citizens Bank Bldg.
Jones, David G. 206 Beverly Terrace Apts.
Jones, Horace E. 1110 Meridian St.
Kelly, Wendell C. 704 E. Eighth St.
Kiely, John T. 1931 Brown St.
King, Joseph W. 1110 N. Meridian St.
Kopp, Otis A. 333 Jackson St.
Kopp, William R. 333 Jackson St.
Lamey, James L. 447 Citizens Bank Bldg.
Lamey, Paul T. 423 Citizens Bank Bldg.
Larmore, Joseph L. 612 Anderson Bank Bldg.
Larmore, Sarah H. 1301 Winding Way
Litzenberger, Sam W. 622 Citizens Bank Bldg.
Long, Paul L. 710 Anderson Bank Bldg.
Maxson, Roy V. 3240 Maryland Dr.
McDonald, Vergil G. (S) 1110 Meridian St.
Meister, Doris (S) 315 W. 9th St.
Morris, Robert A. 320 Citizens Bank Bldg.
Neale, Alfred E. 1931 Brown St.
Nelson, Paul L. 330 W. Seventh St.
Nesbit, Leonard L. 415 Citizens Bank Bldg.
Patterson, William K. 713 Anderson Bank Bldg.
Polhemus, Warren C. 1803 Pearl St.
Quickel, Daniel S. (S) 709 Anderson Bank Bldg.
Reed, Roger R. 412 Anderson Bank Bldg.
Rosenbaum, Lloyd E. 647 Citizens Bank Bldg.
Ross, Guy E. 1931 Brown St.
Rozelle, Clarence V. 611 Citizens Bank Bldg.
Sharp, William L. 449 Citizens Bank Bldg.
Sheldon, Suel A. 508 Anderson Bank Bldg.
Stamper, Joseph H. 412 Anderson Bank Bldg.
Stamper, Robert J. 412 Anderson Bank Bldg.
Stinson, William M. 333 Jackson St.
Swan, Richard C. Delco Remy
Webb, Harry D. 321 Citizens Bank Bldg.
Weiss, Louis L. 1225 N. Madison
Wilder, Gordon B. 338 W. Eighth St.
Williams, Francis M. 1132 Central Ave.
Williams, Robert H. 1132 Central Ave.
Wright, Cecil S. 207 Beverly Terrace

Stump, Richard L. Chesterfield

Elwood

Buechler, William F. 1817 S. A St.
Drake, Marion C. 1201 Main St.
Fitzpatrick, Harry W. (S) 1309 S. Anderson St.
Hanson, Martin F. 1102 S. Anderson St.
Hoppenrath, Wesley M. 1300 Main St.
Hoppenrath, William H. (S) 1300 Main St.
Laudeman, Walter A. 1515 N. A St.
Oldag, George E. 1301 Main St.
Ploughe, Ralph R. 517 S. Anderson St.
Scea, Wallace A. 1300 Main St.
Ulrey, Robert P. 1201 Main St.

Bishop, Harry A. Frankton
Ridgway, Alton H. Lapel
Rinne, John I. (S) Lapel
Williams, Robert D. Markleville
Bogmenko, Leon T. Box 28, Pendleton
Leahy, Howard J. Pendleton
McLaughlin, Calvin P. Pendleton
Van Ness, William C. Summitville

MARION COUNTY

Beech Grove

Berger, Morley 902 Main St.
Kim, Young D. 136 N. 17th St.
Ramage, Walter F. 244 S. First St.
Reilly, Eva F. St. Francis Hospital
Rhea, James C 801 Main St.
Zerfas, Charles P. A. 926 Main St.

Hade, Frederick L. (S) Bridgeport
Zerfas, Leon G. R. R. 1, Camby
Garrison, James L. P. O. Box 29158, Cumberland

Indianapolis

A

Abreu, Benedict E.
Pitman-Moore Co., 1200 Madison Ave. (6)
Adams, Daniel S. (S) 520 Hume Mansur Bldg. (4)
Addleman, Robert H. 3710 N. Pennsylvania St. (5)
Adkins, Harold C. 409 E. 30th St. (5)
Albertson, Frank P. 3544 W. 16th St. (22)
Albrecht, Willard H.
Marion Co. General Hospital (7)
Aldrich, Harry D. 201 Hume Mansur Bldg. (4)
Aldrich, Howard 4316 E. Washington St. (1)
Alexander, Ezra D. 617 Indiana Ave. (2)
Allen, Robert K. 3202 N. Meridian St. (8)
Alvis, Edmond O. 320 Hume Mansur Bldg. (4)
Anderson, James W. 623 N. West St. (2)
Anderson, John T. 3349 Georgetown Rd. (24)
Anderson, Wendell C.
Indiana State Board of Health,
1330 W. Michigan St. (7)

Appel, Richard H.....320 Hume Mansur Bldg. (4)
Arbogast, John L.....I. U. Medical Center (7)
Arbuckle, William E. (S).....1156 Lee St. (21)
Armer, Robert M.....Riley Hospital (7)
Arnold, Aaron L.....607 E. 38th St. (5)
Arnold, Robert D.....3419 E. 10th St. (1)
Aronson, Sidney S.....618 Hume Mansur Bldg. (4)
Aust, Charles H.....1119 N. Linwood (1)
Avery, George O.....17 S. Traub (22)

B

Bacastow, Merle S.....Methodist Hospital (7)
Bachmann, Arnold J.....3440 N. Meridian St. (8)
Bailey, Orville T.
Larue D. Carter Hospital, 1315 W. 10th St. (7)
Baird, Melvin S.....17½ W. 22nd St. (2)
Bakemeier, Otto H...5503 E. Washington St. (19)
Bakemeier, Robert E.....1210 N. Butler (19)
Balch, James F.....709 Hume Mansur Bldg. (4)
Balcom, Francis H.....1635 Temperance (3)
Ball, Joseph E.....4312 E. 10th St. (1)
Banister, Revel F. (S).....2958 Central Ave. (5)
Banks, Horace M.....Methodist Hospital (7)
Baptisti, Arthur Jr.
Marion Co. General Hospital (7)
Barry, Maurice J. (S).....501 Doctors' Bldg. (4)
Bartle, James L.....7450 Pendleton Pike (26)
Bartley, Max D.....607 Hume Mansur Bldg. (4)
Bastnagel, William F.....I.U. Medical Center (7)
Batman, Gordon W...723 Hume Mansur Bldg. (4)
Battersby, J. Stanley....I. U. Medical Center (7)
Batties, Paul A.....617 Indiana Ave. (2)
Bauer, Thomas B.....408 Hume Mansur Bldg. (4)
Baumeister, Herbert E...I. U. Medical Center (7)
Baxter, John P.....Methodist Hospital (7)
Beach, Robert R.....2630 E. 10th St. (1)
Beamer, Parker R.....I. U. Medical Center (7)
Beaver, Howard W.....8 E. Troy (3)
Beck, Evart M.....915 E. 38th St. (5)
Becker, Harry G.....6060 College Ave. (20)
Becquet, Norbert J.....I.U. Medical Center (7)
Beeler, John W.....712 Hume Mansur Bldg. (4)
Beeler, Raymond C. (S)
712 Hume Mansur Bldg. (4)
Behnke, Roy H....VA Hosp., 1481 W. 10th St. (7)
Belshaw, George.....5317 E. 16th St. (18)
Belt, James H.....6225 College Ave. (20)
Benedict, Paul F.....3939 Meadows Dr. (5)
Bennett, Ivan F.
Lilly Clinic, Marion Co. General Hospital (7)
Berman, Edward J...920 Hume Mansur Bldg. (4)
Berman, Jacob K.....920 Hume Mansur Bldg. (4)
Beverland, Malon E. (S)
3036 E. Washington St. (1)
Bibler, Lester D.....811 Underwriters Bldg. (4)
Bill, Robert O.....2901 N. Meridian St. (8)
Bird, Charles R. (S)..301 Hume Mansur Bldg. (4)
Black, Henry R...Marion Co. General Hospital (7)
Blackford, Florence.....5909 E. 10th St. (19)
Blackford, Ralph E.....5909 E. 10th St. (19)
Blackwell, Donald S.....2121 Allison Ave. (24)
Blake, Albert L.....1802 N. Illinois St. (2)
Blatt, A. Ebner.....3400 N. Meridian St. (8)
Bloemker, Edward F.....2729 Shelby St. (3)
Bobowski, Stan J.....Methodist Hospital (7)
Boggs, Eugene F.....2901 N. Meridian St. (8)
Boling, Grover C., Jr.....1440 E. 46th St. (5)
Bond, George S. (S)....1221 N. Delaware St. (2)
Bond, Virginia.....3236 W. 34th St. (22)
Bond, William H.....I. U. Medical Center (7)
Bonsett, Charles A.....902 Hume Mansur Bldg. (4)
Booher, Norman R.....447 E. 38th St. (5)
Booher, Olga Bonke.....447 E. 38th St. (5)
Booker, Harold E.....Riley Hospital (7)
Boone, Robert D.....I.U. Medical Center (7)
Booth, Boynton H.....910 Hume Mansur Bldg. (4)
Bowman, George W.
Marion Co. General Hospital (7)
Bowman, George W.....General Hospital (7)
Boyer, Floyd A.....442 N. Drexel Ave. (1)
Boyer, Philip A.
Pitman-Moore Co., 1200 Madison Ave. (6)
Brady, Thomas A.....818 Hume Mansur Bldg. (4)
Brayton, John R.....704 Underwriters Bldg. (4)
Brayton, Lee.....3342 N. Illinois St. (8)
Breneman, William L.
Marion Co. General Hospital (7)
Brickley, Richard A...605 Hume Mansur Bldg. (4)
Briggs, Robert W.....2140 N. Capitol (2)
Brillhart, James R.....I.U. Medical Center (7)
Brodie, Donald W.....817 C. of C. Bldg. (4)
Brown, Archie E.....1220 S. Belmont Ave. (21)
Brown, David E.....520 Hume Mansur Bldg. (4)
Brown, DeWitt W.....1633 N. Capitol Ave. (2)
Brown, Earl R., Jr.....I.U. Medical Center (7)
Brown, Frances T.....2126 N. Talbot Ave. (2)
Brown, Frank M.....514 W. 43rd St. (8)
Brown, Gordon T.....1949 E. 11th St. (1)
Brown, Thomas C.....Methodist Hospital (7)
Brown, Wendell E.....3426 N. Meridian St. (8)
Browning, James S.....2901 N. Meridian St. (8)
Browning, William M.....3740 Central Ave. (5)
Brownley, Emma J.....5101 W. 13th St. (24)
Bruce, Reginald A.....848 Indiana Ave. (2)
Brueckman, F. Robert.....2356 N. Kenyon (18)
Bruetsch, Walter L...3000 W. Washington St. (22)
Bugh, Charles W.....St. Vincent's Hospital (7)
Bunde, Carl A.
Pitman-Moore Co., 1200 Madison Ave. (6)
Burdette, Harold F.....3202 N. Meridian (8)
Burghard, Rolla D.....4829 E. 38th St. (18)
Burkle, Robert J.....I. U. Medical Center (7)
Burton, Philip B.....I.U. Medical Center (7)
Butler, John O.....234 E. Southern Ave. (25)
Butler, Robert M.....3426 N. Meridian St. (8)
Buttz, Rose J. P. (S).....3227 Guilford Ave. (5)

C

Cahn, Hugo M.....418 E. 30th St. (5)
Caldwell, Marilyn R.....111 E. 53rd St. (20)
Call, Herbert F.....2901 N. Meridian (8)
Campbell, John A.....I. U. Medical Center (7)
Canaday, James W. (S)....5154 Central Ave. (5)
Capestany, Max A.....Methodist Hospital (7)
Caplin, Irvin.....3120 N. Meridian St. (8)
Carson, Wayne.....1802 N. Illinois St. (2)
Carter, Oren E.....668 E. Maple Rd. (5)
Chattin, William R.....4829 E. 38th St. (18)
Chen, Ko Kuei
Eli Lilly & Co., 740 S. Alabama St. (6)
Chernish, Stanley M.
Marion Co. General Hospital (7)
Chevalier, Robert A.....Methodist Hosp. (7)
Chivington, Paul V...407 Hume Mansur Bldg. (4)
Christiansen, Philip A.
V. A. Hosp., 1481 W. Tenth St. (7)
Christie, Marvin.....2436 Cardinal (27)
Chroniak, Walter.....5508 E. Washington St. (19)
Cipparone, Joseph R.
V. A. Hosp., 1481 W. Tenth St. (7)
Clark, Cecil P.....922 Hume Mansur Bldg. (4)
Clark, Lawson J.....3736 N. Delaware St. (5)
Clevinger, William G.....1610 Auburn St. (24)
Close, W. Donald.....I. U. Medical Center (7)
Coade, George E.....I. U. Medical Center (7)
Coates, Jacqueline.....2060 N. Senate Ave. (2)
Coble, Ralph R. (S).....3311 N. Meridian St. (8)
Coddington, Robert C.....2261 Centennial St. (22)
Coggeshall, Warren E.
1015 Hume Mansur Bldg. (4)
Cohn, Alvin F.....1130 Southview Dr. (27)
Collins, Hubert L.....985 N. Arlington Ave. (19)
Collins, Robert C..Marion Co. General Hospital (7)
Conley, Joseph L.....2443 E. Washington St. (1)
Conway, Chester C.....4402 E. New York St. (1)
Conway, Glenn.....1620 S. East St. (25)
Cornacchione, Matthew.....814 S. East St. (25)
Cortese, James V.....435 S. East St. (25)

Cortese, Thomas A. 435 S. East St. (25)
Cottrell, Robert F. I.U. Medical Center (7)
Coughenour, J. Robert 2809 S. Holt Road (41)
Countryman, Frank W. 3233 N. Meridian St. (8)
Cox, Clifford E. R. R. 14, Box 811 (20)
Craft, Kenneth L. 1002 Hume Mansur Bldg. (4)
Crawford, John A. 321 Hume Mansur Bldg. (4)
Cross, David G. 1002 Troy Ave. (3)
Culbertson, Clyde G.
Eli Lilly & Co., 740 S. Alabama St. (6)
Cullen, Paul K. 422 Hume Mansur Bldg. (4)
Cullison, John L. 3425 Green Hills (22)
Culloden, William G. 710 E. 46th St. (5)
Culmer, Walter N. (S)
3541 N. Meridian St., #204 (8)
Cunningham, Gene C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Cure, Charles W. 315 Hume Mansur Bldg. (4)
Curran, Frank J.
5101 E. Pleasant Run Pky., S. Dr. (19)
Currie, Robert W. 512 E. 57th St. (20)
Curry, R. Louis 3375 Forest Manor (18)
Cuthbert, Marvin P. 3400 N. Meridian (8)
Czenkusch, Helen G. 5101 W. 13th St. (24)

D

Dailey, James E. Marion Co. General Hospital (7)
Daley, Edward H. 821 Broad Ripple Ave. (20)
Dallas, Fred R. 5317 E. 16th St. (18)
Dallas, Mary E. I.U. Medical Center (7)
Dalton, John E. 708 Hume Mansur Bldg. (4)
Dalton, William W. 422 Hume Mansur Bldg. (4)
Daly, Joseph M. 234 E. Southern Ave. (25)
Daniel, John C. 1008 Hume Mansur Bldg. (4)
Davidson, N. Cort 3233 N. Meridian St. (8)
Davis, John A. 3720 N. Sherman Dr. (18)
Davis, Margaret M. I. U. Medical Center (7)
Davis, Sam J. 908 Hume Mansur Bldg. (4)
Deal, Eleanor H. 4909 W. 15th St. Speedway (24)
Dearmin, Robert M. 3233 N. Meridian St. (8)
DeArmond, Murray 723 Hume Mansur Bldg. (4)
Deever, John W. 4131 Shelby St. (3)
Deitch, Robert D. 4214 Carrollton Ave. (5)
DeMotte, C. Bowen 808 C. of C. Bldg. (4)
Dennison, Alfred D., Jr. 3400 N. Meridian St. (8)
Denny, Forrest L. 3351 W. 10th St. (22)
Denny, James W. 25 N. Ritter Ave. (19)
Des Jean, Paul A. 4301 E. 38th St. (18)
DeWees, Dwight L. 302 N. Bradley Ave. (1)
Dickey, William M. St. Vincent's Hospital (7)
Dickson, Carolyn L. 501 N. West St. (2)
Dill, Charles W. 3655 S. Sherman Dr. (3)
Dill, Myron K. 3120 N. Meridian St. (8)
Dilts, Robert L. 2521 E. 38th St. (18)
Dintaman, Paul G. 703 Hume Mansur Bldg. (4)
Ditmyer, Paul J., Jr. I. U. Medical Center (7)
Dixon, Fritz R. Marion Co. General Hospital (7)
Dluzansky, James J. I. U. Medical Center (7)
Donahue, James M.
Marion Co. General Hospital (7)
Donato, Albert N. 1429 Shelby St. (3)
Doran, J. Hal 720 Hume Mansur Bldg. (4)
Dorman, Willis L. 6430 E. Washington St. (19)
Doty, James R. Jr.
Marion Co. General Hospital (7)
Doughty, Samuel R., Jr.
821 Broad Ripple Ave. (20)
Dowd, Joseph A. 6177 College Ave. (20)
Drew, Arthur L. Jr. I. U. Medical Center (7)
Dryden, Gale E. 5835 N. Tacoma (20)
Dugan, William M. 410 Hume Mansur Bldg. (4)
Dunbar, Colin V. 3626 N. DeQuincy (18)
Dunning, Lehman M. (S) 2103 Central Ave. (2)
Dupes, Lowell E. 5851 White Oak Ct. (20)
Dyar, Edwin W. 3202 N. Meridian St. (8)
Dyke, Richard W. Marion Co. General Hospital (7)

E

Earp, Evanson B. 717 Hume Mansur Bldg. (4)
Eastman, Joseph R., Jr.
514 Merchants National Bank Bldg. (4)
Eaton, Edwin R. 5505 N. Keystone Ave. (20)
Eaton, Lyman D. 5505 N. Keystone Ave. (20)
Ebert, J. Wayne 1125 Southview Dr. (27)
Eberwein, John H. (S) 2322 Wheeler Ave. (18)
Edwards, Wendell L.
Marion Co. General Hospital (7)
Egbert, Herbert L. 5317 E. 16th St. (18)
Eicher, Palmer O. 3400 N. Meridian St. (8)
Eikenberry, Hugh W. 616 Bankers Trust Bldg. (4)
Eldridge, Gail E. 1440 E. 46th St. (5)
Elkins, James P. 234 E. Southern Ave. (25)
Ellis, William N. 1402 N. Olney St. (1)
Emhardt, John T. 1621 S. East St. (25)
Emhardt, John W. A. 5424 Washington Blvd. (20)
Ensminger, Leonard A. (S)
1321 N. Meridian St. (2)
Evans, Frederick H. 2140 N. Capitol (2)
Evans, Paul V. Marion Co. General Hospital (7)
Everly, Ralph V. 668 E. 38th St. (5)

F

Failey, Robert B. I. U. Medical Center (7)
Farrell, Joseph T. 2807 E. Michigan St. (1)
Fausset, C. Basil 2901 N. Meridian St. (8)
Ferry, Francis A. 1429 Shelby St. (3)
Fiedler, Howard W. I. U. Medical Center (7)
Fields, Donald L. I. U. Medical Center (7)
Fine, Nathaniel J. 764 S. Emerson Ave. (3)
Finneran, Joseph C. 1802 N. Illinois St. (2)
Fisch, Charles Marion Co. General Hospital (7)
Fischer, Albert A. 1745 Howard St. (21)
Fisher, Frank C. Marion Co. General Hospital (7)
Fitzgerald, William J.
313 Fountain Square Theatre Bldg. (3)
Flanagan, Paul M. 3311 N. Meridian St. (8)
Flanders, Robert J. 3202 N. Meridian St. (8)
Flanigan, Meredith B. 3305 Rutledge (8)
Fleischl, Herbert Central State Hospital (22)
Flick, John J. 1443 N. Pennsylvania St. (2)
Flora, Joseph O. 4317 W. Washington St. (21)
Folkening, Norval C. 234 E. Southern Ave. (25)
Forry, Frank (S) I. U. Medical Center (7)
Fortuna, Frank W. Methodist Hospital (7)
Fosgate, Harold L. 7002 E. 13th St. (19)
Foster, Lee N. St. Vincent's Hospital (7)
Foster, Ray D. I. U. Medical Center (7)
Foust, Betty Jean 4046 N. Webster Ave. (26)
Fouts, Dallas B. I.U. Medical Center (7)
Fouts, Paul J. 623 Hume Mansur Bldg. (4)
Franklin, William L. 508 Hume Mansur Bldg. (4)
Freed, Carl A. 2966 Kessler Blvd., N. Dr. (22)
Freeman, Leslie W. I. U. Medical Center (7)
Freeman, Max E. 1745 Howard St. (21)
Fromhold, Willis A. 611 Bankers Trust Bldg. (4)
Fry, Robert D. 517 Hume Mansur Bldg. (4)
Fulton, William H.
Marion Co. General Hospital (7)
Funkhouser, Elmer (S) 702 Underwriters Bldg. (4)

G

Gabovitch, Edward R.
Marion Co. General Hospital (7)
Gaddy, Euclid T. 2602 W. Washington St. (22)
Gaddy, Nelson D. 2602 W. Washington St. (22)
Gambill, William D. 1633 N. Capitol Ave. (2)
Gammieri, Robert L. 661 E. 49th St. (5)
Garber, J. Neill 806 Hume Mansur Bldg. (4)
Garceau, George J. 508 Hume Mansur Bldg (4)
Gard, Daniel A. Box 7606 (Irvington Station)
Gardiner, Sprague H. I. U. Medical Center (7)
Gardner, Austin L.
Marion Co. General Hospital (7)
Gardner, Buckman St. Vincent's Hospital (7)
Garfield, Martin D. 3705 College Ave. (5)
Garner, W. Stanley 2911 E. 10th St. (1)
Garrett, John D. (S) 2523 Central Ave. (5)
Garrett, Robert A. I. U. Medical Center (7)
Gatch, Willis D. (S) 605 Hume Mansur Bldg. (4)
Geider, Roy A. 1525 Prospect St. (3)
Genna, Mary E. Miller I. U. Medical Center (7)

Genovese, Pasquale
V. A. Hospital, 1481 W. 10th St. (7)
George, Charles L.....I.U. Medical Center (7)
Gibson, Alois E.....St. Vincent's Hospital (7)
Gibson, Greta Maxine.5744 Broadway Terrace (20)
Gick, Herman H. (S)....2705 E. Michigan St. (1)
Gifford, Fred E.....710 Hume Mansur Bldg. (4)
Gillespie, Charles F.....3400 N. Meridian St. (8)
Gillespie, Jacob E.....523 Hume Mansur Bldg. (4)
Ginsberg, Stewart T.....1315 W. Tenth St. (7)
Glendening, John L. (S)..3134 N. Delaware St. (5)
Goldenberg, Norman S.....Coleman Hospital (7)
Goldman, Samuel.....1204 Oliver Ave. (21)
Gormley, Joseph J.....2369 Goodlet (23)
Gosman, James H.....2901 N. Meridian St. (8)
Graham, John D.....Methodist Hospital (7)
Graham, William E.....St. Vincent's Hospital (7)
Green, Morris.....Riley Hospital (7)
Green, Oscar.....504 Hume Mansur Bldg. (4)
Greene, Morgan E.....1621 S. East St. (25)
Gregory, Robert L.....Methodist Hospital (7)
Greist, John H.....2901 N. Meridian St. (8)
Griffith, Richard S.
Lilly Clinic, Marion Co. General Hospital (7)
Griffith, Ross E.....401 E. 34th St. (5)
Grimes, Hubert N.....2502 English Ave. (1)
Grisell, Ted L.....5317 East 16th St. (18)
Gruber, Charles M.
Lilly Clinic, Marion Co. General Hospital (7)

H

Habegger, Elmer D.....1802 N. Illinois St. (2)
Habich, Carl (S).....703 Hume Mansur Bldg. (4)
Hadley, David.....702 Hume Mansur Bldg. (4)
Haggard, Edmund B....5914 N. Emerson Ave. (20)
Hahn, E. Vernon.....R. R. 18, Box 376 (24)
Hall, Frank M.....141 S. Meridian St. (25)
Hall, William H.....Methodist Hospital (7)
Haller, Richard C.....1727½ N. Talbott Ave. (2)
Hamer, Homer G. (S)....1711 N. Capitol Ave. (7)
Hammond, James B.
Lilly Clinic, Marion Co. General Hospital (7)
Hampshire, Donald R..1443 N. Pennsylvania St. (2)
Hancock, John G.....2226 W. Michigan St. (22)
Hann, Eldon C.....I. U. Medical Center (7)
Hanna, Thomas A.....1608 N. Lynhurst Dr. (24)
Hansell, Robert M.....7 N. Euclid Ave. (1)
Harcourt, Allan K.....812 C. of C. Bldg. (4)
Harding, M. Richard...308 Hume Mansur Bldg. (4)
Harding, Myron S.....308 Hume Mansur Bldg. (4)
Hare, Earl H.
Indiana State Board of Health 1330 W. Michigan St. (7)
Hare, Laura.....404 Hume Mansur Bldg. (4)
Harger, Robert W.....804 Hume Mansur Bldg. (4)
Harold, Albert H. (S)...7510 Allisonville Rd. (20)
Harold, Norris E. (S).....3545 N. Denny St. (18)
Harris, Carl B.....319 Hume Mansur Bldg. (4)
Harris, Paul N.
Eli Lilly & Co., 740 S. Alabama St. (6)
Harshman, James A.....I. U. Medical Center (7)
Harvey, Verne K., Jr.
Indiana State Board of Health 1330 W. Michigan (7)
Harvey, Verne K., Sr.
V. A. Hospital, 1481 W. Tenth St. (7)
Hasewinkel, Carroll W.....Methodist Hospital (7)
Haslinger, Clarence J.. 2151 E. New York St. (1)
Hatfield, Jack J.....5538 N. Keystone Ave. (20)
Hatfield, Nicholas W..... 2032 N. Rural St. (18)
Hawk, James H.....3736 N. Delaware St. (5)
Hay, Gene R.....1 Goya Court (24)
Haymond, George M.
Marion Co. General Hospital (7)
Haymond, Joseph L.....301 38th St. (5)
Haynes, John T.....Methodist Hospital (7)
Hays, Everett L.....2607 Manker Ave. (3)
Healey, Robert J.....3602 N. Meridian St. (8)
Hedrick, Philip W..... 652 E. 54th St. (20)
Heimburger, Robert F.....I. U. Medical Center (7)
Hemsworth, Dorothy N.....3528 Guilford (5)
Henderson, Francis G.
Eli Lilly & Co., 740 S. Alabama St. (6)
Henderson, Roscoe C..3131 Northwestern Ave. (23)
Henderson, William P.....I. U. Medical Center (7)
Hendricks, Fred A.....6921 N. Keystone Ave. (20)
Hendricks, John W.....911 Hume Mansur Bldg. (4)
Henry, Russell S.....725 Hume Mansur Bldg. (4)
Hepburn, C. K.....1633 N. Capitol Ave. (2)
Hetherington, Arthur M. (S)
4121 E. New York St. (1)
Hetherington, John A...1633 N. Capitol Ave. (2)
Heubi, John E.....668 E. 38th St. (5)
Hickam, John B.....I.U. Medical Center (7)
Hickman, Jack W..Marion Co. General Hospital (7)
Hickman, Walter F. (S)....1210 Oliver Ave. (21)
Hicks, Murwyn L.....821 Broad Ripple Ave. (20)
Hicks, Wilbur D.....310 W. 40th St. (8)
Hill, James K.....4701 W. 30th St. (24)
Himebaugh, James R. S.....5317 E. 16th St. (18)
Himler, James M.....809 Underwriters Bldg. (4)
Hines, Don C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Hodges, Fletcher (S).....3160 N. Penn. St. (5)
Hoffman, Herman.....2439 Central Ave. (5)
Hofmann, J. William (S)
323 Hume Mansur Bldg. (4)
Holman, Jerome E., Sr. (S)...3315 E. 10th St. (1)
Holman, Jerome E., Jr.....3315 E. 10th St. (1)
Hood, Ainslee A.....3205 Shelby St. (27)
Horwitz, Thomas.....424 Hume Mansur Bldg. (4)
Howard, William F.....I. U. Medical Center (7)
Howell, Arthur 2060 Boulevard Pl. (2)
Howell, Joseph D.....760 Bankers Trust Bldg. (4)
Howell, Robert D.....1802 N. Illinois St. (2)
Hoyt, Lester H.....Methodist Hospital (7)
Hoyt, Millard L.....612 Hume Mansur Bldg. (4)
Hubbard, Jesse D.....I. U. Medical Center (7)
Huber, Carl P.....I. U. Medical Center (7)
Huddle, John R.....2963 N. Sherman Dr. (18)
Hudson, Foster J.....3440 N. Meridian St. (8)
Hull, DeWayne L..Marion Co. General Hospital (7)
Hull, Ronald H.....723 Hume Mansur Bldg. (4)
Hummons, Francis D..... 729½ N. West St. (2)
Hurt, Laverne B.....635 E. Kessler Blvd. (20)
Hurteau, William W.....Methodist Hospital (7)
Huse, William M.....703 Hume Mansur Bldg. (4)
Hynes, Roy T.....633 E. 38th St. (5)

I

Irwin, Glenn W., Jr.....I. U. Medical Center (7)
Iske, Paul G.....420 Hume Mansur Bldg. (4)

J

Jackson, Frederick E. (S)..2125 N. Park Ave. (2)
Jackson, James W. (S).....463 W. 32nd St. (8)
Jaeger, Alfred S. (S)..430 Bankers Trust Bldg. (4)
Jaquith, Orville S. (S).....261 Blue Ridge Rd. (8)
Jay, Arthur N.....3233 N. Meridian St. (8)
Jay, James.....I. U. Medical Center (7)
Jeffries, Kenneth I. (S).....3433 Central Ave. (5)
Jenkins, Robert E.....3311 N. Meridian St. (8)
Jennings, Frank L.
V. A. Hospital, 1481 W. Tenth St. (7)
Jewett, Joe H.....3120 N. Meridian St. (8)
Jobes, James E.....110 N. Illinois St., #305 (4)
Jobes, Norman E. (S).....4245 Knollton Rd. (8)
Johnson, Thomas W.....1802 N. Illinois St. (2)
Johnson, William F. (S)..2121 N. Harding St. (2)
Johnson, William H.
Marion Co. General Hospital (7)
Jones, Allen W.....6060 College Ave. (20)
Jones, David E.....828 C. of C. Bldg. (4)
Jones, Francis P.....4212 E. Michigan St. (1)
Jones, Gordon C.....1517 N. Emerson (19)
Jones, Lawrence R.....4525 W. 30th St. (24)
Joseph, Rex M.....1615 S. East St. (25)
Jowitt, Richard H.....1502 N. Emerson (19)
Judd, Donald R.....I. U. Medical Center (7)
Judson, Walter E.....I. U. Medical Center (7)

K

Kahler, Maurice V. 2638 Kessler Blvd. (22)
Kahn, Alexander J. 3120 N. Meridian St. (8)
Kahn, Howard L. 3120 N. Meridian St. (8)
Kaiser, George C. I. U. Medical Center (7)
Kalb, Everett L. 5934 E. 21st St. (18)
Kammen, Leo 3202 W. 16th St. (22)
Kammen, Robert 3202 W. 16th St. (22)
Karnafel, Eugene T. Methodist Hospital (7)
Katterjohn, James C. . . 313 Hume Mansur Bldg. (4)
Kauffman, Nelson N. 2901 N. Meridian St. (8)
Keenan, George B. 1743 Shelby St. (3)
Keenan, Reid L. 615 Hume Mansur Bldg. (4)
Keever, Charles H. 5214 College Ave. (20)
Keiser, Venice D. 5709 Broadway (20)
Kellsey, David C. 320 N. Meridian St. (4)
Kelly, Don E. 702 Underwriters Bldg. (4)
Kelly, John F. Central State Hosp. (22)
Kelly, Walter F. (S) . . 6049 E. Washington St. (19)
Kennedy, Hunter F. 1105 Prospect St. (3)
Kennedy, Joseph T. 821 Broad Ripple Ave. (20)
Kenney, David B. 701 N. Emerson Ave. (19)
Kenzler, Jack 205 Hume Mansur Bldg. (4)
Kerr, Harry R. 2817 E. Washington St. (1)
Ketcham, Jane M. (S) 3906 Ruckle St. (5)
Kilgore, Byron W. 2002 E. 62nd St. (20)
Kilmer, Warren L.
Marion Co. General Hospital (7)
Kime, Edwin N. 4800 E. 42nd St. (18)
King, Harold I. U. Medical Center (7)
King, William E. 811 Hume Mansur Bldg. (4)
Kingsbury, John K. (S)
5462 E. Washington St. (19)
Kinzel, Robert J. W. 3120 N. Meridian St. (8)
Kirkhoff, Paul J. 5317 E. 16th St. (18)
Kirklin, Oren L. 1802 N. Illinois St. (2)
Kirtley, William R.
Eli Lilly & Co., 740 S. Alabama St.
Kissel, Wesley A.
LaRue Carter Hosp., 1315 W. Tenth St. (7)
Kitterman, Harry E. 5317 E. 16th St. (18)
Klain, Benjamin V. 4157 College Ave. (5)
Klatte, Eugene C. I. U. Medical Center (7)
Kleopfer, Ronald G.
Marion Co. General Hospital (7)
Kneidel, John H. 508 E. 38th St. (5)
Knowles, Charles Y. 5317 E. 16th St. (18)
Knowles, Robert P. 2901 N. Meridian St. (8)
Koch, Edwin F., Jr. I. U. Medical Center (7)
Kohlstaedt, Karl C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Kohlstaedt, Kenneth G.
Lilly Clinic, Marion Co. General Hospital (7)
Kooiker, John E. 401 E. 34th St. (5)
Koons, Karl M. 923 Hume Mansur Bldg. (4)
Kopecky, Robert R. 4131 Shelby St. (27)
Kornafel, L. H. 608 K. of P. Bldg. (4)
Kraft, Bennett 760 Bankers Trust Bldg. (4)
Kriel, William B. 5630 W. Washington St. (21)
Kuntz, Herman W. . . . 611 Hume Mansur Bldg. (4)
Kurlander, Gerald J. I. U. Medical Center (7)
Kurtz, Fred B. (S) 5520 N. Illinois St. (8)
Kurtz, Philip L.
Eli Lilly & Co., 740 S. Alabama St. (6)
Kurtz, Richard . . . Marion Co. General Hospital (7)
Kwitny, Isadore J. 3400 N. Meridian St. (8)

L

LaDine, Clarence B. 2508 Station St. (18)
Lalonde, Alban H. Methodist Hospital (7)
Lamb, Emmett B. 205 Hume Mansur Bldg. (4)
Lamb, Russell W. 205 Hume Mansur Bldg. (4)
Lamber, Chet K. 914 Hume Mansur Bldg. (4)
Lambert, Ross W. 4470 Marcy Lane (5)
Landwehr, Alfons Sunnyside Sanitorium (26)
Lane, Charlotte E. Methodist Hospital (7)
Langdon, Harry K. (S)
3264 N. Pennsylvania St. (5)
Lansford, Kenneth G. I. U. Medical Center (7)
Laramore, Ward 5835 N. Keystone Ave. (20)
Larkin, Bernard J. (S) . 305 Hume Mansur Bldg. (4)
Lasich, Anthony R. 820 C. of C. Bldg. (4)
Lawler, George F. 5601 E. St. Clair St. (19)
Leasure, J. Kent 3115 N. Meridian St. (8)
Leatherman, Harter L. 1531 Broadway (2)
Lee, Raymond A. . Marion Co. General Hospital (7)
Leff, Abe H. 3120 N. Meridian St. (8)
Leffel, James M. 1633 N. Capitol Ave. (2)
Leffler, William T. 2141 E. 52nd St. (5)
Lein, John Marion Co. General Hospital (7)
LeMaster, Theodore R. . 304 Hume Mansur Bldg. (4)
Leonard, Henry S. (S) . 303 Hume Mansur Bldg. (4)
Leser, Ralph U. 3233 N. Meridian St. (8)
Levi, Leon 40 W. Maple Rd. (8)
Levin, Ralph T. 3400 N. Meridian St. (8)
Lewis, Paul S. 6357 Rockville Rd. (24)
Lewis, R. Earl 1638 E. Raymond St. (3)
Lichtenberg, Melvin 535 E. 38th St. (5)
Lidikay, Edward C. . . . 621 Hume Mansur Bldg. (4)
Lindenborg, Paul G. 5649 Rosslyn Ave. (20)
Lingeman, Raleigh E. 1802 N. Illinois St. (2)
Lingeman, Roger E. . . . 2081 N. Emerson Ave. (18)
Link, Goethe (S) 608 K. of P. Bldg. (4)
Little, John W. (S) 2735 E. 10th St. (1)
Littlefield, Paul A.
4040 Crooked Creek Overlook (8)
Littlefield, Shirley D.
4040 Crooked Creek Overlook (8)
Lloyd, Frank P. 1540 Columbia Ave. (2)
Loehr, William M. I. U. Medical Center (7)
Loomis, Norman S. 5230 N. Kenwood Ave. (8)
Lord, Glenn C. 104 E. 38th St. (5)
Louden, Robert W. 8545 Westfield Blvd. (20)
Love, George N. 5331 Washington Blvd. (20)
Lozow, David 3939 Meadows Dr. (5)
Lucas, Clarence A., Jr. . . . 2012 Boulevard Pl. (2)
Ludwig, Oscar D. (S) 2251 S. Ransdell (25)
Lukemeyer, George T. I. U. Medical Center (7)
Lunsford, Thomas E. Methodist Hospital (7)
Lurie, Paul R. I. U. Medical Center (7)
Luros, J. Theodore 1633 N. Capitol Ave. (2)
Lybrook, William B. . . . 3731 N. Keystone Ave. (18)

M

MacDougall, John D. 3939 Meadows Dr. (5)
McAree, Francis E. Methodist Hospital (7)
McBride, James S. 810 Hume Mansur Bldg. (4)
McCallum, Donald C. Methodist Hospital (7)
McCallum, Joseph T. C. 237 W. 46th St. (8)
McCallum, Robert N. 4140 Edgemere Ct. (5)
McCartney, Donald H. . 918 Hume Mansur Bldg. (4)
McCaskey, Carl H. (S) 608 Guaranty Bldg. (4)
McClain, Edwin S. 414 Hume Mansur Bldg. (4)
McCormick, Charles O., Jr.
621 Hume Mansur Bldg. (4)
McCoy, Melvin H. 3349 Georgetown Rd. (24)
McDevitt, Daniel R. . . . 8710 Washington Blvd. (20)
McGrath, Michael F. 1929 E. 38th St. (18)
McGuff, Paul E. 4829 E. 38th St. (18)
McIntyre, Charles J. (S)
414 Hume Mansur Bldg. (4)
McIntyre, James M. 2901 N. Meridian St. (8)
McKinley, A. David I. U. Medical Center (7)
McLaren, David E. Methodist Hospital (7)
McLaughlin, William T. 3383 Meadows Ct. (5)
McMillan, Frederick G. (S)
1110 Odd Fellows Bldg. (4)
McQuiston, Ralph J. 608 Guaranty Bldg. (4)
McTurnan, Robert W. 5646 N. Illinois St. (8)
Mackey, Harry S. (S) 4309 Central Ave. (5)
Mackey, John E. 3400 N. Meridian St. (8)
Madden, Robert J. 4612 E. Tenth St. (1)
Madtson, A. Ricks 822 Hume Mansur Bldg. (4)
Magennis, Herbert L. (S) . 468½ W. Washington (4)
Manalan, Maurice M. . . 5831 E. Washington St. (19)
Manders, Karl L. 2901 N. Meridian St. (8)
Manion, Marlow W. 601 Hume Mansur Bldg. (4)
Mann, Mortimer 3602 N. Meridian St. (8)
Mann, Richard E. 1315 W. Tenth St. (7)
Manning, K. Randolph . 723 Hume Mansur Bldg. (4)

Manzie, Michael W.....1633 N. Capitol Ave. (2)
Marks, Maurice I.....2901 N. Meridian St. (8)
Marsh, Carl M.....2626 N. Alabama St. (5)
Marsh, Myrle F.....I. U. Medical Center (7)
Marshall, Albert L., Jr.
Indiana State Board of Health, 1330 W. Michigan St. (7)
Marshall, Cavins R. (S).....43 W. 30th St. (8)
Marshall, Thomas R.....I. U. Medical Center (7)
Martin, Hugh E.
Pitman-Moore Co., 1200 Madison Ave. (6)
Martin, Loren H.....2626 W. Washington St. (22)
Martz, Bill L.
Lilly Clinic, Marion Co. General Hospital (7)
Martz, Carl D.....912 Hume Mansur Bldg. (4)
Marvel, Robert J.....3311 N. Meridian St. (8)
Marymount, Jesse H.....I. U. Medical Center (7)
Masters, John M.....805 Hume Mansur Bldg. (4)
Masters, Robert J.....805 Hume Mansur Bldg. (4)
Matheus, Charles G.....I. U. Medical Center (7)
Matthew, W. Burleigh 520 Hume Mansur Bldg. (4)
Matthews, Bernard J.....4612 E. 10th St. (1)
Matthews, William M.....4612 E. 10th St. (1)
Maxam, B. T.....400 Hume Mansur Bldg. (4)
Meaney, James J.
LaRue Carter Hospital, 1315 W. Tenth St. (7)
Megenhardt, Dennis S...1633 N. Capitol Ave. (2)
Meiks, Lyman T.....Riley Hospital (7)
Melin, John R.....3440 N. Meridian St. (8)
Melloh, Ardis F.....2821 E. 10th St. (1)
Mendenhall, Clarence D.
4016 E. Washington St. (1)
Mentendiek, Maurice H.
205 Hume Mansur Bldg. (4)
Mericle, Earl W.....1633 N. Capitol Ave. (2)
Merrell, Paul 420 Hume Mansur Bldg. (4)
Mershon, Jack B.....5505 N. Keystone Ave. (20)
Mertz, John H. O.....1711 N. Capitol Ave. (7)
Meulbroek, Harvey....1908 N. Capitol Ave. # 6 (7)
Michael, Isaac E....2966 Kessler Blvd., N. Dr. (20)
Middleton, Harvey N.....1828 N. Illinois St. (2)
Millar, Glenn C.....Methodist Hospital (7)
Miller, David I....Marion Co. General Hospital (7)
Miller, Frank H.....201 Hume Mansur Bldg. (4)
Miller, Harold L.....St. Vincent's Hosp. (7)
Miller, J. Don (S).....3142 Broadway (5)
Miller, Jerry R.....I. U. Medical Center (7)
Miller, John D.....Sunnyside Sanitorium (26)
Miller, Raleigh S.....6211 College Ave. (20)
Miller, Roscoe E.....I. U. Medical Center (7)
Million, Rodney R.....Robert Long Hospital (7)
Mitchell, Edward O....5704 N. Keystone Ave. (20)
Mitchell, George H...6049 E. Washington St. (19)
Moenning, John E.
Marion Co. General Hospital (7)
Moenning, Walter P.....618 K of P Bldg. (4)
Montgomery, William F.
904 Hume Mansur Bldg. (4)
Moore, Donald F.
LaRue Carter Hospital, 1315 W. 10th St. (7)
Moore, Harold T.....Methodist Hospital (7)
Moore, Richard B.....5005 N. Illinois St. (8)
Moore, William G.....General Hospital (7)
Morchan, Samuel.....3769 College Ave. (5)
Morgan, Margaret E.....4144 N. Penn. St. (5)
Moriarty, John R.....5602 Madison Ave. (3)
Morrison, Lewis E.....603 Hume Mansur Bldg. (4)
Morrow, Dean H.....I. U. Medical Center (7)
Morrow, Robert E.....I. U. Medical Center (7)
Morton, Joseph L.....St. Vincent's Hosp. (7)
Morton, Walter P.....3434 Fall Creek Blvd. (5)
Moser, Rollin H.....400 Hume Mansur Bldg. (4)
Moss, Bobby L.....4533 E. 21st St. (18)
Moss, Herschel C.....401 E. 34th St. (5)
Mothersill, Mark H. (S).....3650 College Ave. (5)
Moulton, Lillian G....1327 N. Pennsylvania St. (2)
Mouser, Robert W.....6201 Park Ave. (20)
Mueller, Lillian B. (S).....4026 Broadway (5)
Muller, Lullus P.....3120 N. Meridian St. (8)
Muller, Paul F.....3311 N. Meridian St. (8)
Muller, Victor H.....St. Vincent's Hosp. (7)
Mumford, E. Bishop (S).....812 C. of C. Bldg. (4)
Musser, A. Wendell.....I. U. Medical Center (7)
Myers, Charles W.....R. R. 18, Box 256 (24)
Myers, Roy V.....1904 N. Rural St. (18)

N

Nafe, Cleon A.....822 Hume Mansur Bldg. (4)
Nagan, Robert F.....606 Hume Mansur Bldg. (4)
Nay, Richard M.....1015 Hume Mansur Bldg. (4)
Nayyar, Som N.....I. U. Medical Center (7)
Need, Louis T.....1927 S. Meridian St. (25)
Neeley, Alonzo S. (S)
2324 E. Pleasant Prkwy. N. Dr. (3)
Nelson, Audrey H.....4132 Patricia (24)
Nelson, John W.....I. U. Medical Center (7)
Nester, Henry G.....307 City Hall (4)
Nicholas, Dennis.....2425 E. 38th St. (18)
Nie, Louis W.....2901 N. Meridian St. (8)
Nohl, John M.....975 N. Emerson Ave. (19)
Nolin, Richard T.....6007 Michigan Rd. (8)
Nolting, Henry F. (S).....261 W. 40th St. (8)
Norman, William H....908 Hume Mansur Bldg. (4)
Norris, Howard L.....704 Hume Mansur Bldg. (4)
Norris, Max S.....510 Hume Mansur Bldg. (4)
Nourse, Myron H.....1711 N. Capitol Ave. (7)
Nugent, Edwin J.....Allison Div. GMC (6)
Nurnberger, John I.....I. U. Medical Center (7)

O

O'Brian, Earl J.....3041 Lafayette Rd. (22)
Ochsner, Harold C.....Methodist Hospital (7)
Offutt, Andrew C...Indiana State Board of Health, 1330 W. Michigan St. (7)
Olson, John R.....313 Hume Mansur Bldg. (4)
Olvey, Ottis N.....3769 Park Ave. (5)
O'Malley, Martha A.....Ind. St. Bd. of Health 1330 W. Michigan St. (7)
Orders, Clark E. (S) .440 Bankers Trust Bldg. (4)
Ormiston, Michael W...Sunnyside Sanitarium (26)
Otten, Claude F.....812 C. of C. Bldg. (4)
Ottinger, Ross C. (S).....5211 N. Meridian St. (8)
Overhulse, Paul R.....923 Hume Mansur Bldg. (4)
Owen, John E.....605 Hume Mansur Bldg. (4)
Owens, Tracy C.....2823 N. Meridian St. (8)

P

Palmer, Charman F.....Methodist Hosp. (7)
Palmer, Robert M.....I. U. Medical Center (7)
Palmer, Robert W.....1633 N. Capitol Ave. (2)
Pandolfo, Harry.....234 E. Southern Ave. (25)
Pappas, Paul N.....I. U. Medical Center (7)
Parker, George F., Jr...1502 N. Emerson Ave. (19)
Parker, John F.....1706 E. Washington St. (1)
Parker, L. Burton Marion Co. General Hospital (7)
Parker, Portia.....2226 W. Michigan St. (22)
Parr, Robert L.....3043 E. 38th St. (18)
Paskind, J.....Marion Co. General Hospital (7)
Patton, Martin T.....107 W. 30th St. (8)
Paulissen, George T.....741 Markwood Ave. (27)
Paz, Luis.....Methodist Hospital (7)
Pearson, John S.....American United Life Ins. Co., 30 W. Fall Creek Parkway (6)
Pearson, Lyman R.....311 Hume Mansur Bldg. (4)
Pebworth, Aubrey C. (S)..1625 W. Morris St. (21)
Peck, Franklin B. Jr.
Lilly Clinic, Marion Co. General Hospital (7)
Peck, Franklin B. Sr.
Eli Lilly & Co., 740 S. Alabama St. (6)
Peirce, James D.
Eli Lilly & Co., 740 S. Alabama St. (6)
Pennington, Walter E. (S)
214 Hume Mansur Bldg. (4)
Perlov, Sylvan H.....5505 N. Keystone Ave. (20)
Permer, Erwin.....136 E. 30th St. (5)
Peterson, Deward D.
Marion Co. General Hospital (7)
Petranoff, Theodore V.....515 N. Tibbs Ave. (22)
Pettijohn, Fred L. (S).....2460 Central Ave. (5)

Pfaff, Dudley A.
V. A. Regional Office, 36 S. Pennsylvania St. (4)
Phillips, David L. 605 E. 38th St. (5)
Pickett, Robert D. 400 Hume Mansur Bldg. (4)
Pierce, Emmett, Jr.
Marion Co. General Hospital (7)
Pierce, William J. Methodist Hospital (7)
Pilcher, Jack E. 1802 N. Illinois St. (2)
Plasterer, Edward D. . . 1833 Eisenhower Dr. (24)
Pontius, Edwin E. Methodist Hosp. (7)
Popplewell, Arvine G.
Marion Co. General Hospital (7)
Porter, George S. I. U. Medical Center (7)
Porterfield, Hubert W.
408 Hume Mansur Bldg. (4)
Powell, Richard C. I. U. Medical Center (7)
Pribble, Robert H.
Marion Co. General Hospital (7)
Price, Francis W. 1002 E. Troy Ave. (3)
Price, James O. 512 Hume Mansur Bldg. (4)
Priebe, Fred H. . . . Marion Co. General Hospital (7)
Pryor, Richard C. 6111 College Ave. (20)

Q

Quigley, Joseph B. 817 Hume Mansur Bldg. (4)

R

Rabb, Harry S. 3139 E. 10th St. (1)
Raber, Robert M. 1633 N. Capitol Ave. (2)
Rader, George S. 1010 Hume Mansur Bldg. (4)
Radigan, Leo R.
VA Hospital, 1481 W. Tenth St. (7)
Rafalski, Thomas A. 3120 N. Meridian St. (8)
Ragan, William D. 3400 N. Meridian St. (8)
Ralston, John D. Central State Hosp. (22)
Ramsey, Frank B. 1802 N. Illinois St. (2)
Rapp, George F. St. Vincent's Hosp. (7)
Reed, Philip B. 4131 N. Meridian St. (8)
Reed, Ronald R. Methodist Hospital (7)
Rees, Russel C. 6114 E. Washington St. (19)
Reibel, Donald B. Methodist Hospital (7)
Reid, Charles A. 2445 Shelby St. (3)
Reid, James D. 440 N. Winona St., # 414 (2)
Reid, Robert H. Methodist Hospital (7)
Reisler, Simon (S) 318 Bankers Trust Bldg. (4)
Rhamy, Robert K. I. U. Medical Center (7)
Rice, Frederic A. 7017 Pendleton Pike (26)
Rice, Raymond M.
Eli Lilly & Co., 740 S. Alabama St. (6)
Richardson, Thad T. 513 S. Sherman Dr. (3)
Richter, Arthur B. . . . 720 Hume Mansur Bldg. (4)
Ricketts, Joseph W. (S) . . 2901 N. Meridian St. (8)
Ridgeway, Ora W. (S) 411 E. 16th St. (2)
Ridolfo, Anthony S.
Eli Lilly & Co., 740 S. Alabama (6)
Rigg, John F. 421 Hume Mansur Bldg. (4)
Riner, Jack K. 1618 N. Temple (18)
Ritchey, James O. 608 Hume Mansur Bldg. (4)
Ritter, Wayne L. 404 Hume Mansur Bldg. (4)
Robb, John A. 238 Hume Mansur Bldg. (4)
Robertson, Ray B. . . . 6118 E. Washington St. (19)
Roesch, Ryland P. 3620 Marrison Pl. (5)
Roeske, Nancy A. 220 W. Beverly Dr. (5)
Rogers, Donald L. 3426 N. Meridian St. (8)
Roggenkamp, Milton W.
6347 Forest View Dr. (20)
Rohn, Robert J. I. U. Medical Center (7)
Roll, John W. 3628 N. Sherman Dr. (18)
Roller, Charles W. (S) 915 Hervey (3)
Romberger, Floyd T., Jr. . . 3440 N. Meridian St. (8)
Rosenak, Bernard D. . . 226 Hume Mansur Bldg. (4)
Rosenbaum, David
V. A. Hospital, 1481 W. 10th St. (7)
Rosenbaum, Irving, Jr. 401 E. 34th St. (5)
Roshe, Joseph I. U. Medical Center (7)
Ross, Alexander T. I. U. Medical Center (7)
Roth, Bertram S. 6358 College Ave. (20)
Row, D. Hamilton . . . 906 Hume Mansur Bldg. (4)
Rubin, Gerald S. 419 Hume Mansur Bldg. (4)
Ruddell, Karl R. (S) 3202 N. Meridian St. (8)
Ruddell, Keith 3202 N. Meridian St. (8)
Rudesill, Cecil L. (S) . . 405 Hume Mansur Bldg. (4)
Rudesill, Robert L. 405 Hume Mansur Bldg. (4)
Rudolph, Kenneth J. 1827 N. Norfolk (24)
Russell, John R. I. U. Medical Center (7)
Rust, Byron K. 3740 Central Ave. (5)
Rust, Roland B. 3939 Meadows Drive (5)
Ruth, Martin L. 4304 E. Washington St. (1)
Rutherford, Cyrus W. (S)
4601 N. Pennsylvania St. (5)
Ryan, Glen V. 2428 W. 16th St. (22)

S

Sage, Russell A. 505 Hume Mansur Bldg. (5)
Salb, Max C. 826 C. of C. Bldg. (4)
Samter, Thomas G. I. U. Medical Center (7)
Sanders, Harry M. 4829 E. 38th St. (18)
Sandorf, Marvin H. 1102 Prospect St. (3)
Schaefer, C. Richard (S) . . 1838 N. Meridian St. (2)
Schaffer, Edward V. . . . 806 Hume Mansur Bldg. (4)
Schechter, John S. 3400 N. Meridian St. (8)
Scheier, Emil W. 1542 Prospect St. (3)
Schlaegel, Theodore F., Jr.
419 Hume Mansur Bldg. (4)
Schlegel, Donald M. 1802 N. Illinois St. (2)
Schmalhausen, Ansel W. Methodist Hospital (7)
Schmidt, Loren F. 605 Hume Mansur Bldg. (4)
Schmoyer, Maurice R. . . . Community Hospital (19)
Schneider, Carl J. 1008 N. Beville Ave. (1)
Schnute, Richard B. I. U. Medical Center (7)
Schuchman, Abe 3763 Broadway (5)
Schuchman, Gabriel 3451 College Ave. (5)
Schuster, Dwight W. . . 723 Hume Mansur Bldg. (4)
Schut, Almon L. I. U. Medical Center (7)
Schwarz, Anton
Pitman-Moore Co., 1200 Madison Ave. (6)
Scott, George E. 3636 N. Layman Ave. (18)
Scott, I. Winfield 3400 N. Meridian St. (8)
Scott, John R. 6214 Broadway (20)
Scott, Robert P. 209 Hume Mansur Bldg. (4)
Scott, Samuel L. 6325 Guilford Ave. (20)
Seaman, Charles F. . . . 1010 Hume Mansur Bldg. (4)
Sedam, Herbert L. 4548 College Ave. (5)
Segar, Louis H. 818 E. 48th St. (5)
Segar, William E. Riley Hosp. (7)
Sellmer, George W. 8545 Westfield Blvd. (20)
Sexson, Hiram T. 3731 N. Keystone (18)
Shafer, Marion R. 614 Hume Mansur Bldg. (4)
Shanafelt, Donald K. 1802 N. Illinois St. (2)
Sheehan, Francis G. . . . 6049 E. Washington St. (19)
Shelley, Richard 6016 E. Washington (19)
Sherster, Harry 1135 S. Meridian St. (25)
Shipley, Edward
LaRue Carter Hospital, 1315 W. Tenth St. (7)
Shullenberger, Wendell A. . . . 3740 Central Ave. (5)
Shumacker, Harris B., Jr. . . I. U. Medical Center (7)
Sicks, Okla W. 606 Hume Mansur Bldg. (4)
Sidebottom, Earl W. . . 507 Hume Mansur Bldg. (4)
Sidell, James P. Methodist Hospital (7)
Siderys, Harry 3002 N. Tibbs Ave. (22)
Siebe, Jack C. 4829 E. 38th St. (18)
Siersdorfer, Theodore N. (S)
5559 W. Morris St. (21)
Sigmond, Harvey W. . . 321 Hume Mansur Bldg. (4)
Silver, Richard A. . . . 712 Hume Mansur Bldg. (4)
Simmons, James E. I. U. Medical Center (7)
Simms, J. Leon 2453 Northwestern Ave. (23)
Simpson, William D. . . 1121 N. Arlington Ave. (19)
Sims, J. Lawrence 3400 N. Meridian St. (8)
Slichenmyer, Jack E. . . I. U. Medical Center (7)
Sluss, David H. 808 C. of C. Bldg. (4)
Sluss, John W. (S) 808 C. of C. Bldg. (4)
Smith, David Joe L. S. Ayres & Co. (9)
Smith, David L. 2901 N. Meridian St. (8)
Smith, Edward B. I. U. Medical Center (7)
Smith, E. Rogers 822 Hume Mansur Bldg. (4)
Smith, Francis C. 983 N. Arlington Ave. (19)
Smith, Roy Lee 707 Underwriters Bldg. (4)
Smith, William B. 2229 Northwestern Ave. (23)
Snapp, Richard A. 3120 N. Meridian St. (8)

Snider, Byron....2717 S. East St. (3)
Solomon, Reuben A....414 Hume Mansur Bldg. (4)
Sommers, Stephen D....Riley Hospital (7)
Soper, Hunter A....1015 Hume Mansur Bldg. (4)
Souter, Martha C....3360 N. Meridian St. (8)
Southworth, John W....1315 W. Tenth St. (7)
Sovine, Joe W....922 Hume Mansur Bldg. (4)
Spahr, John F., Jr....3440 N. Meridian St. (8)
Spalding, Joseph J....706 Hume Mansur Bldg. (4)
Sparks, Alan L....1024 Hume Mansur Bldg. (4)
Spears, John M....5562 Madison Ave. (27)
Speckman, Glenn H....2120 E. 10th St. (1)
Spivey, Russell J....2616 N. Pennsylvania St. (5)
Spolyar, Louis W...Indiana State Board of Health, 1330 W. Michigan St. (7)
Sprenger, Thomas R....General Hosp. (7)
Sputh, Carl B., Jr....301 Doctors' Bldg. (4)
Stadler, Harold E....5508 E. Washington St. (19)
Staff, Robert A....R.R. 8, Box 215 (31)
Stansbury, William E....3628 N. Sherman Dr. (18)
Staten, Jesse C....Chevrolet Body Div., GMC, 340 White River Pkwy., W. Dr. S. (22)
Stayton, Chester A., Jr. 313 Hume Mansur Bldg. (4)
Steinmetz, Edward F. Marion Co. General Hospital (7)
Stephens, Donald E....6332 Guilford Ave. (20)
Stephens, Kuhrman H..501 Hume Mansur Bldg. (4)
Stevens, Sydney L....303 Hume Mansur Bldg. (4)
Stoelting, Vergil K....I. U. Medical Center (7)
Stone, Alvin T....6202 College Ave. (20)
Stone, David F. Eli Lilly & Co., 740 S. Alabama (6)
Stone, Robert C...Marion Co. General Hospital (7)
Storey, D. Edmund....813 Broad Ripple Ave. (20)
Storey, Joseph L....3454 N. Illinois St. (8)
Storms, Roy B. (S)....5041 Central Ave. (5)
Streeter, Ralph T....3131 E. 38th St. (18)
Strickland, Neil R....Methodist Hospital (7)
Stroup, Tyler J....216 K. of P. Bldg. (4)
Stucky, Elsworth K....1349 Madison Ave. (25)
Stump, Loyd K....3939 Meadows Dr. (5)
Stump, Thomas A....I. U. Medical Center (7)
Stygall, James H. (S)....1221 N. Delaware St. (2)
Suelzer, John G....I. U. Medical Center (7)
Summerlin, Jack D....I. U. Medical Center (7)
Sutton, William E....521 Hume Mansur Bldg. (4)
Swan, John R....915 Hume Mansur Bldg. (4)
Symmes, Alfred T....625 E. 38th St. (8)
Szumilas, Peter P. Marion Co. General Hospital (7)
Szynal, John S....633 E. 38th St. (5)

T

Talbott, Dan E....1802 N. Illinois St. (2)
Tanner, Henry S....321 Hume Mansur Bldg. (4)
Taube, Jack I....1007 Hume Mansur Bldg (4)
Taylor, Clifford C....Community Hospital (19)
Taylor, Cyril....I. U. Medical Center (7)
Taylor, Frederic W...822 Hume Mansur Bldg. (4)
Taylor, Max T....Marion Co. General Hospital (7)
Teague, Frank W....918 Hume Mansur Bldg. (4)
Teixler, Victor A....224 Hume Mansur Bldg. (4)
Test, Charles E....1002 Hume Mansur Bldg. (4)
Teter, George V....401 E. 34th St. (5)
Tether, Joseph E....510 Hume Mansur Bldg. (4)
Tharpe, Ray....3202 N. Meridian St. (8)
Thatcher, Hugh K., Jr....4548 College Ave. (5)
Thomas, Charles R....Methodist Hosp. (7)
Thomas, Edward P....917 W. 30th St. (23)
Thomas, Fred A....St. Vincent's Hospital (7)
Thomas, Lowell I....615 Hume Mansur Bldg. (4)
Thomas, Morris E....1802 N. Illinois St. (2)
Thompson, John V....7899 Ridge Rd. (20)
Thompson, Joseph F....I. U. Medical Center (7)
Thompson, Paul D. 404 Hume Mansur Bldg. (4)
Thompson, Wayne H....1633 N. Capitol Ave. (2)
Thornburg, Kenneth E...1633 N. Capitol Ave. (2)
Thornton, Harold C....301 E. 38th St. (5)
Throop, Frank B....3400 N. Meridian St. (8)
Tindall, George T....6002 Windsor Dr. (18)
Tinsley, Frank W....3044 LaFayette Rd. (22)
Tinsley, Walter B., Jr....3044 LaFayette Rd. (22)
Tinsley, Walter B.(S)....603 K. of P. Bldg. (4)
Tischer, E. Paul....208 Hume Mansur Bldg. (4)
Tondra, John M....408 Hume Mansur Bldg. (4)
Torrella, Jose A....5324 W. 16th St. (24)
Tosick, William A. Marion Co. General Hospital (7)
Toumey, Fred L....1802 N. Illinois St. (2)
Trusler, Harold M....408 Hume Mansur Bldg. (4)
Tuchman, Joseph H....2040 E. 46th St. (5)
Tucker, Warren S....414 Hume Mansur Bldg. (4)
Tyner, Harlan H....3202 N. Meridian St. (8)

U-V

Ullom, Ralph B....Methodist Hospital (7)
Vandivier, Robert M...209 Hume Mansur Bldg. (4)
Van Dorn, Myron J....2165 Weslynn Dr. (8)
Van Fleet, Josephine....Indiana State Board of Health, 1330 W. Michigan St. (7)
Van Meter, C. Powell....3419 E. 10th St. (1)
Van Nuys, John D....I. U. Medical Center (7)
Van Tassel, Charles J..709 Hume Mansur Bldg. (4)
Van Vactor, Helen D...226 Hume Mansur Bldg. (4)
Vellios, Frank....I. U. Medical Center (7)
Vollrath, Victor J....5202 N. Illinois St. (8)
Von Der Haar, Gerard....4016 E. Michigan St. (1)
Vore, Robert E....Marion Co. General Hospital (7)
Voyles, Charles F. (S)....1802 N. Illinois St. (2)

W

Wainscott, Clinton S. Marion Co. General Hospital (7)
Waldo, J. Thayer....610 Hume Mansur Bldg. (4)
Walker, Frank C. (S)..414 Hume Mansur Bldg. (4)
Walker, Robert K....413 E. 34th St. (5)
Wallace, Collins R....I. U. Medical Center (7)
Walther, Joseph E....3202 N. Meridian St. (8)
Walton, William M....1802 N. Illinois St. (2)
Warbinton, Fred P....Methodist Hospital (7)
Ward, Wesley C....3 E. 46th St. (5)
Warfel, Frederick C. (S)....4817 Broadway (5)
Warman, Alvah P. (S)....1363 E. Maple Rd. (5)
Warriner, James B....1012 N. Emerson Ave. (19)
Warshaw, Seymour....I. U. Medical Center (7)
Warvel, John H....614 Hume Mansur Bldg. (4)
Weaver, Marlin....I. U. Medical Center (7)
Weber, Norbert...Marion Co. General Hospital (7)
Wehrman, Jule O. (S)....410 N. Meridian St. (4)
Weigand, Clayton G....Eli Lilly & Co., 740 S. Alabama St. (6)
Weinland, George C....Larue D. Carter Hospital, 1315 W. 10th St. (7)
Weiss, Jason....4914 W. Sixteenth St. (24)
Weller, Charles A. (S)...3720 N. Delaware St. (5)
West, Joseph L....6714 Rockville Rd. (41)
Westfall, B. Kemper....2901 E. 38th St. (18)
Westfall, John B...1025 Hume Mansur Bldg. (4)
Wheeler, David E. VA Hospital, 1481 W. Tenth St. (7)
White, Donald J....502 Bankers Trust Bldg. (4)
White, Douglas H...1015 Hume Mansur Bldg. (4)
White, John B....806 Hume Mansur Bldg. (4)
White, Nicholas....Methodist Hospital (7)
White, Philip T....I. U. Medical Center (7)
Widdifield, G. E....2614 Madison Ave. (3)
Wilkens, Irvin W....1743 Shelby St. (3)
Williams, Charles D....2422 Station St. (1)
Williams, Clifford L...Central State Hospital (22)
Williams, Harold W....Methodist Hospital (7)
Williams, Howard S....115 E. 16th St. (2)
Williams, Hugh L....4829 E. 38th St. (18)
Williams, Paul D....Central State Hospital (22)
Willitts, Bruce K....Methodist Hospital (7)
Wilmore, Ralph C....I. U. Medical Center (7)
Wilson, Fred M....I. U. Medical Center (7)
Wilson, Oliver R....3440 N. Meridian St. (8)
Wise, William R....120 E. 22nd St. (2)
Wishard, William N., Jr...1711 N. Capitol Ave. (7)
Witham, Robert L....821 Broad Ripple Ave. (20)

Wolfram, Don J.....208 Hume Mansur Bldg. (4)
Wood, Donald E.....6325 Guilford Ave. (20)
Wood, William H.....3120 N. Meridian St. (8)
Woodard, Abram S.....668 E. 38th St. (5)
Wooden, Thomas F.....I. U. Medical Center (7)
Woolling, Kenneth R...718 Hume Mansur Bldg. (4)
Worley, Joseph P.....5839 E. Washington St. (19)
Worley, Richard H.....5317 E. 16th St. (18)
Wrege, Malcolm L.....1502 N. Emerson Ave. (19)
Wright, J. William, Jr..301 Hume Mansur Bldg. (4)
Wyttenbach, John E....503 Hume Mansur Bldg. (4)

Y

Yacko, Michael L.....821 Broad Ripple Ave. (2)
Yingling, Robert J.....I. U. Medical Center (7)
Young, James W.....6302 Guilford Ave. (20)
Young, John E.....4829 E. 38th St. (18)
Young, John M.....4535 Marcy Lane (5)
Yurdin, Donald H.....I. U. Medical Center (7)

Z

Zell, Evertson H.....812 C. of C. Bldg. (4)
Zerfas, Phyllis K.....R. R. 1, Box 220 (27)
Zore, Joseph J.....I. U. Medical Center (7)

Lewis, Robert J.....Lawrence
Asher, Ernest O. (S).....New Augusta
Asher, James W.....New Augusta
Thrasher, John R. (S)
R. R. 1, Box 362, New Augusta
Freeborn, Warren S.....Oaklandon
Miller, Joseph A.....Oaklandon
Palmer, Harley P.....Southport
Paynter, Morris B.....Southport
Jones, George L.....Wanamaker

Bohner, Caryle B.....Huasca, Hidalog, Mexico
Booze, James
377 USAF Hosp., A.P.O. 117, New York, N. Y.
Bradley, Louis F.
1641 Flournoy, Chicago 12, Illinois
Brayton, John R., Jr.
Naval Air Station, Pensacola, Fla.
Buell, Forrest R.
Denver Gen. Hospital, Denver, Colorado
Burman, Leonard
116 Cottonwood Road, Oceanside, California
Call, William H.
2750 Southwestern, San Angelo, Texas
Clark, George A.
1664 Graefield, Birmingham, Michigan
Cullen, Paul K. Jr.
Mayo Clinic, Rochester, Minnesota
Dierdorf, Fred W.
Ind 7520th U. S. A. F. Hosp.,
APO 125, New York, N. Y.
Dirks, Kenneth R.
Madigan Army Hospital, Tacoma, Washington
Finfrock, James D.
VA Hospital, Fayetteville, Arkansas
Fisher, Gerald.....Ippy, French Equatorial Africa
Fralich, Joseph C.
Milwaukee Co. Hospital, Milwaukee, Wisconsin
Gabe, William E.
61 Heather Lane, Orinda, California
Gachaw, Gabra S.....7 Kiernan Dr., Rantoul, Ill.
Hall, Jack H.
New England Deaconess Hospital, Boston, Mass.
Huffman, Galen C.
Columbus Psy. Inst. and Hosp., Columbus 10, Ohio
Jennings, F. Lamont
8607 S. University, Chicago, Illinois
Jones, Roland W.
USN Hospital, Bethesda, Maryland
Kenoyer, Wilbur L.
3700 USAF Hospital, Lackland AFB, Texas
Lochry, Ralph L. (S)
63 Isle of Venice, Fort Lauderdale, Fla.
Marty, Sophocles
USN Hospital, Corpus Christi, Texas
MacCollum, M. Speers
Luke AFB, Glendale, Arizona
Mertz, Henry O. Sr.
R.R. #2, Box 1619, Nokomis, Fla.
Mori, Victor M.
Ind State T.B. Hospital,
Bluegrass Ave., Louisville, Ky.
Moss, Harlan B.
1122 E. College Avenue, Iowa City, Iowa
Murray James S.
606 N. Roxbury, Beverly Hills, Calif.
Norris, Mary Alice
c/o Col. J. F. Surratt, Hq. NACOM, A.P.O. 757,
New York, N. Y.
Pinsky, Sheldon T.....4755 Noble, Bellaire, Ohio
Rhodes, Theodore D.
R.R. #2, Box 1595, Nokomis, Fla.
Rice, Reed...720 16th Ave. N.E., Rochester, Minn.
Robinson, Frank C. (S)
221 Via Firenze, Newport Beach, Calif.
Rogers, Thomas P.....USN Hospital,
San Diego 33, Calif.
Rohrbacker, Donald M.
Williams AFB, Chandler, Arizona
Rudolph, Stephen J., Jr.
832nd TAC Hosp., Cannon AFB
New Mexico
Rupel, Ernest
1841 Venetian Pt. Dr., Clearwater, Fla.
Salzman, Morris
350 E. 30th St., New York 16, N. Y.
Shoptaugh, A. Glenn Jr.
30750th USAF, Sheppard AFB
Wichita Falls, Texas
Stanley, John S.
470 N. E. 25th St., Miami 37, Florida
Steury, Ernest M.
Kenya Colony, British East Africa
Talarico, Leonard H.
6044 Lansdowne Ave., St. Louis 9, Missouri
Taylor, Richard A.
28 W. Adams, #1002, Detroit, Mich.
Thurston, Harrison S. (S)
1204 Earlham Drive, Dayton 6, Ohio
Tinney, William E. (S)
P. O. Box 1186, Pass-A-Grille, Florida
Weisenberger, Brockton L.
USPHS Indian Hospital, Rosebud, S. Dakota
White, Donald G.
304 Stevens Dr., Colorado Springs, Colo.
Williams, Russell S.
20th Station Hosp., A.P.O. 696,
New York, N. Y.
Wilson, Ned A.....529 Alpine Way, Marietta, Ga.
Ziperman, H. Haskell
Brooke Army Med. Center, Ft. Sam Houston,
Texas

MARSHALL COUNTY

Hampton, James N.....Argos
Kelly, Frank (S).....Argos
Connell, Vactor O.....Bourbon
Marshall, George L. (S).....Bourbon
Bowen, Otis R.....Bremen
Burket, Cecil R.....Bremen
Cripe, Earl P.....Bremen
Schreiner, John E.....Bremen
Stine, Marshall E.....Bremen
Baker, Milan D.....Culver
Norris, Ernest B.....Culver
Reed, Donald.....Culver

Plymouth

Connell, Paul S.....320 N. Center St.
Coursey, James O.....109 N. Walnut St.
Klingler, Maurice O.....213 W. LaPorte St.
Kubley, James D.....304 N. Walnut St.
Pomeroy, Rex K.....121 E. Garro St.
Reed, Robert G., Jr.....109 N. Walnut St.
Rimel, James F.....213 W. LaPorte St.

Robertson, James S.....304 N. Walnut St.
Vore, Louring W.....121 E. Garro St.

Thompson, Alfred A. (S).....Tyner

MARTIN COUNTY

(See Daviess-Martin)

MIAMI COUNTY

Shrock, Ethan E.....Amboy
Hill, Lloyd.....Denver
Malott, Fred R.....Converse
Sennett, William K.....Macy
Rendel, Harold E.....Mexico

Peru

Barnett, Ralph E.....65 N. Miami St.
Boone, Max L.....65 N. Miami St.
Burrous, E. Lee.....27 W. Sixth St.
Carlson, Edward A. (S).....11½ W. Main St.
Ferrara, Donald W.....18 W. Fifth St.
Ferrara, Samuel J.....18 W. Fifth St.
Herd, Cloyn R.....15 S. Wabash
Johnson, Owen.....106 W. Sixth St.
Malouf, Stephen D.....53 S. Broadway
Snyder, Parker M.....207 Senger-Mavrick Bldg.
Tan, Constancio C.....18 W. Fifth St.
Teaboldt, George.....18 W. Fifth St.
Wildman, Roscoe E.....27 W. Sixth St.

Hayes, Robert E.
Butterworth Hospital, Grand Rapids, Michigan
Kimmel, George E.
27 Tremont St., Stoneham 80, Mass.

MONROE COUNTY

(See Owen-Monroe)

MONTGOMERY COUNTY

Crawfordsville

Alexander, Stephen J.....306 Ben-Hur Bldg.
Burks, Jess E.....411 Ben Hur Bldg.
Cooksey, Thomas L. (S).....109½ S. Washington St.
Cornell, Robert A.....219 Ben Hur Bldg.
Daugherty, Fred N.....120 W. Pike St.
Dodds, Wemple.....Culver Hospital
Eggers, Richard.....120 W. Pike St.
Fisher, Frank L.....R. R. Donnelley & Sons Co.
Haller, Thomas C.....411 Tinsley Ave.
Humphreys, John W.....312 Jones Ave.
Kinnaman, Howard A.....206 Ben Hur Bldg.
Kirtley, James M.....416 Ben Hur Bldg.
Lingeman, Byron N.....419 Ben Hur Bldg.
Mount, William M.....413 Ben Hur Bldg.
Peacock, Norman F.....219 Ben Hur Bldg.
Pierson, Allen D.....305 E. Main St.
Pierson, Robert H.....305 E. Main St.
Shannon, Wesley.....901 Cottage Ave.
Sharp, John L.....219 Ben Hur Bldg.
Wallace, Hawthorne C.....411 Tinsley Ave.

Otten, Ralph E.....Darlington
Blix, Fred M.....Ladoga
Denny, Frank T.....Ladoga
Wong, Norman F.....Linden
Davis, William H.....New Market
Kindell, Hurschell D.....New Richmond
Thompson, Claude N.....Waynetown
Parker, Carl B.....Wingate

MORGAN COUNTY

Martinsville

Brubeck, Robert E.....60½ E. Morgan St.
Eisenberg, David A.....310 N. Main St.
Gibbs, Joseph W.....Home Lawn Sanitarium
Gray, Leon.....171 E. Washington St.
Miller, Ray D.....290 E. Washington St.
Pitkin, Edward M.....195 E. Washington St.
Pitkin, McKendree C.....440 E. Washington St.
Taylor, Loren F.....60½ E. Morgan St.
Van Wienen, John.....60 W. Morgan
Willan, Horace R.....109 S. Jefferson St.
Winter, William P.....60½ E. Morgan St.

Murphy, Maurice G. (S).....Morgantown

Mooresville

Bivin, James H.....Mooresville
Comer, Kenneth E.....130 N. Indiana
Karpel, Bernard.....Medical Arts Bldg.
Kendrick, William.....130 N. Indiana
Van Bokkelen, Robert W.....Medical Arts Bldg.

Farr, James C.....Paragon

NEWTON COUNTY

(See Jasper-Newton)

NOBLE COUNTY

Bowman, Charles M.....Albion
Nash, Justin R.....Albion
Mattmiller, Everette D.....Avilla
Sneary, Kenneth D.....Avilla
Sneary, Max E.....Avilla

Kendallville

Bryan, Robert E.....129 E. Main St.
Carey, Willis W. (S).....Lutheran Home
Gutstein, Richard R. (S).....120 Diamond
Hepner, Herman.....101½ N. Main St.
Lawson, Isaac H. (S).....125½ S. Main St.
Messer, Frank W.....115 E. Rush St.
Slough, O. Thomas.....112 W. Mitchell
Stallman, Carl F.....409 E. Wayne St.
Williams, Harold O.....115 E. Rush St.

Ligonier

Chase, James A.....104 S. Main St.
Stultz, Quentin F.....401 S. Cavin St.
Webster, Paul L.....321 S. Cavin St.

Fipp, August L.....Rome City
Pulskamp, Bertrand H.....Wolcottville
Luckey, Harold A.....Wolf Lake
Luckey, Robert C.....Wolf Lake
Roth, James R.....Wolf Lake

OHIO COUNTY

(See Dearborn-Ohio)

ORANGE COUNTY

Keseric, N. E.....French Lick Springs
Sugarman, Benjamin E.....French Lick Springs
Baker, Robert E. (S).....Orleans
Hodgin, Philip T.....Orleans
Schoolfield, William E.....Orleans
Clark, Ivan A.....Paoli
Hammond, Keith.....Paoli
Manship, Stanley.....Paoli
McCalla, Charles X.....Paoli
Spears, John K.....Paoli
Miller, Henderson L. (S).....West Baden Springs

OWEN-MONROE COUNTIES

Bloomington

Baxter, Neal E.....306 E. Fifth St.
Bidney, Evelyn B.....321 S. Jordan Ave.
Borland, Raymond M.....R. R. 3
Buckingham, Richard E.....344 College Ave.
Creek, Jean A.....312 N. Walnut St.
Estes, Ambrose C.....121 E. Kirkwood Ave.
Fowler, Richard R.....104 N. Grant St.
Geiger, Dillon D.....300 E. Kirkwood
Hardtke, Eldred F.....509 E. Fourth St.
Hepner, Herman S.....312 N. Walnut St.

Holland, Deward J. (S) 313 N. College Ave.
Holland, Philip T. 108 W. 7th St.
Holtzman, Paul W. 615 N. College
Hrisomalos, Frank N. 306 E. Fifth St.
Karsell, William A. 306 E. Kirkwood
Link, William C. 110 E. Fourth St.
Lundblad, Wilfred M. 1805 E. Tenth St.
Lyons, Robert E. 321 E. Fifth St.
Marchant, Clarence H. 350 S. College Ave.
McIntire, Clarence B. Bloomington Hospital
McLelland, Mary Rhamy R. R. 2
Middleton, Thomas O 404 E. Seventh St.
Milan, Joseph F. 106 N. Grant St.
Miller, John M. 1210 E. Wylie
Owen, Margaret A. 200 S. Washington St.
Pizzo, Anthony Bloomington Hospital
Poolitsan, George C. 407 N. Walnut St.
Quarles, E. Bryan Indiana University
Ramsey, Hugh S. 307 E. Fifth St.
Reed, William C. 307 E. Fifth St.
Rieger, I. Taylor 102 N. Grant St.
Rogers, Otto F., Jr. 210 N. Washington St.
Rollins, Thomas K. 114 E. Seventh St.
Ross, Ben R. 314 E. Seventh St.
Ross, James B. 314 E. Seventh St.
Schell, Harry D. 114 E. Fourth St.
Schuman, Edith B. Indiana University
Sibbitt, Joseph W. 300 E. Fifth St.
Smith, Herschel S. 110 S. Lincoln
Smith, Rodney D. (S) 115 N. Washington St.
Spencer, Beaufort A. 114 N. Lincoln
Stangle, William J. 640 S. Rogers
Topolgus, James N. 403 N. Walnut St.
Welpott, Jean F. Indiana University
Wenzler, Paul J. 110 S. Washington St.
Wilson, Talmage L. 301 E. Kirkwood

Stouder, Charles E. Ellettsville
Mitchell, George L. (S) Smithville
Brown, Marcel S. Spencer
Kay, Oran E. Spencer
Smith, Frederick R. Spencer

PARKE-VERMILLION COUNTIES

Clinton

Evans, Frederick J. 242 S. Third St.
Gerrish, Wakefield D. (S) Clinton
Herzberg, Milton 222 Elm St.
Kercheval, John M. 220 Blackman

Lauer, Dorothy B. Dana
Britton, Welbon D. Montezuma
De Renne, William L. Newport
Johnson, William A. (S) Perrysville

Rockville

Bloomer, Richard S. 115 N. Market St.
Dowell, Emil H. Ohio St.
Harstad, Casper 216 W. High St.
Kempf, Gerald F. Indiana State Sanitarium
Merrell, Basil M. 110 E. York St.
Pace, Jerome V. Indiana State Sanitarium
Pirkle, Hubert B. Indiana State Sanitarium

PERRY COUNTY

Bush, Hargis R. Cannelton

Tell City

Dome, Hardin S. (S) 704 Ninth St.
Dukes, David A. 521 Main St.
Gilbert, Robert G. Perry Co. Mem. Hosp.
Glenn, Fred C. (S) 436 Main St.
Herr, John W. Tell City
James, John M. 746 Ninth St.
James, Nicholas A. (S) 746 Ninth St.
Lohoff, Lewis C. 507 Main St.
Neifert, Noel L. 515 Main St.
Smith, Fred, Jr. 507 Main St.

Snyder, Earl R. (S) Troy

PIKE COUNTY

Petersburg

Hall, Donald L. 1101 Main St.
Omstead, Milton 110 S. Sixth St.

Higgins, James L.
551st USAF Hospital, Otis AFB, Mass.

PORTER COUNTY

Chesterton

Ashmore, Herbert C. 139 Calumet Rd.
Hall, Thomas C. 621 Broadway
Harless, Clarence M. 123 Indiana Ave.
Read, John E. Wilson Ave.
Robertson, William C. 600 E. Morgan

Kleinman, Francis J. Hebron

Valparaiso

Brown, James C. 101 Lincolnway
Covey, Thomas J. 60 W. Jefferson
Davis, Carl M. 202 Indiana Ave.
DeGrazia, Eugene J. 810 LaPorte Ave.
Dittmer, Jack E. 23 Lincolnway
Dittmer, Thomas L. 23 Lincolnway
Eades, Ralph C. 6 Napoleon St.
Frank, John R. (S) 23 Lincolnway
Green, Leonard J. 8 N. Garfield
Griffin, Charles G. 813 La Porte Ave.
Koenig, Robert L. 810 La Porte Ave.
Makovsky, Theodore 808 Lincolnway
O'Neill, Martin 810 LaPorte Ave.
Scheimann, Lois 702 Lincolnway
Schmidt, Richard H. Porter Co. Hospital
Stoltz, Robert M. 501 Lincolnway
Vietzke, Paul C. F. 60 Jefferson St.

Gordon, Joseph L. Wheeler

POSEY COUNTY

Montgomery, Samuel B. (S) Cynthiana
Ropp, Harold E. New Harmony
Boren, Paul Poseyville
Boren, Samuel W. (S) Poseyville
Boyle, Carroll Poseyville
Woods, Arba L. (S) Poseyville

Mount Vernon

Challman, William B. 431 W. Third St.
Crist, John R. 114 W. Second St.
Hirsch, Herman L. 126 W. Fifth St.
Oliphant, Frank W. 701 Mulberry St.
Vogel, L. John 131 W. Third St.

PULASKI COUNTY

Dublin, Madeline P. Francesville
Lacy, John D., Jr. Medaryville
Eshelman, Henry R. Monterey

Winamac

Carneal, Thomas E. (S) 111 N. Monticello
Halleck, Harold J. Winamac
Hollenberg, Edward L. 105 N. Franklin
Karns, John D. 105 N. Franklin
Thompson, William R. 111 N. Monticello

PUTNAM COUNTY

Veach, Lester W. Bainbridge
Veach, Richard L. Bainbridge
Gray, Clyde C. (S) Cloverdale

Greencastle

Dester, Herbert E. Box 76
Dettloff, Frederick Alamo Bldg.
Fuson, Wenfred J. Alamo Bldg.
Johnson, James B. 105 E. Washington St.
Nichols, Anne Sackett 707 E. Seminary St.
Rhea, Gilbert D. 126 E. Washington St.
Schauwecker, Cleon M. 239 Hillsdale Ave.
Smith, A. Wilson DePauw University
Steele, Dick J. Alamo Bldg.
Tennis, George T. Alamo Bldg.
Tipton, William R. 110 S. Vine St.
Wiseman, V. Earle 239 Hillsdale Ave.

Byrne, Louis E. Roachdale
Richards, Edgar E. Russellville

RANDOLPH COUNTY

Nixon, Byron Farmland
White, Harvey E. Farmland
Harmon, Wayne Lynn
Jordan, Leo E. Lynn
Martin, Charles E. (S) Lynn
Shallenberger, Henry R. Modoc
Hinchman, Jean F. Parker
Potter, Richard M. Ridgeville

Union City

Chambers, Leroy B. 305 N. Union
Landon, David J. R.R. #2
McClure, Morris E. 334 W. Oak St.
Phipps, Leland K. 227 W. Oak St.
Reid, Robert W. (S) 706 W. Division St.
Wagoner, B. D. 232 W. Oak St.

Winchester

Brenner, Andrew M. 327 E. Franklin St.
Dininger, William S. 102 E. South St.
Engle, Russell B. 210 S. Main St.
Koch, Howard W. 103 S. East St.
Painter, Lowell W. 124 E. Franklin St.
Slick, Crystal R. 457 Elm St.
Sparks, Paul W. 214 S. Main St.
Ruby, Fred McK. (S)
8128 Brookside Pl., Wauwatosa, Wis.

RIPLEY COUNTY

Hisrich, Lloyd W. Batesville
Freeland, Bill E. Batesville
Warn, William J. Milan
Lippoldt, Charles L. Oldenburg
Row, George S. Osgood
Smith, R. Lee Osgood
McConnell, William C. Sunman
Fletcher, Charles F. (S) Sunman
Hopkins, Lester H. Versailles
Parker, John B. Versailles

RUSH COUNTY

McNabb, George B. Carthage
Sheets, Charles E. Manilla
Worth, C. Willard Milroy

Rushville

Atkins, Clarence C. 225 N. Morgan St.
Corpe, Kenneth F. R. R. No. 4
Dean, Donald I. 310 E. Fifth St.
Denny, Melvin H. 127 W. Third St.
Ellis, Davis W. 229 N. Morgan St.
Green, Frank H. 134 E. Second St.
Johnson, Robert B. 841 N. Harrison
Kennedy, Robert O. (S) 118 W. Third St.
McKee, Harry G. 335 N. Main St.
Norris, Marvin G. 134 E. Second St.
Nutter, Wyndham H. 1003 N. Morgan

ST. JOSEPH COUNTY

Houser, D. Stanley Lakeville
How, John T. (S) Lakeville

Mishawaka

Barone, Carmelo V. 307 W. Fourth St.
Bassler, Carl R. (S) 102 Lincolnway W.
Christophel, Verna 109 W. Third St.
Duvall, William N. (S) 714 N. Mason St.
Farner, James E. 114 Lincolnway E.
Fujawa, Matthew J. 721 Lincolnway E.
Ganser, Richard A. 111 S. Race St.
Goethals, Charles J. 602 Lincolnway W.
Mahank, Camiel C. 223 S. Spring St.
Martin, Charles F. 322 S. Mill St.
Reed, Robert F. 316 Lincolnway E.
Rosenwasser, Jacob 225 Lincolnway E.
Sirlin, Edward M. 109 S. Church St.
Spalding, Wendell L. 427 Lincolnway E.
Templeton, Ames R. 522 Calhoun St.
Van Rie, Leo P. (S) 116 S. West St.
Walerko, Frank 124 S. Race St.
Walters, Charles E. 319 S. Spring St.
Whitlock, Francis C. 110 N. Race St.
Whitlock, Merle E. 123 W. Fourth St.
Wixted, John F. 314 Lincolnway E.
Wixted, Julia F. 314 Lincolnway E.
Wurster, Herbert C. 221 E. Third St.
Wyland, Byron J. (S) 116½ W. Third St.
Zimmer, Henry J. 119½ Lincolnway W.

Luzadder, John E. New Carlisle
Hardy, John J. (S) North Liberty
Randall, Thomas A. North Liberty
Smith, Lee J. North Liberty
Warrick, Homer L. Osceola

South Bend

A

Acker, Robert B. (S) 418 Sherland Bldg. (1)
Arisman, Ralph K. 607 Odd Fellows Bldg. (1)

B

Backs, Alton J. 1401 Lincolnway W. (28)
Baran, Charles 404 Sherland Bldg. (1)
Bartsch, Harvey L. 424 Sherland Bldg. (1)
Bechtold, Samuel E. 730 Sherland Bldg. (1)
Bell, Horace D. 420 N. Hill St. (17)
Bennett, Jene R. 531 N. Main St. (1)
Berke, Robert D. 102 E. Colfax Ave. (1)
Biasini, Benedict A. 403 Dixie Way North (17)
Bickel, David A. 515 Odd Fellows Bldg. (1)
Birmingham, Peter J. (S) 426 Sherland Bldg. (1)
Bishop, Charles A. 122 N. Lafayette Blvd. (1)
Bixler, Louis C. 615 Sherland Bldg. (1)
Blackburn, Erwin 508 Sherland Bldg. (1)
Bodnar, Leslie M. 525 N. Michigan (1)
Booth, Franklin M. 530 Sherland Bldg. (1)
Borough, Lester D. 710 J. M. S. Bldg. (1)
Brechtl, Harvey J. 728 W. Colfax Ave. (1)
Bryan, Robert J. 1002 Lincolnway W. (16)
Buchanan, Wallace D. 825 Sherland Bldg. (1)
Buechner, Frederick W. 116 N. Main St. (1)
Bussard, Clifford F. (S)
202 Whitcomb-Keller Bldg. (1)
Bussard, Frank 202 Whitcomb-Keller Bldg. (1)
Butts, Milton A. 118 N. Walnut St. (28)

C

Carter, F. R. Nicholas....605 Sherland Bldg. (1)
Cassady, James V.....921 Lincolnway E. (18)
Cassady, John R.....921 Lincolnway E. (18)
Clark, Stanley A. (S) .1242 E. Jefferson Blvd. (17)
Clark, William H.....520 Sherland Bldg. (1)
Colip, George D.....514 Sherland Bldg. (1)
Colosey, Frederick J...3121 Mishawaka Ave. (15)
Condit, David H.....122 N. Lafayette Blvd. (1)
Conklin, Raymond L...215 Swanson Circle W. (15)
Cook, Gordon C.....717 N. Main St. (1)
Cooper, Harry L. (S)....410 Sherland Bldg. (1)
Crowley, Joseph B.....Notre Dame Univ.
Culbertson, Carl S.....531 N. Main St. (1)
Custer, Edward W.....Healthwin Hospital (17)

D

Denham, Robert H.....401 Sherland Bldg. (1)
Devoe, Kenneth.....418 N. Michigan St. (1)
Dietl, Ernest L.....820 Sherland Bldg. (1)
Dodd, Robert D.....2311 Miami St. (14)
Dolezal, Bernard J.....119 S. Eddy St. (17)
Donnelly, Everett F.....530 W. Indiana Ave. (14)
Dunlap, D. Logan.....203 J. M. S. Bldg. (1)

E

Eades, R. Charles.....527 Colfax (17)
Ebin, Judah L.....816 Odd Fellows Bldg. (1)
Edwards, Bernard E.....704 N. Main St. (1)
Egan, Sherman.....203 J. M. S. Bldg. (1)
English, John P.....122 N. Lafayette Blvd. (1)
Ericksen, Lester G.....615 Sherland Bldg. (1)
Erickson, Gustaf W...122 N. Lafayette Blvd. (1)

F

Feferman, Martin E.....315 Sherland Bldg. (1)
Feldman, Max.....1921 Miami St. (14)
Filipek, Walter J.....311 Odd Fellows Bldg. (1)
Firestein, Ben Z.....703 J. M. S. Bldg. (1)
Firestein, Ray.....416 Sherland Bldg. (1)
Fish, Edson C.....326 Sherland Bldg. (1)
Fisher, Lawrence F.....1717 E. Colfax (17)
Frank, Herbert.....3610 W. Western Ave. (25)
Frank, Lyall L.....224 W. Navarre (1)
Frash, DeVon W.....308 J. M. S. Bldg. (1)
Frey, William B.....316 N. Ironwood Dr. (15)
Friedman, Morris S.....503 Sherland Bldg. (1)
Frith, Louis G.....521 W. Washington Ave. (1)

G

Gaffney, Raymond.....525 N. Michigan St. (1)
Ganser, Ralph V.....302 Sherland Bldg. (1)
Gates, George E.....122 N. Lafayette Blvd. (1)
Gilman, Marcus M.....403 Odd Fellows Bldg. (1)
Godersky, George E...512 Odd Fellows Bldg. (1)
Graf, John P.....326 Sherland Bldg. (1)
Green, George F.....822 Sherland Bldg. (1)
Green, Norval E.....704 N. Main St. (1)
Grillo, Donald.....723 Sherland Bldg. (1)
Grorud, Alton C.....122 Lafayette Blvd. (1)
Grove, James H.....825 Sherland Bldg. (1)

H

Haley, Paul E.....816 Sherland Bldg. (1)
Hall, James M.....230 Sherland Bldg. (1)
Hamilton, Charles O.....602 N. Michigan (1)
Hanley, Harriet F.....316 N. Ironwood Dr. (15)
Haugseth, Ellsworth K...122 Lafayette Blvd. (1)
Helman, Harry W. (S)..120 Franklin Place (1)
Helmer, John F.....826 Sherland Bldg. (1)
Hilbert, John W.....410 W. Washington Ave. (1)
Hildebrand, John O.....1307 E. Ewing Ave. (14)
Hill, Theodore A.....107 N. Eddy (17)
Hill, Wallace C.....728 Sherland Bldg. (1)
Hillman, Marion W.....206 E. Bartlett St. (1)
Hillman, William H. (S)
1317 Marquette Blvd. (16)
Holdeman, Lillian S....404 N. Lafayette Blvd. (1)
Holdeman, Richard W..404 N. Lafayette Blvd. (1)
Holtzman, Norman N.....3123 S. Michigan (14)
How, Louis E.....60649 S. Michigan (14)
Hyde, Carroll C.....122 N. Lafayette Blvd. (1)

J-K

Johns, Nicholas C.....718 Sherland Bldg. (1)
Kamm, Bernard A.....526 Sherland Bldg. (1)
Karn, John W.....326 Sherland Bldg. (1)
Knapp, Arthur L. (S) .2215 Mishawaka Ave. (15)
Knode, Kenneth T.....729 Sherland Bldg. (1)
Krueger, John E.....326 Sherland Bldg. (1)
Kuhn, Frederick L.....1215 S. Michigan (18)

L

Lamb, J. Leonard.....706 J. M. S. Bldg. (1)
Lane, William H.....418 N. Main St. (1)
Lang, Joseph E.....318 Sherland Bldg. (1)
Levatin, Bernard I.....711 Odd Fellows Bldg. (1)
Levkoff, Abner H.....3610 W. Western Ave. (19)
Lionberger, John R.....615 Sherland Bldg. (1)
Liss, Emanuel C.....117 S. Eddy St. (17)
Lockhart, Philip B.....825 Sherland Bldg. (1)

M

MacLeod, John K.....120 N. Lafayette Blvd. (1)
Marquis, Gordon.....120 N. Lafayette Blvd. (1)
Martinov, William E.....822 Sherland Bldg. (1)
Mason, Bernard A.....122 N. Lafayette Blvd. (1)
McCraley, William J.....406 Sherland Bldg. (1)
McDonald, Ralph M.....410 J. M. S. Bldg. (1)
Metcalfe, Grant E.....319 Odd Fellows Bldg. (1)
Miller, Milo, K.....122 N. Lafayette Blvd. (1)
Mott, Cassell A...1301½ W. Washington St. (16)
Mueller, Hilbert M...122 N. Lafayette Blvd. (1)
Murphy, Eugene C.....122 N. Lafayette Blvd. (1)
Murphy, Josephine F.....625 J. M. S. Bldg. (1)

N-O

Nelson, F. Dale.....704 N. Main St. (1)
Nelson, Raymond E.....206 E. Bartlett St. (1)
Olson, Kenneth L.....615 Sherland Bldg. (1)
Oren, William F.....530 Sherland Bldg. (1)

P

Parsons, Robert L.....424 Odd Fellows Bldg. (1)
Pauszek, Thomas B...726 W. Washington St. (16)
Petrass, Andrew.....516 Sherland Bldg. (1)
Phelps, Stephen R.....818 Sherland Bldg. (1)
Plain, George.....122 N. Lafayette Blvd. (1)
Proudfit, Charles H...525 Odd Fellows Bldg. (1)
Pyle, Harold D.....119 S. Eddy St. (17)

R

Rasmussen, Ruth F...122 N. Lafayette Blvd. (1)
Rigley, Edward L.....408 Sherland Bldg. (1)
Rosenheimer, George M...418 N. Michigan St. (1)
Rubens, Eli.....2314 Miami (14)
Rudolph, Carl J.....110 W. Bartlett St. (1)

S

Sanderson, Robert B.....730 Sherland Bldg. (1)
Sandock, Isadore.....402 Sherland Bldg. (1)
Sandock, Louis F.....428 Sherland Bldg. (1)
Sandoz, Harry H.....612 Odd Fellows Bldg. (1)
Schiller Herbert A.....226 Sherland Bldg. (1)
Scott, Frank M.....122 N. Lafayette Blvd. (1)
Selby, Keith E.....407 Lincolnway W. (1)
Sellers, Francis M.....3209 Mishawaka Ave. (15)
Sensenich, Roscoe L. (H)....128 S. Scott St. (25)
Sharp, Merle C.....717 N. Main St. (1)
Shelley, Edward S.....207 S. Taylor (25)
Shriner, Richard L...319 Odd Fellows Bldg. (1)
Sisson, Norvel D.....531 N. Main St. (1)
Skillern, Penn G. (S)
1002 Bldg. & Loan Tower (1)
Skillern, Scott D.....430 Sherland Bldg. (1)
Slominski, Harry H...708 Odd Fellows Bldg. (1)
Spenner, Raymond W.....726 Sherland Bldg. (1)
Smith, Truman S.....825 Sherland Bldg. (1)

Staunton, Henry A.....3016 Mishawaka Ave. (15)
Stiver, Daniel D.....822 Sherland Bldg. (1)
Stogdill, William J.....525 Sherland Bldg. (1)
Stratigos, Joseph S.....17615 State Rd. 23 (15)

T

Thompson, John M.....921 Lincolnway E. (18)
Thompson, Robert A.
913 S. Twyckenham Dr. (15)
Thornton, Maurice J.....825 Sherland Bldg. (1)
Tirman, Wallace S.....615 Sherland Bldg. (1)
Traver, Perry C. (S)....1010 Riverside Dr. (16)

V-W-X-Y-Z

Vagner, S. Bernard
1303½ W. Washington Ave. (16)
Vurpillat Francis J...132 N. Lafayette Blvd. (1)
Walker, Edwin M., Jr.....326 Sherland Bldg. (1)
Ward, James W.....19248 Summers Dr. (17)
Weiss, Eugene.....2521 S. Michigan (14)
Wilhelm, Agatha M..1832 E. Wayne at Eddy. (15)
Wilson, James M.....621 J. M. S. Bldg. (1)
Zeiger, Irvin.....3123 Mishawaka Ave. (15)

Skeen, Earl D. (S).....Walkerton
Cline, Kenneth L.....Wyatt

Backs, Mark F.
228 Cowbell Rd., Willow Grove, Pa.
Ellison, Alfred...7304 Encelia Dr., La Jolla, Calif.
Fish, Clyde M. (S)
1533 S. E. Sixth St., Deerfield, Florida
Orr, W. Robert.....3916 Springfield St.,
Kansas City (3), Kans.
Savery, Charles E.
1609 S. E. Sixth St., Deerfield Beach, Fla.

SCOTT COUNTY

Bogardus, Carl R.....Austin
McClain, Marvin L.....Scottsburg
Napper, Floyd S.....Scottsburg

SHELBY COUNTY

Nigh, Rufus M.....Fairland
Davis, John A.....Flat Rock

Shelbyville

Alden, John O.....103 W. Washington St.
Dalton, Wilson L.....117 W. Washington St.
Gehres, Robert W.....15 S. Tompkins St.
Inlow, Herbert H.....103 W. Washington St.
Inlow, William D.....103 W. Washington St.
Miller, Richard C.....17 Mechanic St.
Richard, Norman F.....103 W. Washington St.
Scott, V. Brown.....103 W. Washington St.
Spindler, Robert D.....165 W. Mechanic St.
Tindall, Paul R. (S).....20 N. Pike St.
Tindall, William R.....505 S. Harrison St.
Tower, James H., Jr.....120 W. Jackson St.
Whitcomb, Roger F.....302 Methodist Bldg.

SPENCER COUNTY

Gailey, Ivan Chrisney
Barrow, John H.....Dale
Medcalf, Norman L. (S).....Lamar
Jolly, Wesley P.....Richland
Atchison, Kenneth C. (S).....Rockport
Glackman, John C., Jr.....Rockport
Monar, Michael Rockport
Ambrose, Kenneth E..P.O. Box 308, Monmouth, Ill.

STARKE COUNTY

Leinbach, Earl Hamlet

Knox

DeNaut, James F.....4 N. Heaton St.
Henry, Howard J.....107 S. Main St.
Ingwell, Guy B.....201 S. Heaton St.
Krsek, Archie J.....R. R. 3, Box 81, c/o Lucas
McClure, Clark.....107 S. Main St.

North Judson

Matthew, John R.....135 S. Lane St.

STEUBEN COUNTY

Angola

Artz, Richard W.....416 E. Maumee
Barton, Robert 416 E. Maumee
Cameron, Don F.....416 E. Maumee
Cameron, Mary H.....416 E. Maumee
Crum, Marion M.....301 E. Maumee
Hartman, John J.....209 W. Felicity
Kissinger, Knight L.....Elmhurst Hospital
Mason, Donald G.....416 E. Maumee
Rausch, Norman W.....416 E. Maumee

Blosser, Blaine A. (S).....Fremont
McCormack, Lloyd L.....Fremont
Alford, James A.....Hamilton
Schrepferman, Wayne Hamilton
Cameron, Donald F...449 W. High St., Bryan, Ohio

SULLIVAN COUNTY

Brown, John S.....Carlisle
Whipps, Charles E. (S).....Carlisle
Dukes, Betty Dugger
Dukes, Frederic M. (S).....Dugger
Dukes, Joe E.....Dugger
Bethea, Robert O.....Farmersburg

Sullivan

Bedwell, Marion H.....16 N. Court St.
Crowder, James H.....Sullivan
Higbee, Paul (S).....4 E. Washington St.
Maple, James B. (S).....117 W. Washington St.
Parmenter, Harry B.....117 W. Washington St.
Scott, Irvin H.....117 W. Washington St.

Taylor, John R.....105 N. Main, Palestine, Ill.
Daugherty, William L.....Hutsonville, Ill.

SWITZERLAND COUNTY

(See Jefferson-Switzerland)

TIPPECANOE COUNTY

Lafayette

Ade, Charles H.....2211 South St.
Ade, Mary Keller.....2211 South St.
Baker, John R.....1603 Potomac Ave.
Balkema, Catherine M.....3 N. 18th St.
Bayley, William E.....Home Hospital
Bolin, Robert C.....308 N. Eighth St.
Buhrmester, Harry C., Jr.....308 N. Eighth St.
Burkle, John C. (S).....133 N. Fourth St.
Burns, John T.....2502 South St.
Calvert, Raymond R.....314 N. Sixth St.
Canganelli, Vincent G...Wabash Valley Sanitarium
Carpenter, James B.....15 N. 25th St.
Cole, Ira.....2315 South St.
Coyner, Alfred B.....509 Lafayette Life Bldg.
Davis, Howard B.....308 N. Eighth St.
Donahue, George R.....718 Lafayette Life Bldg.

Dubois, Ramon B.....23 N. 25th St.
Eaton, Marion J.....214 Lafayette Life Bldg.
Engeler, James E.....308 N. Eighth St.
Ferguson, William B.....2211 South St.
Fields, Donald C.....312 N. Eighth St.
Flack, Russell A.....217 N. Sixth St.
Frasch, Mahlon G.....Lafayette Life Bldg.
Frey, Harley B.....405 Lafayette Life Bldg.
Gery, Richard E.....308 N. Eighth St.
Gripe, Richard P.....308 N. Eighth St.
Haas, Charles F.....2211 South St.
Harden, Murray E.....2420 Ferry St.
Harter, Eli B.....312 N. Eighth St.
Herrold, George W.....20 N. 24th St.
Holladay, Lloyd J.....411 Lafayette Life Bldg.
Hughes, Richard R.....31 N. 25th St.
Hull, James E.....2211 South St.
Hunsberger, Walter G.....308 N. Eighth St.
Hunter, Frank P.....617 Lafayette Life Bldg.
Johnson, Herbert S.....312 N. Eighth St.
Johnson, Lowell R.....2315 South St.
Jones, David.....24 N. 24th St.
Karberg, Richard J.....420 Columbia St.
Klatch, Ben Z.....2211 South St.
Klepinger, Harry E.....824 Lafayette Life Bldg.
Kohne, Robert W.....3010 Underwood
Laws, Kenneth F.....501 Lafayette Life Bldg.
Levering, Guy P. (S).....2113 S. Eighth St.
Loop, Frederick A.....2211 South St.
McAdams, Hugh B.....2011 Kossuth St.
McAdams, Robert.....2011 Kossuth St.
McClelland, Donald C.....312 N. Eighth St.
McFadden, James M.....35 N. 25th St.
McKinley, Joseph.....312 Lafayette Life Bldg.
McKinney, Daniel H.....814 Lafayette Life Bldg.
Marsh, George W.....1405 N. 14th St.
Martin, Joe.....2433 S. Ninth St.
Marvel, Howard R.....308 N. 8th St.
Mather, Charles R.....20 N. 24th St.
Miller, Roland E.....2200 Scott St.
Neumann, Kenneth O.....618 Lafayette Life Bldg.
Onorato, Joseph J.....2433 S. Ninth St.
Pearlman, Samuel S. (S).....107 N. Sixth St.
Peterson, Joel A.....609 Lafayette Life Bldg.
Peyton, Frank W.....15 N. 25th St.
Ratcliff, Frank W.....405 Lafayette Life Bldg.
Rothrock, Philip W.....2200 Scott St.
Ruschli, Edward B.....510 Lafayette Life Bldg.
Shively, John L.....2211 South St.
Sholty, William M.....405 Lafayette Life Bldg.
Smith, Lowell C.....637 Ferry St.
Stahl, Edward T.....308 N. Eighth St.
Steele, Hugh H.....308 N. Eighth St.
Strayer, Joseph W.....612 Lafayette Life Bldg.
Trout, Carl J.....314 N. Sixth St.
Tubbs, George R. (S).....2503 Main St.
Underwood, George M.
Jefferson Sq. Shopping Center
Van Buskirk, Edmund L.....308 N. Eighth St.
Van Den Bosch, Wallace R.....2216 South St.
Vermilya, Robert W.....405 Lafayette Life Bldg.
Williams, Robert E.....15 N. 25th St.

Mitchell, Edgar T. (S).....Romney
Babb, Forrest J.....Stockwell

West Lafayette

Ash, Harold H.....712 Bexley Rd.
Carroll, Bertha Rose.....Purdue University
Combs, Loyal W.....Purdue University
Cooper, Faith M.....Purdue University
Crockett, Franklin S. (H).....424 Littleton St.
Hass, Caroline E.....402 Northwestern Ave.
Hass, Thomas W.....402 Northwestern Ave.
MacLeod, Donald F.....30 Memorial Dr.
Meikle, Louise J. (S).....606 Terry Lane
Rommel, Clarence H.....456 Northwestern
Schmiedicke, Paul H.....Purdue University
Stansell, Gilbert B.....746 Northridge Dr.
Wilms, John H.....Purdue University

Bush, Jack A.
USNS 961, Box 8, F.P.O., San Francisco, Calif.
Wagoner, John R.
2712 Nottingham, Houston, Tex.

TIPTON COUNTY

Belding, Ray T.....Kempton
Stouder, Albert E.....Kempton
Tranter, William F.....Sharpsville

Tipton

Burkhardt, Boyd A.....202 S. West St.
Carter, Jean V.....130 N. Main St.
Compton, George.....219 N. Independence
Gossard, Meredith B.....308 N. Independence
Kincaid, Raymond K.....202 S. West St.
Kurtz, William A.....202 S. West St.

Ericson, Harold L.....Windfall
Moser, Elmer B. (S).....Windfall

UNION COUNTY

(See Wayne-Union)

VANDERBURGH COUNTY

Evansville

A

Acre, Robert R.....706 Walnut St. (8)
Adler, Raymond N.....714 Second Ave. (10)
Adye, Wallace M.....1607 N. Stringtown Rd. (11)
Alexander, John E.....609 Hulman Bldg. (8)
Anderson, Milton H.....Evansville State Hosp. (2)
Antes, Earl H.....420 Cherry St. (13)
Antonetti, John A.....Deaconess Hospital (10)
Arendell, Robert E.....1623 Lincoln Ave.
Austin, Eugene W.....3700 Belle Meade(15)
Austin, M. A. (S).....3900 Washington Ave. (15)

B

Baker, Herman M.....402 Hulman Bldg. (8)
Baker, Mason R.....1008 S. Evans Ave. (13)
Barclay, Irvin C.....114 S. E. Second St. (8)
Barnhart, Willard T.....701 Chestnut St. (13)
Baylor, Edward M.....501 E. Cherry St. (13)
Beck, Robert E.....600 Mary St. (10)
Begley, Joseph W. Jr.....314 S. E. Riverside Dr. (13)
Bender, Martin J.....912 Hulman Bldg. (8)
Bennett, Abner P.....412 S. E. Fourth St. (13)
Bissonnette, Roger P.....420 Cherry St. (13)
Boswell, Robert W. C.....2351 Division St. (14)
Boyd, Stella N.....502 Hulman Bldg. (8)
Brakel, Frank J.....420 Cherry St.
Britt, Robert.....420 Cherry St. (13)
Brown, George W.....2404 W. Penn (12)
Bryan, Stanton L.....607 Hulman Bldg. (8)
Buehner, Donald F.....3700 Bellemeade (15)
Burger, Thomas C.....3700 Bellemeade (15)
Burnikel, Ray H.....527 Sycamore St. (8)
Burress, Clyde R.....723 Mary St. (10)

C

Cacia, John J.....609 Hulman Bldg. (8)
Caldwell, William C. (S)
504 Old National Bank Bldg. (8)
Carlson, Ralph F.....517 Sycamore St. (8)
Cheydleur, Eleanor P.
314 S. E. Riverside Dr. (13)
Clark, Thomas W.....420 Cherry St. (13)
Clements, Albert F.....3315 Lincoln Ave. (15)
Clouse, Paul A.....613 S. Weinbach Ave. (14)
Cockrum, William M.....908 Hulman Bldg. (8)
Cole, William L.....10 N. Weinbach (11)
Coleman, Joseph E.....3700 Bellemeade (15)
Combs, Herman T.....807 W. Indiana (10)
Combs, John H.....412 S. E. Fourth St. (13)
Combs, Pearl B. (S).....4109 Lincoln (15)
Corcoran, Patrick J. V.....3700 Bellemeade (15)
Crawford, James H.....221 Chestnut St. (13)

Crevello, Albert J.....26 N. Sixth St. (10)
Crimm, Paul D.....Boehne Hospital (12)
Crudden, Charles H...Clearview Sanitarium (10)
Cullnane, Chris W.....2312 W. Franklin St. (12)

D

Daves, William L.
608 Old National Bank Bldg. (8)
Davidson, Harold H.....420 Cherry St. (13)
Deems, Myers B.....314 S. E. Riverside Dr. (13)
Denzer, Edward K.....108 S. E. Second St. (8)
Denzer, William O.....112 S. E. Second St. (8)
Dieckman, Herbert S.....3700 Bellemeade (15)
Diefendorf, Charles F. (S)
2106B W. Franklin (12)
Dodd, Roberts K.....2605 Lincoln Ave. (14)
Downer, Luther H.....521 Oak Street (13)
Drake, Dale W.....St. Mary's Hospital (10)
Dunham, Henry H.....420 Cherry St. (13)
Durkee, Melvin S.....3700 Bellemeade (15)
Dycus, Walter A.....319 N. St. Joseph Ave. (12)
Dyer, Wallace K.....221 Chestnut St. (13)

E

Ehrich, William S. (S)
Evansville State Hospital (2)
Eisterhold, John A....314 S. E. Riverside Dr. (13)
Engel, Edgar L.....126 S. E. Seventh St. (8)

F

Faith, Ira L.....950 Blue Ridge Dr. (15)
Faul, Henry J.....815 Hulman Bldg. (8)
Faw, Melvin L.....420 Cherry St. (13)
Fenneman, Robert J...402 S. E. Seventh St. (8)
Fickas, Dallas.....704 Hulman Bldg. (8)
Fisher, William C.....413 First Ave. (10)
Fitz, Gerald, Maurice D.
924 Bayard Park Dr. (13)
Fleming, Thomas C.....Mead Johnson & Co. (21)

G

Garland, Edgar A.....606 S. Weinbach (14)
Gaul, L. Edward.....509 Hulman Bldg. (8)
Getty, William H.....420 Cherry St. (13)
Giorgio, Douglas J.....916 S. Burkhardt Rd. (15)
Griep, Arthur H.....5414 Madison Ave. (15)
Guckien, Joseph L.....609 Hulman Bldg. (8)

H

Hammond, R. Case.....701 Chestnut St. (13)
Hare, Daniel M.....706 Walnut St. (8)
Harned, Ben K.....420 Cherry St. (13)
Hart, L. Paul.....3700 Bellemeade Ave. (15)
Hartley, Clarence A., Jr.....221 Chestnut St. (13)
Hartz, F. Minton.....123 S.E. Second St. (8)
Hawk, Edgar A.....Mead Johnson & Co. (21)
Heard, Albert.....322 E. Cherry St. (13)
Heinrich, Weston A...314 S. E. Riverside Dr. (13)
Hendershot, Eugene L...412 S. E. Fourth St. (13)
Hermayer, Stephen....220 S. E. Seventh St. (13)
Herrmann, Gordon T.....3700 Bellemeade (15)
Herzer, Clarence C.....322 N. Fulton (10)
Himebaugh, Gilbert.....3700 Bellemeade (15)
Hobbs, Arthur A.....600 Mary St. (10)
Hoopes, Jane M.....3700 Bellemeade (15)
Hoover, J. Guy.....517 Sycamore St. (8)
Hovda, Richard B.....St. Mary's Hospital (15)
Huggins, Victor S.
703 Citizens Nat'l Bank Bldg. (8)
Hyatt, Gilbert T.....1106 W. Franklin St. (10)

J

Jernigan, William R.....1400 Cass Ave. (14)
Johnson, Gardner C. (S)..1412 Parkside Dr. (14)
Johnson, Harold V.....2114 W. Franklin St. (12)
Johnson, Stephen L.....521 Sycamore St. (8)

K

Karn, William N...Evansville State Hospital (2)
Kauffman, Harley M.....219 Walnut St. (8)
Kessler, Robert B.....1338 Division St. (14)
Kiechle, Frederich L.....726 S. E. First St. (13)
Kincaid, Robert S.....1000 N. Spring St. (11)
Kleindorfer, Roscoe L...819 W. Franklin St. (10)

L

Laubscher, Clarence....6621 Kratzville Rd. (10)
Lawrence, Joseph C.....413 First Ave. (10)
Leibundguth, Henry.....221 Chestnut St. (13)
Leich, Charles F.....124 S. E. First St. (8)
Lyman, Frank L.....Mead Johnson & Co. (21)
Lynch, Harold D.....216 S. E. Riverside Dr. (13)

M

McCool, Joseph H.....314 S. E. Riverside Dr. (13)
McDonald, Joseph D.....517 Sycamore St. (8)
MacKenzie, Pierce.....126 S. E. Seventh St. (8)
Mason, Everett E.....906 Hulman Bldg. (8)
Mathews, James R.....118 S. E. First St. (8)
Mayberry, Alton.....3700 Bellemeade (15)
Miller, Laverne B.....714 N. Main St. (11)
Miller, Milton.....15 W. Franklin St. (10)
Miller, Minor.....201 S. E. Third St. (13)
Miller, Robert J.....1905 Division St. (14)
Mills, Fred E.....Deaconess Hospital (10)
Mino, Raymond W.....723 Mary St. (10)
Mino, Robert A.....723 Mary St. (10)
Moehlenkamp, Charles E.
614 N. Governor St. (11)
Muelchi, Adeline F.....518 Hulman Bldg. (8)
Murphy, Edward U.....901 Hulman Bldg. (8)
Myre, Theodore T.....517 Sycamore (13)

N

Nenneker, Henry (S)....1912 Harmonyway (12)
Newman, Alvin E.....912 Hulman Bldg. (8)
Newsome, C. K.....525 Lincoln Ave. (13)
Nicholson, Ray W.....3700 Bellemeade (15)
Niedermayer, Alfred J..960 Washington Ave. (13)
Nisenbaum, Harold...312 Old Nat'l Bank Bldg. (8)
Nonte, Leo R.....1218 Lincoln Ave. (14)

O

Oswald, Robert H.....126 S. E. Seventh St. (8)

P

Pastor, Julius W.....713 First Ave. (10)
Pemberton, Jack J...319 N. St. Joseph Ave. (12)
Pollard, Walter S. (S)..115 S. E. Second St. (8)
Porro, Francis W.....713 First Ave. (10)
Present, Julian.....113 S. E. Second St. (8)
Price, Shirley G.....420 Cherry St. (13)
Pugh, Willis L.....413 First Ave. (10)

R

Ratcliffe, Albert W.....510 S. E. First St. (13)
Reich, Clarence E.....1209 N. Fulton (10)
Rietman, H. Jerome
Evansville State Hospital (2)
Ritchie, William D.....555 Herndon Dr. (11)
Robinson, Earle U.....615 Bellemeade (13)
Rosenblatt, Bernard B.....709 Hulman Bldg. (8)
Royster, George M. (S)
810 Citizens Nat'l Bank Bldg. (8)
Royster, Robert A.
810 Citizens Nat'l Bank Bldg. (8)
Rusche, Henry J.....313 W. Iowa (10)
Russell, Richard H.....1015 Harrelton Court (15)

S

Schimmelpfennig, Robert W.
1013 Parrett St. (13)
Schirmer, Robert H.....1118 W. Franklin St. (12)
Schneider, Charles P...2211 W. Franklin St. (12)
Schriefer, Victor V.....1120 N. Main St. (11)
Sinn, Charles M.....402 Hulman Bldg. (8)
Slaughter, Howard C.....908 Hulman Bldg. (8)
Slaughter, John C.....3700 Bellemeade (15)
Slaughter, Owen L.....3700 Bellemeade (15)
Smith, Roy M.....1307 Stringtown Rd. (11)

Snively, William D., Jr.
Mead Johnson and Co. (21)
Sprecher, Herman C.....527 Sycamore St. (8)
Springstun, Walter R.....601 Hulman Bldg. (8)
Steckler, Robert J.....1400 Cass Ave. (14)
Steele, Paul W.....1218B Lincoln Ave. (14)
Sterne, John H.....221 Chestnut St. (13)
Stork, Urban.....420 Cherry St. (13)
Strueh, Paul E.....220 S. E. Seventh St. (13)

T

Tager, Stephen N.....3700 Bellemeade (15)
Thompson, Naiad Mason....420 Cherry St. (13)
Tilden, Margaret H.....700 Mary St. (10)
Tisserand, John B. Jr.....3700 Bellemeade (15)
Tuholski, James M.....Mead Johnson & Co. (21)
Turner, Isabel B.....2208 E. Walnut St. (14)
Tweedall, Daniel C.....527 Sycamore St. (8)

U-V

Viehe, Robert W.....207 S. E. First St. (13)
Visher, John W..805 Old National Bank Bldg. (8)

W

Walker, William F.....420 Cherry St. (13)
Walter, Robert F.....1514 S. Kentucky Ave. (14)
Warner, Charles L.....420 Cherry St. (13)
Waters, George W...Evansville State Hospital (2)
Watson, James L.....1158 Lincoln Ave. (14)
Weber, Edgar H.....123 S. E. Second St. (8)
Weiss, Henry G.....614 Hulman Bldg. (8)
Welborn, Mell B.....420 Cherry St. (13)
Wilhelmus, C. Kenneth..115 S. E. Seventh St. (8)
Wilhelmus, Gilbert M.....1028 Washington (15)
Willis, Charles F.....1100 S. Bedford Ave. (13)
Willison, George W.....3700 Bellemeade (15)
Wilson, David.....517 Mary St. (10)
Wilson, John D.....3700 Bellemeade (15)
Wilson, Ralph.....517 Mary St. (10)
Woods, William P. (S)....5050 Lincoln Ave. (15)
Wynn, Justice F.....906 Hulman Bldg. (8)

X-Y-Z

Young, C. Curtis.....126 S. E. Seventh St. (8)
Zeier, Francis G.....420 Cherry St. (13)
Zimmerman, Harold.....6 S. E. Second St. (8)
Ziss, Robert C.....216 S. E. Riverside (13)
Zwickel, Ralph E.....417 Third & Main Bldg. (8)

Brockmole, Arnold W.
2430 Bird Street, Oraville, Calif.
Buchholz, Ransom R.....Georgetown, Texas
Oppenheimer, Ernst
VA Hospital, 235 E. 22nd St., New York 10, N. Y.

VERMILLION COUNTY

(See Parke-Vermillion)

VIGO COUNTY

Loving, Jury B.....New Goshen
McIntosh, Wilbert Riley
Jett, Clyde W.....Seelyville

Terre Haute

A

Advincula, Luis.....Union Hospital
Allen, Orris T. (S).....422 Rose Dispensary Bldg.
Anderson, Walter C.....2235 Wabash Ave.
Ault, Roy.....3050 Poplar St.

B

Baldridge, William O...12 Points State Bank Bldg.
Bannon, William G.....416 Rose Dispensary Bldg.
Blum, Leon L.....210 Rose Dispensary Bldg.
Bopp, Henry, Jr.....221 S. Sixth St.
Bopp, James.....236 S. 21st St.
Boyd, H. Clark.....221 S. Sixth St.
Bradley, Stephen C. (S).....916 S. 25th St.
Bristol, Henry M. S.....1218½ Wabash Ave.
Bronson, Paul J.....3050 Poplar St.
Brown, Robert R.....221 S. Sixth St.

C

CaJacob, Melville E.....1000 S. Sixth St.
Caldwell, Milton V.....721 Wabash Ave.
Cavins, Alexander W.....221 S. Sixth St.
Combs, Charles N. (S).....2516 N. Ninth St.
Combs, Stuart R.....3050 Poplar St.
Congleton, George C. (S)
308 Merchants National Bank Bldg.
Conklin, James O.....500 Rose Dispensary Bldg.
Conway, Thomas J.....221 S. Sixth St.
Curry, Claude A.....103 Allendale Place

D

Davis, Merle J.....221 S. Sixth St.
Decker, Harvey B.....14 Rea Bldg.
Denny, E. Rankin.....3050 Poplar St.
Drummy, W. W. 221 S. Sixth St.
Dyer, George W.....2235 Wabash Ave.

E

Edwards, Henry G.....221 S. Sixth St.

F

Freed, John E., Jr.....414 Rose Dispensary Bldg.
Freed, John E. (S).....1030 S. Sixth St.
Fuqua, Harold B.....1616 N. Ninth St.

G

Gerrish, Donald A.....R. R. 7
Gilbert, Ivan.....505 Rose Dispensary Bldg.
Goodman, Hubert T...410 Rose Dispensary Bldg.
Gossom, Donn R.....Rose Dispensary Bldg.
Grindrod, John M.....Ind. State Teachers College

H

Harkness, Robert G.....301 Rose Dispensary Bldg.
Haslem, Ezra R.....401 Rose Dispensary Bldg.
Haslem, John R.....221 S. Sixth St.
Hogan, Thomas W.....627 Cherry St.
Hoover, Dewey A.....14½ N. Third St.
Humphrey, Paul E.....500 Rose Dispensary Bldg.
Hunt, Edgar J.....R. R. 1

J

Johnson, Paul D.....822 N. Fifteenth St.

K

Kabel, Robert N.....3050 Poplar St.
Krieble, William W.....221 S. Sixth St.
Kunkler, Arnold W.....1700 N. Seventh St.
Kunkler, Joseph (S).....408 Chestnut
Kunkler, William C.
212 Merchants Nat'l Bank Bldg.

L

LaBier, Clarence R. (S).....1630 Wabash Ave.
LaBier, C. Russell.....1630 Wabash Ave.
Lancet, Robert O.....2101 Wabash Ave.
Lee, James.....St. Anthony Hospital
Loewenstein, Werner L.....1537 S. Seventh St.
Luckett, Coen L.....211 Fairbanks Bldg.
Lyons, L. Mason.....59 S. 18th St.

M

McBride, Noel S...407 Merchants Nat'l Bank Bldg.
McCrea, Fred R.....221 S. Sixth St.
McEwen, James W.....670 Cherry St.
McLaughlin, Gordon C.....608 Tribune Bldg.
Mahoney, Charles L.....221 S. Sixth St.
Malone, Leander A.....721 Wabash Ave.
Mankin, William J.....402 Tribune Bldg.
Mason, Lester M....312 Merchant Nat'l Bank Bldg.
Mattox, Don M.....1700 N. Seventh St.

Meyn, Werner P.....221 S. Sixth St.
Miklozek, John E.....1461 S. Seventh St.
Milleson, Ann L. M.....826 S. Center St.
Musselman, Glen G.....7222 Wabash Ave.

N-O

Nay, Ernest O.....221 S. Sixth St.
Neudorff, Louis G.....221 S. Sixth St.
Oliphant, Robert W.....1603 S. 7th St.

P

Pearce, Roy V.....1440 S. 25th St.
Pierce, Harold J. (S).....627 Cherry St.

R

Reed, Robert C.....211 Fairbanks Bldg.
Reynolds, Richard J.....901 S. 25th St.
Richart, James V.....414 Rose Dispensary Bldg.
Riggs, Floyd C.....2228 Wabash Ave.
Rogers, R. Shirrell.....26 N. Sixth St., West Terre Haute
Rubin, Milton M.....221 S. 19th St.

S

Sayers, Frank E.....436 Bluebird Dr.
Scherb, Burton E.....104 N. Seventh St.
Schott, Edward J. (S).....653 Oak St.
Schumaker, Robert A.....3050 Poplar St.
Selsam, Etta B. (S) 203 Merchants Nat'l Bank Bldg.
Shanklin, Vernon A. (S).....672½ Wabash Ave.
Showalter, John R.....1233 Maple Ave.
Siebenmorgen, Louis (S).....1200 S. Eighth St.
Siebenmorgen, Paul.....1200 S. Eighth St.
Silverman, Norman M.....1634 S. Seventh St.
Smoots, Samuel A. (S).....1307 Maple Ave.
Speas, Robert C.....402 Tribune Bldg.
Stewart, Walter E. (S).....721 Wabash Ave.
Stoelting, J. Lewis.....507 Rose Dispensary Bldg.
Strecker, William L.....2250 Wabash Ave.
Strong, Daniel S. (S).....2610 Lafayette Ave.
Sullivan, John M.....1712 Franklin St.

T-U-V

Taylor, Donald J.....423 Rose Dispensary Bldg.
Topping, Malachi C.....3050 Poplar St.
Ulmer, David R. (S).....2500 Wabash Ave.
Van Arsdall, Clarence R.....17 S. Ninth St.
Veach, William L.....500 Rose Dispensary Bldg.
Voges, Edward C.....702 College Ave.

W

Weber, Joseph G. S.....723 Wabash Ave.
Weinbaum, Jack G.....206 Rose Dispensary Bldg.
White, James V.....721 Wabash Ave.
Wiedemann, Frank E. (S) 222 Rose Dispensary Bldg.
Wilson, Fred L.....1501 S. Third St.
Wyeth, Charles (S).....1100 S. Seventh St.

X-Y-Z

Zwerner, Paul F.....12 Points State Bank Bldg.

WABASH COUNTY

Walker, James L. (S).....Lafontaine

North Manchester

Balsbaugh, George.....107 W. Seventh St.
Brubaker, Ora G. (S).....111 N. Market St.
Bunker, Ladoska Z.....North Manchester
Cook, Charles E.....114 W. Main St.
Keller, Frank G. (S).....Peabody Memorial Home
Seward, George W.....111 E. Main St.
Smith, Lloyd H.....1118 N. Wayne St.
Venable, George L.....106 W. Main St.
Warvel, Joseph L. (S).....North Manchester

Wabash

Dannacher, William D.....284 N. Wabash
Elward, Carl J.....1280 Columbus
Hanneken, Vincent J.....86 N. Comstock
LaSalle, Richard M.....55 West Market St.
LaSalle, Robert M. Jr.....55 West Market St.
LaSalle, Robert M. Sr.....55 W. Market St.
Mills, John F.....24 E. Main St.
Pearson, William E.....290 N. Wabash
Rauh, Robert A.....620 Bond St.
Steffen, Arthur J.....70 W. Hill
Steffen, Julius T.....443 N. Wabash
Stoops, Jean T.....280 N. Wabash
Whisler, Frederick M.....10 W. Hill
Goldstone, Harry A. 244 Second St., California, Penn.
Kidd, James G.....Veterans Hosp., Wood, Wis.

WARREN COUNTY

(See Fountain-Warren)

WARRICK COUNTY

Boonville

Dimmett, Robert P.....214 S. Second St.
Hoover, Peter B.....223 W. Locust St.
Stover, Wendell C.....125½ S. Second St.
Terry, Robert H.....117 S. Second St.
Wilson, Paul E. (S).....126 N. Third St.
Woodson, Dan E.....117 S. Second St.

Dutchman, William R.....Chandler
Colvin, Robert C.....Newburgh
Rogers, Arthur R.....Newburgh
Wilhelmus, Charles M. (S).....Newburgh

WASHINGTON COUNTY

Tower, Thomas K.....Campbellsburg
Paynter, William.....Pekin

Salem

Apple, Eddie R.....407 W. Market St.
Coleman, Henry G.....Mitchell Bldg.
Episcopo, Arsenius R.....308 N. Main St.
Fultz, Roy L.....304 W. Market St.
Huckleberry, Irvin E.....502 W. Mulberry St.

WAYNE-UNION COUNTIES

Clark, Marion E.....Cambridge City
Hill, Paul G.....Cambridge City
Kenyon, Charles E.....Cambridge City
Barton, Willoughby M.....Centerville
Hutchison, Donald R.....Fountain City
Zimmerman, William H.....Dublin
Hollenberg, Alfred E.....Hagerstown
Miller, William A.....Hagerstown

Liberty

Clarkson, Clarence G.....304 E. Union St.
Lewis, James F.....28 E. Union St.
McWilliams, William B.....Liberty
Thompson, Will A. (S).....106 S. Main St.

Denny, Edgar C. (S).....Milton

Richmond

Adney, Frank B.....215 Medical Arts Bldg.
Ake, Loren.....410 First National Bank Bldg.
Allen, Hubert E. (S).....21 S. Eighth St.
Allen, Robert T.....36 S. Eighth St.
Ballenger, William E.....309 Medical Arts Bldg.
Blossom, Paul W.....825 S. A St.
Brooks, G. Tanner.....29 S. 12th St.
Brown, Richard J.....310 Colonial Bldg.
Buche, Frederick P. (S).....106 S. Seventh St.

Coble, Frank H. 51 S. Eighth St.
Cook, Norman R. 303 First National Bank Bldg.
Cox, Leon T. 1210 E. Main St.
Daggy, B. T. Medical Arts Bldg.
Daggy, James R. 35 S. Eighth St.
Dingle, Paul E. 216 Medical Arts Bldg.
Dreyer, Ralph W. 2 S. W. 17th St.
Ebbinghouse, Tom 98 W. Main St.
Ensey, Philip L. 512 W. Main St.
Griffis, Vierl C. (S) 201 S. 23rd St.
Guthrie, James R. 25 S. Eighth St.
Hadley, Harvey (S) 627 S. 14th St.
Hagie, Frank E. 1110 S. A St.
Harmon, Carl J. 407 Medical Arts Bldg.
Herring, George N. Richmond State Hospital
Hill, Gladys Marie 407 Medical Arts Bldg.
Hill, Harold D. 412 Medical Arts Bldg.
Hunt, Gayle J. Reid Memorial Hospital
Johnson, George M. 136 Medical Arts Bldg.
Johnson, Paul S. (S) 215 Medical Arts Bldg.
Kime, Charles E. 810 S. A St.
Klepfer, Jefferson Richmond State Hospital
Kreitl, Dorothy R. Richmond State Hospital
Laird, Leslie A. Richmond State Hospital
Lee, Glen Ward 139 Medical Arts Bldg.
Ling, John F. 505 First National Bank Bldg.
Logan, James Z. 303 Second National Bank Bldg.
Loomis, Charles H. 310 Medical Arts Bldg.
Mader, John H. 2000 E. Main St.
Malcolm, Russell 127 Medical Arts Bldg.
Meredith, Elwood J. 203 Medical Arts Bldg.
Millis, Arthur B. 505 First Nat'l. Bank Bldg.
Park, Byron J. 418 Medical Arts Bldg.
Passino, James Reid Memorial Hospital
Ramsdell, Glen A. 407 First Nat'l. Bank Bldg.
Ross, Harry P. 410 Second National Bank Bldg.
Ross, James S. 321 S. 14th St.
Runge, Paul W. 1426 E. Main St.
Sage, Charles V. 48 S. 11th St.
Sherer, Kenneth E. 422 Medical Arts Bldg.
Shields, Tom S. 47 S. 11th St.
Smith, John R. 510 S. A St.
Snyder, Morris C. 130 Medical Arts Bldg.
Stamper, Lucian A. 402 Medical Arts Bldg.
Stepleton, John D. Reid Memorial Hospital
Stillwell, William R. 2607 South C Place
Sweet, Howard E. 35 S. Eighth St.
Taylor, William R. 308 Medical Arts Bldg.
Vance, William C. 1008 South A St.
Wanninger, Horace 408 Second Nat'l Bank Bldg.
Warrick, Francis B. 1426 E. Main St.
Weinstein, Edwin B. 204 Colonial Bldg.
Weitemier, Raymond A. 2000 E. Main St.
Wertenberger, Morris D. Reid Memorial Hospital
Whallon, Arthur J. (S) 29 S. 10th St.
Wiland, Olin K. Reid Memorial Hospital
Wisener, Guthrie H. (S) 213 Medical Arts Bldg.
Wynegar, David E. Richmond State Hospital
Yencer, Martin W. (S) 22 N. 14th St.
Zeps, E. Frances 701 S. 16th St.

Marsh, Chester A. (S) 906 Dexter St., Los Angeles 42, Calif.
Hiatt, Russell L. VA Hospital, Louisville, Ky.
Heck, Rolfe A. College Corner, Ohio
Shepard, Fred F. College Corner, Ohio

WELLS COUNTY

Bluffton

Bishop, Robert E. 303 S. Main St.
Boonstra, Charles E. 303 S. Main St.
Brickley, Harry D. (S) 227 S. Main St.
Buckner, Joy F. 116 E. Walnut St.
Caylor, Charles H. 303 S. Main St.
Caylor, Harold D. 303 S. Main St.
Caylor, Truman E. 303 S. Main St.
Cook, Robert G. 303 S. Main St.
Dorrance, Thomas O. 303 S. Main St.
Eisaman, Jack L. 303 S. Main St.
Gitlin, Max M. 121 E. Market St.
Gitlin, William A. 121 E. Market St.
Hamilton, Orville G. 227 S. Main St.
Jackson, Charles E. 303 S. Main St.
Kephart, S. Bruce 303 S. Main St.
Mead, Clarence H. (S) 227 S. Main St.
Meier, Donald W. 303 S. Main St.
Milroy, Robert A. 303 S. Main St.
Nachman, Elias 303 S. Main St.
Panos, Constantine G. 227 S. Main St.
Phillips, John F. 303 S. Main St.
Pietz, David G. 303 S. Main St.
Rudy, Donald B. R.R. #3
Stevens, Adam C. 303 S. Main St.
Symon, William E. 303 S. Main St.
Talbert, Pierre C. 303 S. Main St.
Webster, Joel S. 303 S. Main St.
White, Charles G. 303 S. Main St.
Yanson, Mannfredo R. S. 303 S. Main St.
Yoder, Richard P. 303 S. Main St.

Gingerick, Charles M. Liberty Center
Davidoff, Manuel A. Ossian
Hardin, Wayne E. Ossian

Brewer, Robert A. Hqs. Co. 1st Bn. 2nd AC APO 114, New York, N.Y.

WHITE COUNTY

Galbreth, Jesse P. (S) Burnettsville
Derhammer, George L. Brookston
Gish, Howard M. Brookston
Henderson, Robert N. Brookston
Netherton, Clyde R. (S) Chalmers
Houser, Wayne W. Monon
McClure, Stanley E. Monon

Monticello

Beck, David C. 135 S. Illinois St.
Carney, John C. 116 N. Illinois St.
Dickerson, W. Martin 120 S. Illinois St.
Fullerton, Robert L. 201 Beach Dr.
Hibner, Nolan A. 110 S. Main St.
Morris, Warren V. 118 Court St.

Mayfield, Clifford H. (S) Reynolds
Baynes, Frank L. Wolcott
Forbes, Violet Crabbe Wolcott

WHITLEY COUNTY

Hershey, Ernest A. (S) Churubusco
Minick, Linus J. Churubusco

Columbia City

Brandt, William E. Columbia City
Brenton, Harold L. 215 E. Van Buren
Hamilton, Thomas Columbia City
Heritier, C. Jules 116 S. Chauncey
Langohr, John 215 E. Van Buren St.
Lehmberg, Otto F. C. 118 E. Van Buren St.
Niccum, Warren L. 215 E. Van Buren St.
Nolt, Ernest V. (S) 103 N. Line
Reid, Donald B. 118 E. Van Buren
Vogel, John L. 215 E. Van Buren St.
Wait, Jerome H. 112 N. Main St.
Wilson, John 116 S. Chauncey

Huffman, Verlin P. South Whitley

WOMAN'S AUXILIARY
to the
INDIANA STATE MEDICAL ASSOCIATION

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PRESIDENT	Mrs. Joseph Black	671 Braewick Rd. Sunset Parkway	Seymour
PRESIDENT-ELECT	Mrs. Edward L. Rigley	1704 Ridgedale Rd.	South Bend
FIRST-VICE-PRESIDENT	Mrs. Burton Kintner	3520 E. Jackson	Elkhart
SECOND VICE-PRESIDENT	Mrs. R. Case Hammond	6820 Arcadian Hwy.	Evansville
THIRD VICE-PRESIDENT	Mrs. Richard Gripe	1623 S. Fifth	Lafayette
FOURTH VICE-PRESIDENT	Mrs. Paul Merrell	5367 Kenwood	Indianapolis
RECORDING SECRETARY	Mrs. George Wagoner		Delphi
CORRESPONDING SEC'Y	Mrs. Jack Shields	721 W. Spring	Brownstown
TREASURER	Mrs. Kenneth Brown	1654 Hedden Park	New Albany
HISTORIAN	Mrs. Philip Holland	1001 S. Jordan Ave.	Bloomington
PARLIMENTARIAN	Mrs. Wm. R. Tindall	616 S. Harrison	Shelbyville
DISTRICT COUNCILOR CHAIRMAN	Mrs. M. O. Scamahorn	Pittsboro	

COMMITTEE CHAIRMEN

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TREASURER	Mrs. D. H. Condit	1521 E. Wayne St.	South Bend
BULLETIN	Mrs. Fielding Williams		Huntingburg
CIVIL DEFENSE	Mrs. Kenneth Schneider		Nashville
EDITORIAL	Mrs. Frank Green	516 N. Morgan	Rushville
FINANCE	Mrs. Wendell Stover	20 Lake Shore Dr.	Boonville
LEGISLATION	Mrs. Otis Bowen		Bremen
MENTAL HEALTH	Mrs. Frank Hogle	Logansport State Hosp.	Logansport
ORGANIZATION	Mrs. E. L. Rigley	1704 Ridgedale Rd.	South Bend
TODAY'S HEALTH	Mrs. H. R. Swihart	1621 E. Jackson	Elkhart
MEDICAL CARE INSURANCE	Mrs. Joseph Dudding		Hope
PROGRAM	Mrs. Albert Marshall, Jr.	7802 Allisonville Rd.	Indianapolis
PUBLICITY	Mrs. Dwight Schuster	4503 Washington Blvd.	Indianapolis
PUBLIC RELATIONS	Mrs. I. S. Hostetter	300 Winthrop	Muncie
RECRUITMENT	Mrs. Russell Palmer	2006 W. Fourth Place	Gary
RULES	Mrs. Harry Harvey	2228 Crescent Ave.	Ft. Wayne
RURAL AND COMMUNITY HEALTH	Mrs. Sam Campbell		R. R. 1, Noblesville
SAFETY	Mrs. Robert Acher		Greensburg

MEMBERSHIP ROSTER—BY COUNTIES

ADAMS COUNTY

Berne

Beaver, Mrs. N. E. 866 Columbia
Bose, Mrs. Robert L. 255 Dearborn
Luginbill, Mrs. Howard 817 W. Main St.
Rich, Mrs. Norvelle S. R. R. 4

Decatur

Burk, Mrs. J. M. 221 S. Third
Freeby, Mrs. William Decatur, Ind.
Girod, Mrs. A. H. 1004 W. Monroe
Harless, Mrs. Fred L. Monroeville, Ind.
Kohne, Mrs. G. J. 304 W. Adams
Reppert, Mrs. Rolland Road 224, Decatur
Schetgen, Mrs. J. V. Box 236, Geneva
Terveer, Mrs. John B. 1721 W. Monroe St.
Zwick, Mrs. H. F. 401 E. Rugg

ALLEN COUNTY

Bluffton

Brickley, Mrs. Harry D. 227 S. Main
Buckner, Mrs. J. 116 E. Walnut
Hamilton, Mrs. O. G. 203 E. Central
Mead, Mrs. C. H. 21 W. Washington

Fort Wayne

A

Adams, Mrs. E. Wade 1902 Forest Park Blvd.
Adams, Mrs. J. R. 2538 Fairfield Vw. Pl.
Aiken, Mrs. Arthur F. R. R. #1, Waterswold Dr.
Aiken, Mrs. Nevin E. 5540 Leo Rd.
Arata, Mrs. Justin E. 4220 Fairfield

B

Bailey, Mrs. Paul 1840 Pemberton
Ball, Dr. J. R. (Margaret) 1414 Park Ave.
Baltes, Mrs. Joseph H. 1309 Sunset Dr.
Barch, Mrs. John W. 1715 Poinsette
Bash, Mrs. W. E. 1201 Korte Lane
Beams, Mrs. Ralph 3710 Wawonaissa
Beierlein, Mrs. Karl M. 2716 Butler Road
Bergendahl, Mrs. Emil 1202 Illsey
Berghoff, Mrs. Raymond 2009 Forest Park
Beutler, Mrs. Theodore 3505 S. Washington Rd.
Blichert, Mrs. Peter 4501 Fairfield
Blosser, Mrs. H. V. 1122 W. Washington
Bolman, Mrs. R. M. 4135 S. Harrison
Borders, Mrs. Theodore 1802 Nevada
Bossard, Mrs. John W. 1712 California
Bowers, Mrs. G. T. 2609 East Dr.
Bridges, Mrs. W. L. Coldwater Rd.
Bromley, Mrs. L. W. 4216 Drury Lane
Brosius, Mrs. Robert H. W. 3302 Garland
Brown, Mrs. Frederic 4129 S. Harrison
Bruggeman, Mrs. H. O. 1202 W. Washington
Bryan, Mrs. Franklin A. 1439 Edgewater
Buckner, Mrs. Doster Bass Rd., R. R. 5
Buckner, Mrs. George D. 4327 Hampshire Drive

C

Calvin, Dr. Jessie C. 312 W. Wayne
Carlo, Mrs. Ernest 4633 Crestwood
Cartwright, Mrs. E. L. 3718 Hiawatha
Chambers, Mrs. Alan 4135 S. Harrison
Clark, Mrs. Wm. 4002 S. Harrison
Cochran, Mrs. H. A., Jr. 420 W. Sherwood Tr.

Connelly, Mrs. Richard.....3331 Webester
Cooney, Mrs. Charles.....1168 Westover Rd.
Craig, Mrs. Richard.....1002 Passadena
Culp, Mrs. John E.....2421 Paulding Rd.

D

Dahling, Mrs. C. W.....Carefree Farms, Doyle Rd., R. R. 2
Datzman, Mrs. Richard C.....5402 Bluffton Rd.
Dunstone, Mrs. H. C.....2433 Paulding Road

E

Eberly, Mrs. Karl C.....1240 W. Rudisill
Emenhiser, Mrs. John L.....1411 Reed Road

F

Ferguson, Mrs. Arthur N.....328 W. Sherwood
Foy, Mrs. H. W.....1816 Forest Park
Franke, Mrs. Gordon.....4452 Sandridge Dr.
Frankhouser, Mrs. Chas. M...7245 Winchester Rd.
Fullam, Mrs. Richard.....2720 Engle Rd.

G

Garton, Mrs. Harry W.....Hamilton Rd., R. R. 6
Gerding, Mrs. Wm. J.....1721 Forest Park Blvd.
Geyer, Mrs. Norman,.....4316 Lillie
Glassley, Mrs. Stephan.....6950 Stellhorn Rd.
Glock, Mrs. Wayne.....Tonkel Road
Goebel, Mrs. Carl W.....4102 So. Harrison
Graham, Mrs. George M.....1126 W. Rudisill
Graham, Mrs. James.....2017 S. Lafayette
Greenlee, Mrs. Robert L.....4024 Mound Pass
Griest, Mrs. Walter D.....4809 Arlington
Griffith, Mrs. H. R.....1913 Forest Park Blvd.

H

Hackett, Mrs. Walter G.....5220 Crandon Lane
Haffner, Mrs. Herman G.....3606 Mulberry Rd.
Haley, Mrs. Alvin J.....3720 Stellhorn Rd.
Haller, Mrs. Robert.....1432 Waldron Circle
Hamilton, Mrs. Emory D.....2405 Florida Dr.
Harvey, Mrs. Harry.....2228 Crescent
Hasewinkle, Mrs. A. M.....3544 Kirkland
Hastings, Mrs. Warren C.....1822 Kensington
Hattendorf, Mrs. A. P.....4041 Old Mill Rd.
Havens, Mrs. Russell E.....1845 Kensington
Hershberger, Mrs. Phillip G....5525 Covington Rd.
Hickman, Mrs. D. M.....1815 Kensington
Higgins, Mrs. Kenneth E.....3460 Sandpoint Rd.
Hipskind, Mrs. Richard E.....3929 Wenonah Lane
Hoetzer, Mrs. E. M.....5233 Doyle Rd.
Hoffman, Mrs. Arthur F.....3619 Harris Rd.
Holsinger, Mrs. Robert E.....4617 Indiana
Horning, Mrs. R. R.....3017 Kenwood
Howe, Mrs. Fordyce L.....2540 Springfield
Humphreys, Mrs. John....3701 S. Washington Rd.

J

Jackson, Mrs. John F.....4922 Indiana
Jurgenson, Mrs. Walter T.....5009 Indiana

K

Karol, Mrs. Herbert J.....1725 Ardmore
Kaufman, Mrs. Julian R.....1724 Crescent
Keck, Mrs. Carleton A.....4633 Crestwood
Kent, Mrs. Richard N.....2717 East Dr.
Keyes, Mrs. Robert C.....1226 Illsey Drive
Kidder, Mrs. O. T.....Lima Rd.
Kimbrough, Mrs. Robert.....4601 Beaver Ave.
Kleifgen, Mrs. W. A.....4602 Tacoma
Klooze, Mrs. Kenneth W.....723 W. Packard
Knight, Mrs. L. W.....1220 Kensington
Krueger, Mrs. J. E.....2424 N. Anthony
Kruse, Mrs. Edward.....4001 Old Mill Rd.
Kruse, Mrs. Walter E.....1242 Maxine Dr.

L

Ladig, Mrs. Donald S.....2720 Fairfield
Lampe, Mrs. Elfred H.....1018 Kinnaird
Land, Mrs. Francis L.....4520 Beaver
Laycock, Mrs. Richard.....5019 Stellhorn Rd.
Leming, Mrs. Ben L.....3005 N. Anthony
Lenk, Mrs. George G.....E. State St. Ext. 5507
Lill, Mrs. L. C.....4221 Buell Dr.
Lloyd, Mrs. Robert P.....3609 S. Anthony
Lohman, Mrs. Robert M.....2138 Owaissa
Lorman, Mrs. James G.....3401 Kirkwood
Loudermilk, Mrs. J. L.....1732 Pemberton
Lyon, Mrs. Wm. C.....2530 Beechwood Court

M

McArdle, Mrs. Edward G....1133 W. Rudisill Blvd.
McBride, Mrs. W. O.....610 Beechwood Circle
McCallister, Mrs. John W.....4215 Drury Lane
McDowell, Mrs. G. A.....2322 Forest Park Blvd.
McEeachern, Mrs. Cecil.....4242 Old Mill Rd.
McKeeman, Mrs. D. H.....1615 Ardmore
Mackel, Mrs. Frederick.....610 Nuttman
Manning, Mrs. George.....4115 Indiana
Marshall, Mrs. Caesar L.....1215 McCulloch
Mayes, Mrs. Warren B.....4815 Tacoma
Mensch, Mrs. James R.....2014 Kensington
Mercer, Mrs. S. R.....3235 W. Washington
Meyer, Mrs. Hans.....2615 Trier Rd.
Meyer, Mrs. T. O.....3728 Kirkwood
Michaelis, Mrs. S. C.....1255 Korte Lane
Miller, Mrs. Carl G.....457 Oakdale Dr.
Miller, Mrs. Edward D.....2615 East Drive
Miller, Mrs. H. Paul.....6408 S. Calhoun
Miller, Mrs. Mahlon.....1115 Illsley Dr.
Miller, Mrs. Orval J.....1810 Kensington
Miller, Mrs. Richard.....1322 W. Foster Parkway
Miller, Mrs. Wm. J.....3932 S. Calhoun
Moats, Mrs. Carl F.....3210 N. Washington
Moeller, Mrs. Victor C.....4723 St. Joe Center Rd.
Moravec, Mrs. Arthur.....4711 Old Mill Rd.
Mortenson, Mrs. Leland J....1310 N. Foster Pkwy.
Mueller, Mrs. Lawrence W., 3423 S. Washington Rd.
Murdock, Mrs. Harry L.....1212 Kensington

N-O

Nahrwold, Mrs. E. W.....3314 Irvington Dr.
Nill, Mrs. John.....440 W. Fleming
Nolan, Mrs. Gerald.....1102 Kensington
O'Brian, Mrs. John F.....1215 N. Anthony Blvd.
O'Rourke, Mrs. Carroll.....Covington Road
Oyer, Mrs. J. H.....2206 Wawonaissa

P

Painter, Mrs. Donald S.....Southridge Rd.
Parker, Mrs. C. B.....2215 Paulding Rd.
Parrot, Mrs. Donald J.....1809 Kensington
Perrin, Mrs. Kermit F.....2828 Lake Ave.
Perry, Mrs. Frederick G.....709 Kinnaird
Philbert, Mrs. Richard N.....2503 Drexel Ave.
Pickett, Mrs. Merle E.....4509 Atwood Dr.
Ponzcek, Mrs. Edward J.....6515 S. Calhoun
Popp, Mrs. Milton F.....3148 Parnell Ave.
Powell, Mrs. M. Jack.....7412 Ridgeknoll Rd.

R

Ranke, Mrs. Henry.....2301 Fairfield
Rhamy, Mrs. B. W.....4312 Beaver
Rissing, Mrs. Walter J.....3200 Irvington
Rodriquez, Mrs. Juan.....4720 Crestwood Dr.
Roser, Mrs. Arthur J.....3559 Leesburg Rd.
Rossiter, Mrs. D. L.....724 Oakdale Dr.
Rothberg, Mrs. Maurice.....4319 Hartman Rd.
Rousseau, Mrs. John W.....3913 Mound Pass

S

Sahlman, Mrs. Hans.....2402 Woodward
Salon, Mrs. Harry W.....4017 Hiawatha Blvd.
Salon, Mrs. Joel.....4935 Old Mill Road
Salon, Mrs. N. L.....7939 Scottwood Court
Sarver, Mrs. Francis E.....4629 Tacoma
Savage, Mrs. A. R.....South Ridge Road, R. R. 1
Schellhouse, Mrs. Earl M.....3610 Mulberry Rd.
Schlademan, Mrs. K. R.....4029 Weisser Park
Schmidt, Mrs. Eugene E.....1119 Maxine Dr.

Schmoll, Mrs. Robert J.....4811 Tacoma
Schneider, Mrs. Louis A.....1351 W. Sherwood Tr.
Schoen, Mrs. Fred.....5128 S. Wayne
Schubert, Mrs. J. C.....4716 Lillie
Scoins, Mrs. W. H.....4301 Taylor
Scott, Mrs. H. Vaughn.....5224 Fairfield Ave.
Senseny, Mrs. Eugene F.....3112 Beaver
Shaw, Mrs. James E.....3932 Rosewood Drive
Shinabery, Mrs. Lawerence.....1850 Broadway
Singer, Mrs. Elmer.....825 Oakdale Dr.
Smith, Mrs. Phillip L.....2701 Fairfield
Smith, Mrs. Richard B.....709 E. Oakdale
Smith, Mrs. Roger.....1722 Pemberton
Snyderman, Mrs. S. C.....3222 N. Washington Rd.
Somers, Mrs. G. H.....1253 W. Rudisill
Spencer, Mrs. C. Herbert.....2106 Paulding Road
Stauffer, Mrs. Richard.....4120 S. Harrison
Steigmeyer, Mrs. D. J.....1503 Kensington
Stellner, Mrs. Howard A.....3323 Butler Court
Stier, Mrs. Paul.....13120 Ravine Trail, R. R. 6
Stump, Mrs. Edwin E.....1118 Elm St.
Sullivan, Mrs. Robert E.....137 W. Branning

T

Taylor, Mrs. Robert G.....3104 Alexander Dr.
Tennant, Mrs. D. L.....3513 Kirkland Lane
Terrill, Mrs. Richard.....4727 Old Mill Rd.
Thornton, Mrs. W. E.....601 Oakdale Dr.

V

Van Buskirk, Mrs. E. W.....920 Maxine Dr.

W

Wade, Mrs. R. W.....4105 Dalewood Dr., R. R. 9
Walker, Mrs. Floyd.....1202 Forest Ave.
Ward, Mrs. Gerald.....2014 Curdes
Warfield, Mrs. C. H.....3924 Harris Rd.
Weber, Mrs. John R.....1215 Sheridan Ct.
Welty, Mrs. S. G.....8416 Stellhorn Road
Wilkins, Mrs. Robert W.....4839 Old Mill Rd.
Williams, Dr. (Berniece)..3526 N. Washington Rd.
Wilson, Mrs. Leslie.....2810 S. Wayne Ave.
Wilson, Mrs. Roland B.....4100 Abbott
Wright, Mrs. William C.....1834 Pemberton Dr.

Z

Zehr, Mrs. Noah.....301 W. Creighton
Zweig, Mrs. Elmer.....2015 Pemberton

New Haven

Emenhiser, Mrs. Don C.....1040 Lincoln Highway
Smith, Mrs. G. A.....804 Lincoln Highway

Emme, Mrs. Richard W.....R. R. 2, Grabill
Harless, Mrs. O. Fred.....Monroeville
Saylors, Mrs. Roger D.....R. R. 2 Grabill

BARTHOLOMEW-BROWN COUNTIES

Columbus

Adler, Mrs. David L.....931 Fifth St.
Beggs, Mrs. Lowell F.....2733 Riverside Dr.
Davis, Mrs. Marvin R.....2300 N. Washington St.
Echsner, Mrs. Herman.....1512 28th St.
Fisher, Mrs. Walter S.....906 Franklin
Hart, Mrs. Robert B.....1203 16th
Hawes, Mrs. Marvin E.....2975 Franklin Dr.
Henry, Mrs. Alvin L.....1926 Lafayette Avenue
Knotts, Mrs. Slater.....Harrison Lake
Krueger, Mrs. Robert.....Griffa Ave.
Macy, Mrs. George W.....2623 Riverside Dr.
Marr, Mrs. Griffith.....Marr Rd.
McCullough, Mrs. Henry.....Old Indianapolis Rd.
Mohler, Mrs. Floyd.....2615 Franklin
Norton, Mrs. Harold J.....909 Pearl St.
O'Bryan, Mrs. Richard.....1602 Washington
Overshiner, Mrs. Lyman.....1715 Franklin
Reid, Mrs. Robert.....2712 Lafayette Avenue
Ryan, Mrs. Wm. J.....2244 Pearl
Schmitt, Mrs. R. K.....2639 Riverside Dr.
Sigmund, Mrs. Wm. B.....Davis Road
Smith, Mrs. Donald C.....1629 Franklin St.
Williams, Mrs. E. W.....1902 Franklin St.
Wissman, Mrs. Wm. L.....2335 Riverside Dr.
Yoder, Mrs. Dewey D.....713 Lafayette Ave.
Zaring, Mrs. Byron K.....2419 Riverside

Dudding, Mrs. Joseph E.....Hope
Jacobs, Mrs. E. Robert.....Hope
Schneider, Mrs. Kenneth.....Nashville
Seibel, Mrs. Robert.....Nashville

BENTON COUNTY

Leak, Mrs. Robert.....Boswell
Coddens, Mrs. A. L.....Earl Park
Miller, Mrs. Dan T.....Fowler
Turley, Mrs. Verne L.....Fowler
Scheurich, Mrs. Virgil.....Oxford
Rutherford, Mrs. C.....Otterbein

BLACKFORD COUNTY

Hartford City

Dodd, Mrs. J. U.....The Oaks
Dudgeon, Mrs. Charles A.....421 E. North St.
Jackson, Mrs. Dean D.....401 W. Washington St.
Owsley, Mrs. Guy A.....The Oaks
Park, Mrs. George O.....R.R. 2, State Rd. 26W
Weldy, Mrs. Brice P.....227 W. Franklin St.
Werry, Mrs. L. E.....1223 N. High St.
Wierzalis, Mrs. Edward.....520 N. Jefferson St.

Burns, Mrs. Paul E.....223 E. High St., Montpelier
Douglas, Mrs. William T.
205 E. Monroe St., Montpelier

BOONE COUNTY

Schaaf, Mrs. Alvin.....Jamestown

Lebanon

Coons, Mrs. John D.....121 Ulen Blvd.
Coons, Mrs. Ritchie.....138 Ulen Blvd.
Grigsby, Mrs. Bland.....904 Northfield Drive
Headley, Mrs. Lloyd M.....137 Ulen Blvd.
Honan, Mrs. Paul.....202 East Dr.
Kern, Mrs. Clarence.....1019 N. Meridian
Lenox, Mrs. Jack.....205 East Dr.
Weddle, Mrs. Charles.....1210 N. East
Wiseheart, Mrs. Robert.....123 Ulen Blvd. Dr.

Gregg, Mrs. Edwin.....Thorntown
Lovett, Mrs. Harvey.....Zionsville
Bailey, Mrs. Lawrence S.....Zionsville
Harvey, Mrs. Ralph.....Zionsville

CARROLL COUNTY

Van Kirk, Mrs. John.....Burlington
Maggart, Mrs. Ralph.....Camden

Delphi

Baker, Mrs. Eldon E.....816 S. Hamilton
Crampton, Mrs. Chas.....218 East Monroe
Petry, Mrs. Thomas N.....211 W. North St., Delphi
Seese, Mrs. Robert M.....201 W. North St.
Wagoner, Mrs. Geo. W.....305 W. Summit St.

Adams, Mrs. Max.....Box 67, Flora
McLaughlin, Mrs. James..511 East Main St., Flora

CASS COUNTY

Dutchess, Mrs. Charles T.....Galveston

Logansport

Adamski, Mrs. M. S.....614 17th
Bailey, Mrs. Earl W.....2522 North
Ballard, Mrs. Charles A.....R. R. 4
Bean, Mrs. Joseph S.
Burnett, Mrs. Paul C.....Logansport State Hosp.
Cobb, Mrs. Clarence M.....R. R. 1
Davis, Mrs. John.....2119 North
Eckert, Mrs. Russell A.....R. R. 1
Fitzgerald, Mrs. Brice.....1930 High
Fogel, Mrs. Ernest J.....Logansport St. Hospital
Gatzimos, Mrs. Christos D.....314 Fourteenth
Glendening, Mrs. Richard L.....2300 May Fair Dr.
Hall, Mrs. Bernard R.....3100 E. Broadway
Harrington, Mrs. James F.....2316 Rolling Ridge
Hedde, Mrs. E. L.....2304 Chase Rd.
Hillis, Mrs. L. J.....2508 E. Broadway
Hogle, Mrs. Frank D.....Logansport State Hosp.
Holmes, Mrs. Will W.....2537 East Broadway
King, Mrs. Jay M.....2319 May Fair Dr.
Maschmeyer, Mrs. R. H...Logansport St. Hospital
Mikan, Mrs. V. Robert.....R. R. 5
Morrical, Mrs. R. J.....415 Highland
Schenck, Mrs. Foss.....97 21st St.
Viney, Mrs. Charles.....26th and High St.
Wilson, Mrs. Paul.....R. R. 5
Winter, Mrs. Donald K.....R. R. 5

Flanagan, Mrs. E. P.....106 May, Walton
Lybrook, Mrs. D. E.....Young America

CLARK COUNTY

Charlestown

Goodman, Mrs. Eli.....802 Market
Shina, Mrs. Haskel, Charlestown.....State Rd. 403

Clarksville

Mudd, Mrs. Joseph.....103 W. Rosewood Dr.
Wilner, Mrs. Alan.....214 Rosewood Dr.
Wolverton, Mrs. George.....115 Rosewood Dr.

Carr, Mrs. Joseph.....Pine Rd., Henryville
Greene, Mrs. W. R.....Henryville

Jeffersonville

Adair, Mrs. Sam.....50 Wildwood Rd.
Bizer, Mrs. Mier.....155 Forrest Dr.
Bruner, Mrs. George.....804 E. Court St.
Buckley, Mrs. Ernest.....14 Blanchel Terrace
Buehler, Mrs. George.....192 Forest Dr.
Carlberg, Mrs. Dale L.....2 Blanchel Terrace
Carney, Mrs. J. T.....2602 Hollywood Dr.
Clark, Mrs. Wm. B., Jr.....Blackston Mill Road
Dare, Mrs. Lee.....215 Sparks
Graham, Mrs. O. P.....713 E. Maple
Havens, Mrs. Alfred Lyle.....203 Sparks Ave.
Havens, Mrs. Thomas.....400 Chippewa
Huoni, Mrs. John.....6 Blanchel Terrace
Isler, Mrs. Nathaniel.....901 Morningside Dr.
Reed, Mrs. Edsel.....302 Mockingbird
Roby, Mrs. A. L.....2708 Hollywood Dr.
Weems, Mrs. Mallory P.....Hopkins Lane

Sturgis, Mrs. Donald G...542 Linnwood, Sellersburg
Vandevert, Mrs. Arthur, 202 Highland, Sellersburg

DEARBORN-OHIO COUNTIES

Aurora

Baker, Mrs. Leslie M.....204 Fifth
Jackson, Mrs. Kenneth.....Aurora
Olcott, Mrs. Charles W.....422 Sunnyside
Treon, Mrs. James F.....505 Fifth St.

McNeeley, Mrs. Matthew J.....Dillsboro
Elliott, Mrs. John C.....Guilford

Lawrenceburg

Fagaly, Mrs. William J.....57 Oakley
Houston, Mrs. Fred D.....930 Miller Ave.
Morrison, Mrs. George.....Old U.S. 50
Pfeifer, Mrs. James M.....550 Ludlow
Streck, Mrs. Francis A.....547 Ridge Ave.
Vail, Mrs. George A.....634 Ludlow

DECATUR COUNTY

Tremain, Mrs. M. A.....Adams

Greensburg

Acher, Mrs. Robert P.....446 E. Washington
Callaghan, Mrs. W. C.....R. R. 1, Lincoln Park
Dickson, Mrs. Dale D.....825 N. Broadway
Miller, Mrs. James C.....178 N. Michigan Ave.
Morrison, Mrs. J. Trevor....161 N. Michigan Ave.
Overpeck, Mrs. Charles.....R. R. 8
Shaffer, Mrs. William R.....214 N. Franklin
Walker, Mrs. Louis A.....332 E. North St.

Porter, Mrs. Edward.....Westport

DELAWARE COUNTY

Puterbaugh, Mrs. Karl.....Albany
Hurley, Mrs. John.....Daleville
Downard, Mrs. Leland.....Gaston
Montgomery, Mrs. Lall G.
Box 149A, RFD 1, Gaston

Muncie

A

Adams, Mrs. William B.....W. Jackson St. Pike
Alvey, Mrs. Charles R.....3001 Torquay
Anthony, Mrs. Harvey M.....822 W. Charles

B

Ball, Mrs. Clay A.....1015 Linden
Ball, Mrs. Philip.....3201 Oaklyn Ave.
Benken, Mrs. Lawrence.....1001 N. Tillotson
Bergwall, Mrs. Warren.....1507 Winthrop
Bibler, Mrs. Henry.....2625 Parkway Dr.
Botkin, Mrs. Clyde G.....2904 Riverside Ave.
Botkin, Mrs. Thomas.....2500 Bethel Pike
Brown, Mrs. Leland.....605 Waid Ave.
Brown, Mrs. Stewart D.....R. R. 3, Hamilton Pk.
Brown, Mrs. Thomas.....Isanogel Road
Burwell, Mrs. Stanley W.....3124 Gilbert
Butterfield, Mrs. Robert.....222 Winthrop Rd.
Butz, Mrs. Ralph.....2929 Godman Ave.

C

Clark, Mrs. Robert.....911 University
Clauser, Mrs. Eldo.....1 Briar Rd.
Clevenger, Mrs. Joseph H.....3124 University Ave.
Covalt, Mrs. Wendell.....120 Berwyn
Cure, Mrs. Elmer T.....913 University Ave.

D

Deutsch, Mrs. Wm.....2100 Petty Rd.
Dunn, Mrs. Farrell W.....1417 Wheeling Ave.
Dunning, Mrs. Thos.....3627 Clover Lane

E-F

Eissman, Mrs. Eugene.....211 Alden Rd.
Funk, Mrs. John.....3700 Peachtree Lane

G

Garling, Mrs. L. C.....37 Briar Rd.
Geckler, Mrs. Charles E.....1007 W. North St.
Gill, Mrs. Tom.....45 Warwick Rd.
Greiber, Mrs. Marvin.....310 Riley Rd.
Gustafson, Mrs. Milton.....230 Stradling Rd.

H-I

Hall, Mrs. O. A. 2302 Lanewood
Hall, Mrs. Robert 1609 Royale Dr.
Hayes, Mrs. T. R. 19 Warwick Road
Henderson, Mrs. Ramon 75 Warwick Rd.
High, Mrs. Ralph 2825 University Ave.
Hill, Mrs. Howard 106 Berwyn Rd.
Hostetter, Mrs. I. S. 300 Winthrop
Hurley, Mrs. Anson 101 Berwyn
Imhof, Mrs. J. D. 307 Granville Ave.

K-L

Kammer, Mrs. Walter F. 1005 W. Parkway Dr.
Kirshman, Mrs. F. E. 41 Briar Rd.
Ko, Mrs. Richard R. R. 7
Koss, Mrs. Wm. 1504 Winthrup Rd.
Lutz, Mrs. Robert 2400 W. 28th

M-N

McClintock, Mrs. James A. 3121 University Ave.
McCoy, Mrs. George 516 Waid Ave.
McDowell, Mrs. Fletcher 698 Weber Dr.
Moore, Mrs. Tom 1011 E. Parkway Dr.
Morris, Mrs. J. W. 222 Stradling Rd.
Moss, Mrs. M. J. 1010 W. Parkway Dr.
Nelson, Mrs. Harold 3216 Torquay Rd.

O

Owens, Mrs. Richard R. 3011 Oaklyn Ave.
Owens, Mrs. Thomas 608 E. Charles

P-Q

Peacock, Mrs. Robert R. R. 3
Pippinger, Mrs. W. G. 1200 N. Tillotson
Quick, Mrs. Wm. 2009 University Ave.

R

Rathkey, Mrs. Arthur S. 2919 Beechwood Ave.
Rettig, Mrs. Arthur 614 N. McKinley Ave.
Rivers, Mrs. Glynn 307 Alden Rd.

S

Saperstein, Mrs. Morris 700 Riverside Ave.
Schulhof, Mrs. M. G. 921 W. Parkway
Smith, Mrs. J. S. 1006 E. First St.
Speck, Mrs. Carlson 421 Bittersweet
Stanley, Mrs. John R. 1515 N. Tillotson Ave.
Starks, Mrs. William 2820 W. Main St.
Steele, Mrs. F. M. 3013 Devon
Stibbins, Mrs. Warren 2908 Torquay Rd.
Stout, Mrs. Francis 1003 University

T

Taylor, Mrs. Donald 307 N. Manning St.
Taylor, Mrs. James A. 1613 Riley Rd.
Tomlin, Mrs. Hugh M. 2920 Beechwood Ave.

W

Walker, Mrs. Jack R. R. 6, Box 385A
Ware, Mrs. Herbert 1705 Rosewood

Y

Young, Mrs. G. S. 114 Berwyn Rd.

Hinchman, Mrs. Jean Parker
Hill, Mrs. Robert Yorktown
Moore, Mrs. Will C. White Oak Farm, Yorktown
Rutledge, Mrs. Jean R. R. #1, Yorktown

DUBOIS COUNTY

Barrow, Mrs. John Dale, Box 55
Backer, Mrs. Henry George Ohio St., Ferdinand

Huntingburg

Amini, Mrs. Sohrab R. F. D. #2
Bretz, Mrs. John Orchard Road
Heaton, Mrs. Elton Cedar Heights
McKinney, Mrs. Mildred 517 4th St.
Scales, Mrs. Alfred B. R. R. 2
Scales, Mrs. Allen
Steinkamp, Mrs. Emil 302 Walnut
Stork, Mrs. Harvey K. 523 First
Williams, Mrs. Fielding 511 Geiger

Jasper

Bevan, Mrs. John R. R. 2
Bogmenko, Mrs. Leon Holland
Casper, Mrs. Joseph 205½ West 7th St.
Gootee, Mrs. Thomas Dorbett Street
Heck, Mrs. Martin C. 388 W. 15th
Held, Mrs. George A. 716 W. Ninth
Klamer, Mrs. Charles H. 616 W. 13th St.
Ploetner, Mrs. Edward Dorbett Street
Salb, Mrs. J. P. R. R. #5
Wagner, Mrs. Arthur R. R. 5, Box 188

ELKHART COUNTY

Bristol

Neidballa, Mrs. E. G. R. R. 1
Patrick, Mrs. Glen P. R. F. D. 1
Schlosser, Mrs. H. C. Seven Gables

Elkhart

Bender, Mrs. R. L. 125 N. Riverside
Benson, Mrs. James E. 1501 Fulton St.
Billings, Mrs. Elmer 165 Gage Ave.
Bloom, Mrs. George R. 1100 E. Jackson Blvd.
Bowdoin, Mrs. George E. 3809 Greenleaf Blvd.
Campbell, Mrs. Patrick B. 1618 Cone St.
Classen, Mrs. Pete R. 635 W. Wolf Ave.
Compton, Mrs. Walter A. 2225 Greenleaf Blvd.
Conklin, Mrs. R. L. 215 Swanson Circle West
Cormican, Mrs. Herbert L. 2002 E. Jackson
Crandall, Mrs. L. A., Jr. 3600 W. Indiana
Dovey, Mrs. E. G. 1430 Ervin
Elliott, Mrs. L. A. 405 S. Second
Elliott, Mrs. Thomas A. 2001 Stevens
Fleming, Mrs. Claude F. 229 W. Jackson
Futterknecht, Mrs. James C. 2012 Morton Ave.
Gattman, Mrs. G. Beach 414 N. Michigan
Hannah, Mrs. Jack W. 1906 E. Jackson
Hemingway, Mrs. Norman 1700 Rainbow Bend
Horswell, Mrs. R. G. 1629 E. Jackson Blvd.
Hull, Mrs. A. W. 3333 Greenleaf Blvd.
Hunn, Mrs. M. F. 202 W. Beardsley
Hurley, Mrs. James William 1705 Roys Ave.
Ivy, Mrs. John H. 1311 Kilbourn St.
Keating, Mrs. John U. 1416 Strong Ave.
Kintner, Mrs. Burton E. 3520 E. Jackson
Kistner, Mrs. Arthur W. 800 Middlebury
Koehler, Mrs. Elmer George 615 N. Riverside Dr.
Leasure, Mrs. Kenneth E. 1006 Baker Dr.
Luckey, Wm. T. 1106½ Bower St.
Lundt, Mrs. Milo O. 519 S. Second
Markel, Mrs. I. J. 215 W. Franklin
Martin, Mrs. Paul H. 1519 Strong
McArt, Mrs. Bruce A. 905 Strong Ave.
Mendez, Mrs. Carlos 1109 Baker Dr.
Miller, Mrs. Galen R. 903 W. Franklin
Miller, Mrs. Hugh A., Jr. 417 Prospect
Mininger, Mrs. Edward P. 1118 E. Jackson
Mishkin, Mrs. Irving 1809 Rainbow Bend Blvd.
Paff, Mrs. Wm. A. 1745 Rainbow Bend Blvd.
Paine, Mrs. George E. 329 Meisner
Pancost, Mrs. Vernon 160 Riverview Ave.
Parshall, Mrs. Dale B. 133 W. Lusher Ave.
Rouen, Mrs. Robert L. 1919 E. Jackson
Rupe, Mrs. L. O. R. R. #4, Oakland Ave. Rd.
Sears, Mrs. M. Maywood 4806 W. Indiana Ave.
Slabaugh, Mrs. Jancy S. 258 N. Main St.
Sobel, Mrs. Z. W. 183 Witmer Ave.
Spray, Mrs. Page E. 658 Kilbourn
Stauffer, Mrs. W. A. 701 Strong
Stout, Mrs. R. B. 1501 Greenleaf

Stubbins, Mrs. William.....15 St. Joseph Manor
Swihart, Mrs. Homer R.....1621 E. Jackson
Swihart, Mrs. Leonard F.....3213 Calumet
Wilson, Mrs. O. E.....2505 Greenleaf Blvd.
Work, Mrs. James A., Jr.....4 St. Joseph Manor
Yoder, Mrs. C. Richard.....409 Prospect

Goshen

Bender, Mrs. C. L.....624 S. Fifth
Bosler, Mrs. Howard A.....211 Egbert Road
Chandler, Mrs. L. H.....412 S. Fifth
Freeman, Mrs. F. M.....309 E. Washington
Graber, Mrs. Virgil R.....R. R. #2
Hostetler, Mrs. C. M.....1602 S. Eighth
Krabill, Mrs. Willard S.....420 Westwood Rd.
Martin, Mrs. Floyd S.....2301 S. Main St.
Nelson, Mrs. D. Chester.....1210 S. Eighth
Quilty, Mrs. Thomas J.....801 S. 7th St.
Simmons, Mrs. Lloyd H.....606 South 3rd St.
Troyer, Mrs. Dana O.....1727 South 13th St.
Turner, Mrs. John.....507 Greene Road
Vander Bogart, Mrs. Harry E.....1411 S. Eighth
Wagner, Mrs. D. G.....307 S. Seventh
Yoder, Mrs. Albert C.....816 S. Sixth
Yoder, Mrs. Jonathan G.....1204 S. Eighth

Nappanee

Fleetwood, Mrs. R. A.....555 N. Nappanee
Kendall, Mrs. F. M.....654 Woodland
Price, Mrs. Douglas W.....607 E. Van Buren

Miller, Mrs. Donald G...105 Brown St., Middlebury
Massanari, Mrs. Walter.....Millersburg
Fosbrink, Mrs. E. L...218 S. Huntington, Syracuse
Rheinheimer, Mrs. Floyd L.....Milford

Wakarusa

Abel, Mrs. Robert.....105 E. Harrison
Amick, Mrs. Charles L.....118 E. Waterford
Guttman, Mrs. John Beck,.....201 N. Elkhart Ave.

FAYETTE-FRANKLIN COUNTIES

Brookville

Foreman, Mrs. Walter A.....617 Main
Smith, Mrs. H. N.....812 Main
Seal, Mrs. Perry F.....901 Main

Connersville

Ashworth, Mrs. Juanita.....2027 Indiana Ave.
Brookman, Mrs. Robert E.....2750 Grand Ave.
Ellis, Mrs. George M.....108 East 10th St.
Gregg, Mrs. Albert F.....835 Lincoln Ave.
Hudson, Mrs. Arlington.....80 East Drive
Kemp, Mrs. W. Alfred.....403 W. 28th St.
Leffel, Mrs. Glen.....1810 Indiana Ave.
Lockhart, Mrs. Jack M.....54 West Drive
Morrow, Mrs. Roy D.....629½ Eastern Ave.
Mountain, Mrs. Francis B.....1720 Virginia Ave.
Sanders, Mrs. Bertram.....1533 Virginia Ave.
Smelser, Mrs. Herman W.....2530 Grand Ave.
Steinem, Mrs. Joseph L.....R. F. D. #3
Watterson, Mrs. Gerald T.....1704 Virginia Ave.

Poston, Mrs. C. L.....R. R. 2, Laurel

FLOYD COUNTY

Engleman, Mrs. H. K.....Georgetown

Jeffersonville

Baxter, Mrs. S. M.....Centralia Ct.
Gentile, Mrs. John P.....3405 Centralia Ct.
McCullough, Mrs. J. Y.....3500 Centralia Ct.
Sloan, Mrs. Herbert.....Lincoln Heights

New Albany

Baker, Mrs. A. M.....2523 Glenwood
Baxter, Mrs. J. W., Jr.....426 Woodrow Ave.
Best, Mrs. Maurice.....1233 Vance Ave.
Bird, Mrs. J. E.....1308 E. Spring
Briscoe, Mrs. C. E.....1413 E. Spring
Brown, Mrs. K. H.....1654 Hedden Park
Byrn, Mrs. Howard.....330 Beharrel Ave.
Cannon, Mrs. Daniel.....1203 E. Spring St.
Davis, Mrs. Parvin.....Paoli Pike
Edwards, Mrs. W. F.....615 Beharrel Ave.
Garner, Mrs. Wm. H.....922 E. Spring
Garner, Mrs. William H., Jr.....922 E. Spring St.
Geyer, Mrs. Joseph H.....Old Vincennes Rd.
Harris, Mrs. Robert W.....1923 Ekin Avenue
Hauss, Mrs. A. P.....Silver Hills
Hess, Mrs. P. Patrick.....Silver Hills
Higgins, Mrs. John.....Old Vincennes Rd.
LaFollette, Mrs. Donald R.....Crestview
LaFollette, Mrs. Robert E.....2510 Glenwood Ct.
Leuthart, Mrs. C. P.....1410 E. Spring
Paris, Mrs. John M.....2003 Lindberg Ct.
Pierson, Mrs. Percy.....1430 Silver St.
Robertson, Mrs. A. N.....323 E. Ninth
Rogers, Mrs. S. T.....1017 E. Spring
Ruoff, Mrs. William.....1706 DePauw Ave.
Sonne, Mrs. Irvin.....1607 Hedden Court
Streepey, Mrs. Jefferson.....1919 DePauw Ave.
Voyles, Mrs. Harry.....425 Beharrel Ave.
Wallace, Mrs. Elmer.....1804 DePauw Ave.
Weaver, Mrs. W. W.....Crestview
Winstandley, Mrs. Wm.....815 Vincennes
Wohlfeld, Mrs. Gerald
Silvercrest, Old Vincennes Rd.
Wolfe, Mrs. Nelson A.....Graybrook Lane
Worley, Mrs. Henry.....1921 DePauw Ave.

FULTON COUNTY

Miller, Mrs. Virgil C.....Akron
Stinson, Mrs. Arthur E.....Athens
Glackman, Mrs. John C.....Culver
Kraning, Mrs. Kenneth K.....Culver

Rochester

Dielman, Mrs. Franklin C.....920 Jefferson
Guthrie, Mrs. James U.....R. R. 2
Herendeen, Mrs. Elbie V.....317 W. Seventh
Johnson, Mrs. F. P.....1100 Washington St.
King, Mrs. Milo O.....110½ E. Eighth
Richardson, Mrs. Chas. L.....506 Pontiac
Rowe, Mrs. Howard H.....417 W. Ninth
Stinson, Mrs. Dean K.....1318 Main

GIBSON COUNTY

Geick, Mrs. R. G.....207 N. Main, Ft. Branch
Marchand, Mrs. Edwin V.....Haubstadt

Oakland City

Clark, Mrs. Carl M.....123 W. Vine St.
Dye, Mrs. William.....518 S. Jackson St.
Wood, Mrs. Russell W.....High St.

Princeton

Carpentier, Mrs. H. F.....319 E. State
Folck, Mrs. J. K.....528 N. Main St.
Graves, Mrs. O. M.....116 E. Spruce
McCarty, Mrs. Virgil.....403 W. Spruce
McElroy, Mrs. R. S.....404 W. Walnut
Peck, Mrs. J. F.....Outer W. Monroe
Weitzel, Mrs. R. E.....309 W. Spruce

GRANT COUNTY

Malott, Mrs. Fred.....Converse
Grant, Mrs. Arthur.....Fairmount
Yale, Mrs. Charles.....Fairmount
Garrison, Mrs. L. J., 305 E. South "C" St., Gas City
Koontz, Mrs. William A.....334 E. Main, Gas City
Shoemaker, Mrs. Richard L.....211 E. South A St.

Marion

Abell, Mrs. Charles....915 Wabash Ave.
Alderfer, Mrs. Henry....806 W. 1st St.
Ansbacher, Mrs. Stefan....R. R. 1
Ayres, Mrs. W. W....920 Jeffras Ave.
Bailey, Mrs. Douglas....R. R. 6, Hickory Hills
Bloom, Mrs. A. Ward....610 River Rd.
Brown, Mrs. Robert M....825 Euclid Ave.
Comeau, Mrs. Wm. J....Shady Hills
Cunningham, Mrs. Robert....1017 Euclid Ave.
Davis, Mrs. Joseph....121 No. Washington St.
Davis, Mrs. Merrill S....723 Euclid Ave.
Davis, Mrs. Richard....Shady Hills
Diamond, Mrs. Leo....710 Jeffras
Ganz, Mrs. Max....904 Jeffras
Goldsmith, Mrs. David....1225 Jeffras Ave.
Hockett, Mrs. Harry G....34 Veterans Hosp.
Hover, Mrs. Galen M....27 A Veterans Hosp.
Hummel, Mrs. R. M....Shady Hills
Jarrett, Mrs. John....113 W. 5th St.
Lahr, Mrs. Richard E....1627 Broadview Dr.
Lavengood, Mrs. Russell W....Charles Rd. R. R.
Langrall, Mrs. Harrison M....Hickory Hills
Lonngren, Mrs. Dudley....307 Kem Rd.
Love, Mrs. V. Logan....Hickory Hills
Miller, Mrs. H. Allison....1010 W. 4th Street
Miller, Mrs. John R....33 A Veterans Hosp.
Oatman, Mrs. Jack....1610 E. Parkview Dr.
Pattison, Mrs. John D....Hickory Hills
Powell, Mrs. J. P....127 River Dr.
Price, Mrs. Ambrose....2938 S. Branson
Renbarger, Mrs. Lester....Wabash Pike
Rhamy, Mrs. Arthur....1230 Euclid Ave.
Rhorer, Mrs. John G....711 Wabash Ave.
Sandy, Mrs. William,....32 Veterans Hosp.
Schroeder, Mrs. R. W....2123 S. Boots St.
Simmons, Mrs. F. H....Shady Hills
Skomp, Mrs. C. E....1123 Euclid Ave.
Smith, Mrs. Barton T....1005 Audubon Dr.
Snowhite, Mrs. Arthur B....508 Whites Ave.
Stenger, Mrs. R. H....227 North "E" St.
Thompson, Mrs. B. Jay....123 River Dr.
Woodbury, Mrs. J. W....712 S. "G" St.
Young, Mrs. Robert....Northwood Dr.

King, Mrs. P. C....Swayzee
Taylor, Mrs. E. C....Upland
Rifner, Mrs. E. S....Van Buren
Beck, Mrs. Thomas....Swayzee
McIlwain, Mrs. Robert...Methodist Home, Warren

HAMILTON COUNTY

Karlick, Mrs. J. R....Arcadia
Donahue, Mrs. C. M....Carmel
Thomas, Mrs. W. Clayton
716 First St., N. E., Carmel
Havens, Mrs. Oscar....Cicero

Noblesville

Ambrose, Mrs. J. C....298 N. Ninth
Campbell, Mrs. Sam....R. R. 1
Hash, Mrs. J. S....R. R. 4
Haywood, Mrs. John....1260 Lincoln Dr.
Kraft, Mrs. Haldon....R. R. #5
Lanning, Mrs. R. Adrian....R. R. 3
Lloyd, Mrs. Joe....560 N. 14th St.
Shanks, Mrs. Ray....R. R. 5
Shonk, Mrs. H. W....408 North Ninth St.

Connoy, Mrs. Andrew....Westfield
Connoy, Mrs. Leo....139 N. Union St., Westfield
Newby, Mrs. Eugene....Sheridan
Waitt, Mrs. Paul....Sheridan

HANCOCK COUNTY

Johnston, Mrs. W. R....Charlottesville
Scott. Mrs. Robert....Charlottesville
Garrison, Mrs. James....Cumberland
Manifold, Mrs. Harold....Merril St., Fortville
Naven, Mrs. W. K....Fortville

Greenfield

Allen, Mrs. Joseph....210 E. Lincoln
Beeson, Mrs. Wilbur....209 N. Penn.
Endicott, Mrs. Wayne....115 McClellen
Farrell, Mrs. John J., Jr....304 W. McKenzie Rd.
Gibbs, Mrs. Charles, 910 Dixie Hwy., Ft. Pierce Fla.
Gill, Mrs. D. D....328 Park
Hunter, Mrs. Donn....126 Roosevelt Drive
Kinneman, Mrs. R. E....McClelland Dr.
Kirby, Mrs. Ted....122 Grandison Rd.
Smith, Mrs. John H....919 Maple Dr.
Vingis, Mrs. Bronie....705 N. State
Woods, Mrs. James R., Jr....715 N. East

Cagle, Mrs. Robert....New Palestine
Larrabee, Mrs. William....New Palestine
Pierson, Mrs. Thomas....New Palestine
Miller, Mrs. Joseph A., 6041 Middle Dr., Oaklandon
Kuhn, Mrs. Robert....Wilkinson
Trees, Mrs. Nellie....Wilkinson
Freeborn, Mrs. Warren....Oaklandon

HENDRICKS COUNTY

Foltz, Mrs. Lloyd....Brownsburg
Scudder, Mrs. A. N....Brownsburg

Danville

Hibner, Mrs. Kermit Q....St. Rd. 36 East
Koch, Mrs. Elmer....301 S. Bowen
Kirtley, Mrs. Robert W....440 W. Marion
Terry, Mrs. Lloyd....292 W. Marion

Ellis, Mrs. L. Hall....Lizton
Scamahorn, Mrs. Malcolm....Pittsboro
Scamahorn, Mrs. Oscar T....Pittsboro

Plainfield

Aiken, Mrs. Milo M....140 N. Center
Haggard, Mrs. David B....Lake Shore Dr., R #2
Johnston, Mrs. Alan....450 Avon Ave.
Stafford, Mrs. J. C....223 Avon
Stafford, Mrs. William C....625 S. East St.

HENRY COUNTY

Zimmerman, Mrs. W. H....Dublin
Wiatt, Mrs. Leonard....108 N. Washington St., Knightstown
Stauffer, Mrs. George....Moreland
Marshall, Mrs. L. C....Mt. Summit
Clark, Mrs. M. E....Cambridge City

New Castle

Amos, Robert L....924 Lincoln Ave.
Bledsoe, Mrs. J. G....319 S. 14th
Burnett, Mrs. A. B....801 Melody Lane
Craig, Mrs. Alex F....711 Crescent Dr.
Davies, Mrs. Robert R....1125 Audubon Road
Fisher, Mrs. John....1135 Woodlawn Dr.
Foster, Mrs. Ray....420 N. Main
Harrison, Mrs. B. L....233 Bundy Ave.
Heilman, Mrs. William C....1111 Audubon Rd.
Heilman, Mrs. Wm. C., Jr....120 N. 24th St.
Hill, Mrs. Kenneth G....100 Leland
Hollenberg, Mrs. A. E....105 N. Franklin St.
Iterman, Mrs. G. E....925 Mourer
Kennedy, Mrs. W. U....701 S. 14th
Life, Mrs. Homer L....1015 W. Broad
Lowery, Mrs. George E....708 I Ave.
McDonald, Mrs. Frank C....527 S. Main
McElroy, Mrs. James S....1213 Audubon Rd.
McGee, Mrs. Robert....1127 Audubon Rd.
McKee, Mrs. Roy G....1417 Church St.
Mosier, Mrs. Jack....New Castle State Hosp.
Saint, Mrs. Wm. K....Park Place
Smith, Mrs. Mark....4205 S. Main St.

Steussy, Mrs. Calvin N.
Stout, Mrs. Walter M.....1103 Audubon Rd.
Thorne, Mrs. Charles E.....1225 Audubon Rd.
Vivian, Mrs. Donald E.....2715 Fair Oaks

Robertson, Mrs. Wm...213 W. Main St., Spiceland

HOWARD COUNTY

Denton, Mrs. Larkin.....S. Meridian, Greentown
Shoup, Mrs. E. M.....N. Meridian, Greentown

Kokomo

Adams, Mrs. C. J.....1216 W. Superior
Alward, Mrs. J. H.....401 W. Walnut
Ault, Mrs. C. H.....3015 Dellwood Drive
Boughman, Mrs. J. D.....1515 W. Jefferson
Bowers, Mrs. C. C.....1530 W. Taylor
Bowers, Mrs. Harvey B.....421 Morningside
Bowers, Mrs. J. A.....1535 W. Jefferson
Bruegge, Mrs. T. J.....1414 Kingston
Cattell, Mrs. Lee M.....R. R. #1
Clarke, Mrs. Elton.....1400 W. Sycamore
Conley, Mrs. T. M.....2811 Dellwood Dr.
Craig, Mrs. R. A.....Route 1
Craig, Mrs. Ruben.....Route 2
Cuthbert, Mrs. F. S.....1027 W. Walnut
Earl, Mrs. M. M.....1735 W. Mulberry
Ferry, Mrs. P. J.....1207 W. Sycamore
Fretz, Mrs. Richard C.....145 Westmorland
Golper, Mrs. M. N.....411 Morningside Drive
Good, Mrs. R. P.....227 N. Forest Dr.
Halfast, Mrs. Richard.....2505 Katherine Ave.
Hutto, Miss Arvilla.....1020 W. Walnut
Hutto, Mrs. O. D.....1020 W. Walnut
Hutto, Mrs. W. H.....211 Conradt
Jewell, Mrs. G. M.....1318 W. Sycamore
Kremers, Mrs. George.....2401 S. Wabash
Lung, Mrs. Bruce.....115 Conradt
Martin, Mrs. Will J.....409 W. Sycamore
McClure, Mrs. Warren.....309 Lody Lane
McIndoo, Mrs. R. E.....820 W. Walnut
Mendelson, Mrs. Stanley.....609 Somerset Dr.
Morrison, Mrs. W. R.....413 Conradt
Murray, Mrs. E. C.....2200 S. Webster
Perkins, Mrs. John.....2425 S. Washington
Phares, Mrs. R. W.....400 S. Western
Prather, Mrs. P. E.....123 Magnolia Dr.
Rudicel, Mrs. M. W.....1604 Kingston Rd.
Schwartz, Mrs. F. C.....West Sycamore Rd.
Shenk, Mrs. E. M.....306 N. Webster
Sorenson, Mrs. Raymond.....1616 W. Walnut
Spangler, Mrs. J. S.....2126 S. Webster
Taraba, Mrs. Ralph.....2520 W. Sycamore
Wachob, Mrs. Tom.....806 James Dr.
Wible, Mrs. James H.....R. R. #2, W. Jefferson Rd.

Evans, Mrs. Robert.....Russiaville
Tranter, Mrs. William F.....Sharpsville

HUNTINGTON COUNTY

Huntington

Brubaker, Mrs. Harold S.....721 Flaxmill Rd.
Casey, Mrs. Stanley M.....408 E. Market
Cope, Mrs. Stanton.....1022 N. Jefferson
Erehart, Mrs. Mark G.....232 W. Market
Eviston, Mrs. J. Boyd.....1392 Poplar
Gray, Mrs. Paul M.....340 E. Market
Grayston, Mrs. Wallace S.....303 E. Market
James, Mrs. Thomas, Jr.....1044 Poplar
Johnston, Mrs. Robert G.....339 E. Market
Marks, Mrs. Howard H.....1433 Cherry
Mitman, Mrs. Floyd B.....1470 Poplar
Nie, Mrs. Grover M.....1518 Cherry
Omstead, Mrs. Trevalyn W.....231 Vine Street
Plasterer, Mrs. E. D.....354 E. Washington
Wagner, Mrs. Richard.....1355 Guilford

Woods, Mrs. Halden C.....Markle

Cooper, Mrs. B. Trent.....Roanoke
Galbreath, Mrs. Russell S...R. R. 2, South Whitley
Bennett, Mrs. J. B.....Warren

JACKSON-JENNINGS COUNTIES

Gillespie, Mrs. G. R.....Brownstown
Shields, Mrs. Jack.....721 W. Spring, Brownstown
Adair, Mrs. W. K..208 S. Armstrong, Crothersville
Bard, Mrs. Frank B...305 E. Howard, Crothersville
Butler, Mrs. Joe B....301 E. Howard, Crothersville
Scharbrough, Mrs. Wm.....Medora
Berkshire, Mrs. Shaffer..433 Margaret, N. Vernon
Calli, Mrs. Louis J.....408 S. State, N. Vernon
Green, Mrs. John.....Elm St., N. Vernon
Johnson, Mrs. William J.
318 Jennings St., N. Vernon
Matthews, Mrs. David W....Walnut St., N. Vernon
Thayer, Mrs. Benet W..214 Jennings St., N. Vernon

Seymour

Baxter, Mrs. Harry.....825 W. Sixth St.
Black, Mrs. J. M...671 Braewick Rd., Sunset Pkwy.
Bobb, Mrs. Kenneth E.....311 Lee Blvd.
Bosch, Mrs. Ralph O.....625 W. Second St.
Day, Mrs. Durbin.....515 W. Sixth St.
Elsner, Mrs. Lawrence.....407 W. Bruce
Gillespie, Mrs. Charles E.....602 N. Walnut
Graessle, Mrs. H. P....640 East Dr., Sunset Pkwy.
Kamman, Miss Martha.....332 W. Oak
Martin, Mrs. Guy.....1408 Ewing Rd.
Osterman, Mrs. L. H.....901 Garden Ave.
Ripley, Mrs. John W.....2001 Ewing
Shortridge, Mrs. Wilbur H.....313 Carter Blvd.
Templeton, Mrs. Ian.....Brown & Walnut
Wiethoff, Mrs. C. A...615 West Dr., Sunset Pkwy.

JASPER-NEWTON COUNTIES

Rensselaer

Beaver, Mrs. Raymond E.....111 Thompson St.
Greene, Mrs. Robert W.....732 Elza St.
O'Brien, Mrs. Francis E.....Rensselaer
Ockermann, Mrs. Kenneth R.....202 Home St.
Williams, Mrs. Earl Kenneth.....617 Dean Place

Brady, Mrs. Kingdon.....Morocco
Hartsough, Mrs. Ralph I.....Remington
Schantz, Mrs. Richard.....Remington
Parker, Mrs. John.....Goodland
Schoonveld, Mrs. Arthur.....Brook
Yegerlehner, Mrs. R. S.....Kentland

JAY COUNTY

Girod, Mrs. Donald A.....106 Moore Ave., Dunkirk
Heller, Mrs. N. L.....Dunkirk

Portland

Badders, Mrs. Ara C.....709 W. North
Cripe, Mrs. Wm. H.....507 W. High
Fitzpatrick, Mrs. James S.....420 N. Pleasant
Gillum, Mrs. Eugene.....W. Votaw Street
Hammond, Mrs. Stanley.....S. Meridian St. Rd.
Keeling, Mrs. F. E.....609 W. Race
Morrison, Mrs. George G.....R. R. #4
Schenck, Mrs. Ralph.....W. Seventh
Spahr, Mrs. Donald E.....615 W. Race
Steffy, Mrs. Ralph M.....321 E. Race

JEFFERSON-SWITZERLAND COUNTIES

Madison

Alcorn, Mrs. Merritt O.....R. R. 1
Beetem, Mrs. Luther F.....411 N. Broadway
Childs, Mrs. Wallace Edward....414 N. Broadway
Haney, Mrs. William Keith.....R. R. 5
Hare, Mrs. Frank W.....705 W. 2nd Street
Jolly, Mrs. Lewis Everette.....J. P. G. Area
May, Mrs. George Arthur.....226 Maywood Lane

McAtee, Mrs. Ott B.....Madison State Hospital
Murray, Mrs. Wm. E.....Madison State Hospital
Pratt, Mrs. Ralph M.....804 W. Main Street
Raines, Mrs. Rinda.....117 Presbyterian Ave.
Shuck, Mrs. Wm. A.....R. F. D. 1
Sloan, Mrs. Keith.....340 Bunton Lane
Whitsitt, Mrs. Schuyler.....718 W. Main
Zink, Mrs. Robert Otto.....502 Broadway

JOHNSON COUNTY

Gammell, Mrs. L. L.
707 E. Main Cross St., Edinburg

Franklin

Andrews, Mrs. Hugh.....1138 Orchard Lane
Bullers, Mrs. Robert C.....551 Center St.
Bullington, Mrs. George.....R. F. D. #4
Chappel, Mrs. A. T.....174 Center Court
Deppe, Mrs. Charles F.....1215 Park Ave.
Ferrara, Mrs. Joseph.....1000 E. King
Foster, Mrs. R. H. K.....1025 Orchard Lane
Jones, Mrs. Charles A.....1010 E. Adams
Mock, Mrs. Harry E.....201 E. Monroe St.
Murphy, Mrs. Harry E.....150 N. Main
Portteus, Mrs. Walter L.....R. R. 2, Box 11-B
Province, Mrs. Wm. D.....51 N. Water St.
Records, Mrs. Arthur W.....216 E. Jefferson
Ritteman, Mrs. George.....R. R. 3
Stogsdill, Mrs. W. W.....R. R. #4
Walters, Mrs. Jack.....876 Glendale Drive

Greenwood

Brown, Mrs. George E.....Beech Park Dr.
Machledt, Mrs. John H.....243 S. Madison
Onyett, Mrs. Harold.....R. R. 3, Box 125
Sheek, Mrs. Kenneth I.....105 N. Brewer
Snodgrass, Mrs. Robert.....52 S. Madison
Tiley, Mrs. George.....40 N. Madison

Hibbs, Mrs. William G..R. R. 1, Box 138, Whiteland

KNOX COUNTY

Shanklin, Mrs. Jack L.....Bicknell

Vincennes

Anderson, Mrs. John.....1202 Busseron St.
Anderson, Mrs. Richard M.....Monroe City Rd.
Arbogast, Mrs. Paul B.....1420 Old Orchard Rd.
Barrett, Mrs. Thomas L.....2520 Old Orchard Rd.
Bartlett, Mrs. Donald T.....1405 Kimmell Rd.
Beckes, Mrs. Ellsworth W.....220 N. Fifth
Black, Mrs. Boyd K.....State Road 67 - N
Chattin, Mrs. Herbert O.....729 Main
Coffel, Mrs. Melvin H.....Simpson Lake
Corsentino, Mrs. Bart.....State Road 41, North
Curtner, Mrs. Myron L.....216 N. Sixth
Edwards, Mrs. Edward T., Jr....Old Bruceville Rd.
Ewing, Mrs. Nathaniel D.....Monroe City Rd.
Fox, Mrs. Maurice S.....616 Shelby St.
Green, Mrs. Carl L.....1414 Weed Lane
Hendrix, Mrs. Charles.....1202 E. Sycamore
Humphreys, Mrs. Joe S.....1602 Weed Lane
McCormick, Mrs. Hubert D.....518 N. Fourth
McDowell, Mrs. M. M.....1322 Audubon Rd.
McMahan, Mrs. V. C.....Monroe City Rd.
Nichols, Mrs. Robert J.....1515 Burnett Lane
Reilly, Mrs. James F.....401 Buntin St.
Schulze, Mrs. Wm.....819 Buntin St.
Shaffer, Mrs. Kenneth.....Ridge Rd.
Smith, Mrs. Ralph O.....Old Burceville Rd.
Smith, Mrs. S. Joseph.....504 N. Fourth Street
Spencer, Mrs. Frederic.....902 Perry Street
Stein, Mrs. Richard A.....1304 E. St. Clair
Stewart, Mrs. Frank.....2nd Street Rd.
Sullenger, Mrs. A. A.....803 Seminary St.
Vaughn, Mrs. Walter R.....406 N. Third
von de Leith, Mrs. William.....Monroe City Rd.
Welch, Mrs. Norbert M.....Monroe City Rd.

KOSCIUSKO COUNTY

Bahler, Mrs. Dean R.....P. O. Box 217, Leesburg
Hursey, Mrs. Virgil G.....Milford
Urschel, Mrs. Dan L.....Mentone
Wilson, Mrs. Wymond.....P. O. Box 421, Mentone
Stalter, Mrs. G. W.....North Webster
Pierson, Mrs. Pearl H... P. O. Box 98, Silver Lake

Warsaw

Bibler, Mrs. Richard H...Phillips Addition, R. R. #5
Cron, Mrs. William.....521 West Eagle St.
Doremire, Mrs. Robert D.....R. 2, Herscher Add'n
Hashemi, Mrs. Hossein..County Farm Rd., R. R. #2
Johnson, Mrs. John J.....R. 2 County Farm Rd.
Murphy, Mrs. Samuel C.....216 South High St.
Richer, Mrs. Orville.....914 E. Main St.
Schlemmer, Mrs. George H.....528 N. Lake
Shrader, Mrs. Carl.....2124 E. Market St.
Thomas, Mrs. E. Winton.....711 E. Main

LAKE COUNTY

Cedar Lake

Miller, Mrs. D. C.....P. O. Box 297
Misch, Mrs. W. A.....Route 2, Box 337

Crown Point

DuSold, Mrs. Donald...Ridgeview R. R. 1, Box 223
Horst, Mrs. W. N.....R. R. 7, Box 151
Troutwine, Mrs. W. R.....620 S. Main

Dyer

Campbell, Mrs. Guy G...2548 Hart, R. R. 1, Box 13E

East Chicago

Barron, Mrs. Elmer.....3902 Ivy
Campagna, Mrs. E. A.....4320 Ivy
Ernst, Mrs. H. C.....4219 Baring
Fleischer, Mrs. J. C.....4135 Ivy
Grosso, Mrs. William G.....4132 Northcote
Gustaitis, Mrs. John W.....4318 Parrish
Niblick, Mrs. James S.....4115 Fir St.
Shapiro, Mrs. Joseph.....4214 Parrish
Shapiro, Mrs. S. W.....4229 Euclid Ave.

East Gary

Mather, Mrs. J. Winford.....2367 Vigo
Valencia, Mrs. M. M.....2498 Dearborn

Gary

Almquist, Mrs. C. O.....550 Lincoln
Armalavage, Mrs. L. J.....6572 Birch
Behn, Mrs. Walter.....1514 W. 5th St.
Bills, Mrs. R. N.....534 Lincoln
Barton, Mrs. Reginald R.....277 Jackson
Bjorklund, Mrs. Carl.....212 S. Connecticut
Black, Mrs. Charles.....2319 Wabash
Brady, Mrs. Samuel J.....451 Garfield
Bringas, Mrs. Irinco.....803 Johnson
Brincko, Mrs. John.....3537 Harrison
Burger, Mrs. Robert.....6735 Hemlock Ave.
Carberry, Mrs. G.....759 Grant
Carbone, Mrs. Joseph.....526 Johnson
Chevigny, Mrs. J. J.....654 Johnson
Cooper, Mrs. Leo K.....670 Hayes
Dierolf, Mrs. Edward J.....630 Montgomery
Elliott, Mrs. Ralph A.....1726 W. Sixth
English, Mrs. Hubert M.....575 Taft
Fadell, Mrs. Mathew.....701 W. 55th Ave.
Gallinatti, Mrs. John.....7413 Locust
Glover, Mrs. W. J.....3540 Taylor Ave.
Goldberg, Mrs. Harold B.....825 W. 35th
Goldstone, Mrs. Adolph.....1430 W. Seventh St.
Goldstone, Mrs. Joseph.....600 Cleveland
Jahns, Mrs. A. A.....655 Roosevelt
Jordon, Mrs. S. Y.....430 W. 44th Street
Kendrick, Mrs. Frank J.....701 Polk St.
Kobrin, Mrs. Meyer W.....2300 W. Sixth
Kopcha, Mrs. Joseph E.....650 Pierce
Korn, Mrs. Jerome M.....2119 W. Fifth
Lebioda, Mrs. Henry S.....230 Morningside

Lewis, Mrs. George N. 573 Roosevelt
May, Mrs. R. Milton 657 Van Buren
Milos, Mrs. Robert 725 Filmore
Minczewski, Mrs. Richard C. 2425 W. 5th St.
Morris, Mrs. Hyman R. 2401 W. Sixth
Moswin, Mrs. Jack A. 701 Arthur
Nelson, Mrs. W. A. 1050 Warren
Nilges, Mrs. Richard 237 Glen Park Ave.
Ornelas, Mrs. Joseph P. 230 W. 36th
Palmer, Mrs. Russell H. 2006 W. Fourth Place
Pappas, Mrs. Edward 569 Pierce
Parratt, Mrs. Louis W. 131 W. 46th
Poracky, Mrs. Bernard 5598 Van Buren
Robinson, Mrs. Walter K. 500 N. Montgomery
Roth, Mrs. Leo 7033 E. 1st
Rubin, Mrs. Simon S. 2131 W. Fifth
Ryan, Mrs. H. J. 630 McKinley
Sala, Mrs. Joseph J. 2333 W. Fifth
Scully, Mrs. J. T. 715 Johnson
Senese, Mrs. Thomas J. 581 Johnson
Shevick, Mrs. Alexander 528 Monroe
Slama, Mrs. George F. 3520 Polk
Sponder, Mrs. Joseph 738 N. Hamilton
Stimson, Mrs. Harry R. 4338 Jefferson
Thomas, Mrs. Daniel D. 2001 W. 7th Street
Thomas, Mrs. G. L. 631 Miami
Trinosky, Mrs. Frank 1100 W. 6th St.
Vye, Mrs. J. Preston 3620 Madison
Yast, Mrs. Charles J. 740 Fillmore
Yocum, Mrs. Paul S. 6999 Hemlock
Yocum, Mrs. Paul, Jr. 2200 Ranburn Drive
Young, Mrs. G. M. 4580 Washington
Zucker, Mrs. Edward 7009 E. 1st St.

Griffith

Lundeberg, Mrs. Ralph A. 303 N. Harvey
Purcell, Mrs. Richard 300 N. Lafayette
Siekierski, Mrs. J. M. 445 N. Broad Street

Hammond

Allegretti, Mrs. Michael L. 6237 Forest
Bacevich, Mrs. A. J. 6939 Olcott
Beconovich, Mrs. Robert 6540 Forest Ave.
Bombar, Mrs. Leslie E. 6826 Rosewood
Bonaventura, Mrs. Angelo P. 7112 Woodmar
Chidlaw, Mrs. B. W. 29 Wildwood Rd.
Clancy, Mrs. James F. 7258 Forest Ave.
Costello, Mrs. Albert J. 6737 Magoun
Cotter, Mrs. Edward R. 7225 Knickerbocker
Eggers, Mrs. Henry W. 6542 Hohman
Egnatz, Mrs. Nick 820 Highland
Elledge, Mrs. Ray 6415 Forest
Fischer, Mrs. Burnell 49 Indi-Illi Park
Gardiner, Mrs. H. Glenn 47 Waltham
Gevirtz, Mrs. Milton B. 6905 Magoun Ave.
Hack, Mrs. Edmund C. 7147 Olcott St.
Hickman, Mrs. A. Lee, Jr. 7412 Knickerbocker
Hopkins, Mrs. J. R. 7107 State Line
Husted, Mrs. Robert G. 7248 Forest
Jones, Mrs. E. S. 50 Kenwood Ave.
Kmak, Mrs. Chester 6832 Magoun Ave.
Komoroske, Mrs. John E. 35 Highland
Koransky, Mrs. David S. 7048 Forest
Lazo, Mrs. Vincente R. 5411 Wood
Marks, Mrs. Ora L. 7111 Olcott
Mason, Mrs. R. L. 132 Rimbach Ave.
Modjeski, Mrs. Joseph R. 7327 Knickerbocker
Modjeski, Mrs. Raymond J. 223 Locust
Neal, Mrs. L. W. 7301 Forest Ave.
Panares, Mrs. S. V. 4 172nd Place
Peck, Mrs. Edward A. 6422 Moraine
Pilot, Mrs. Jean 7137 Knickerbocker Pkwy.
Premuda, Mrs. Franklin F. 7042 Woodmar
Remich, Mrs. Antone C. 6412 Moraine
Rendel, Mrs. Donald T. 18 172nd Place
Rhind, Mrs. A. W. 7126 Forest
Rosevear, Mrs. Henry J. 6531 Forest Ave.
Row, Mrs. Perry Quentin, ... 6706 Hohman Ave.
Rubright, Mrs. Robert 7025 Monroe
Rudolph, Mrs. F. G. 6607 Forest
Santare, Mrs. Vincent 6508 Forest Ave.
Shulruff, Mrs. Harry I. 7244 Hohman
Shanklin, Mrs. E. M. 54 Ruth
Stern, Mrs. S. Lewis 226 Oakwood
Teegarden, Mrs. Joseph A., Jr. 7204 Woodman
Thegze, Mrs. George 7435 Olcott
Wong, Mrs. Samuel N. 632 169th St.

Dhein, Mrs. Donald T. 6744 Jefferson, Merrillville
Beilke, Mrs. C. A. 8723 Parkway Dr., Highland
Larrabee, Mrs. James 2214 Oakdale, Highland
Bernard, Mrs. Marvin 658 Waters, Hobart
Bradley, Mrs. Charles 201 Center
Carter, Mrs. John 1124 State
Faulkner, Mrs. Donald 242 California Ave.

Markey, Mrs. Richard J.
Rosedale Terrace, Crete, Ill.
Mansueto, Mrs. Mario D.
4 Forestdale, Calumet City, Ill.
Potts, Mrs. William
3543 Ridge Rd., E., Lansing, Ill.
Sroka, Mrs. A. G. 17216 Wentworth Ave., Lansing, Ill.
Stasick, Mrs. Murray 228 W. Warren, Lansing, Ill.

Munster

Arbeiter, Mrs. Herbert I. 119 Beverly Place
Arrowsmith, Mrs. James L. 8131 Forest
Benchik, Mrs. Frank 8326 Hawthorne Dr.
Boys, Mrs. F. F. 8517 Crestwood
Chael, Mrs. Tom 252 Belmont Ave.
Eggers, Mrs. Ernest L. 8147 Meadow Lane
Kenney, Mrs. Francis 8131 Forest Ave.
Kuhn, Mrs. Arthur J. 1535 35th St.
Lanman, Mrs. John 1448 MacArthur Blvd.
Lautz, Mrs. Herbert A. 7943 Forest Ave.
Long, Mrs. Keith J. 1327 Ridgeway
Marks, Mrs. Salvo P. 8320 Parkview
Mintz, Mrs. Alfred M. 1423 Kraft
Rasch, Mrs. George C. 1519 35th St.
Rosenthal, Mrs. Carl 8330 Schreiber Dr.
Schlesinger, Mrs. D. 1506 MacArthur Blvd.
Schleisinger, Mrs. Jack 7648 Hohman
Sroka, Mrs. Stanley J. 7540 Forest Ave.
Stevens, Mrs. Edwin 8627 Beech
Teplinsky, Mrs. L. L. 1526 Twelve Oaks Dr.
Trachtenberg, Mrs. Lee 7411 White Oak
Walker, Mrs. A. P. 1504 Park Dr.
Westhaysen, Mrs. Peter V. 127 Beverly Pl.

Whiting

Weinberg, Mrs. B. A. 2022 Lake Ave.

LAWRENCE COUNTY

Benham, Mrs. Lawrence E. R. R. 2, Avoca, Ind.

Bedford

Allen, Mrs. L. Howard 1318 14th
Austin, Mrs. Richard P. 1315 15th
Campbell, Mrs. William T. 3008 16th St.
Duncan, Mrs. Raymond E. 116 Edgewood Dr.
Dusard, Mrs. Joseph C. 1107 N
Edmonds, Mrs. Kendrick T. 1303 15th
Emery, Mrs. Charles B. Brook Knoll
Fountaine, Mrs. Thomas J. 1620 18th
Hammel, Mrs. Howard T. 1822 15th
Hawkins, Mrs. Richard D. 1308 15th
Kastings, Mrs. Gerald E. Parkview Addition
Kerr, Mrs. Donald M. 1415 20th St.
Morrow, Mrs. Robert J. 501 Southwood Drive
Noe, Mrs. William R. 1224 14th
Scherschel, Mrs. John P. 1713 H
Waldo, Mrs. Guy Harold Jr. 2218 I St.
Wohlfeld, Mrs. J. B. 1224 15th
Wynne, Mrs. R. E. 1601 16th

Hamilton, Mrs. James 703 Oak St., Mitchell
Oswalt, Mrs. James 901 Curry St., Mitchell
Robinson, Mrs. William R. R. 1, Mitchell

MADISON COUNTY

LeRoy, Mrs. A. G. Alexandria

Anderson

Aagesen, Mrs. W. J. 1112 North Dr.
Armington, Mrs. Charles L. 823 W. 7th Street
Armington, Mrs. John C. 206 W. 14th St.
Armington, Mrs. R. L. Kilbuck Rd.
Ayres, Mrs. Kenneth D. 2210 Meridian
Austin, Mrs. Charles E. 1612 Westwood Dr.
Baughn, Mrs. W. L. 1517 Winding Way
Beeler, Mrs. Frank K. 20 Overlook Dr.
Benoit, Mrs. Merrill 3232 Maryland Dr.
Bixler, Mrs. Donald P. 1515 Green Way Dr.
Blassaras, Mrs. Crist A. 916 Dresser Dr.
Bowers, Mrs. Richard C. 3508 Dogwood Dr.
Brown, Mrs. James M. 909 Forest Dr.
Buckles, Mrs. David L. 44 Knoll Rd., Edgewood
Conrad, Mrs. Ernest M. 2124 Meridian St.
Doenges, Mrs. James L. 1601 Van Buskirk Rd.
Donaldson, Mrs. Frank C. 308 Winding Way
Drake, Mrs. John C. 920 N. Madison Ave.
Dulin, Mrs. Basil B. 1120 Maryland Drive
Ellis, Mrs. Seth W. 1105 Green Way Dr.
Elsten, Mrs. Wayne A.
1333 Maryland Dr., Forest Manor
Erehart, Mrs. Archie D. 1221 Irving Way
Faust, Mrs. Howard Jr. 1321 W. 8th St.
Ferguson, Mrs. Donald H. 3430 Redwood Rd.
Fischer, Mrs. Warren E. 108 North Shore Blvd.
Gante, Mrs. Henry W. 2005 Nichol
Hart, Mrs. Wm. D. 1026 W. Eighth
Hensler, Mrs. Benton M.
717 Winding Way, Edgewood
Jarrett, Mrs. Paul E. 2541 N. Shore Dr.
Jones, Mrs. Albert T. 3316 Cherry Rd.
Kelly, Mrs. Wendell C. 23 Colony Rd., Edgewood
Kiely, Mrs. John T. 1011 Raible Ave.
King, Mrs. Joseph W. 226 Davis Dr., Edgewood
Kopp, Mrs. William R. 1200 Arrow Ave.
Lamey, Mrs. Paul T. 1740 W. 10th St.
Larmore, Mrs. Joseph L.
1301 Winding Way, Edgewood
Litzenberger, Mrs. Sam W. 837 Forrest Dr.
Long, Mrs. Paul L. 828 Dresser Dr.
Metcalf, Mrs. George B. 830 W. Eighth
Morris, Mrs. Robert A. 410 Golf Club Rd.
Neale, Mrs. Alfred E. 725 Forest Dr.
Nesbitt, Mrs. Leonard L. 60 River Forest
Patterson, Mrs. William K. 8 South Park Dr.
Polhemus, Mrs. Warren C. 1800 W. 11th
Ross, Mrs. Guy E. 1124 N. Madison Ave.
Sharp, Mrs. William L. 725 North Shore Blvd.
Sheldon, Mrs. Suel A. 3240 Maryland Dr.
Stamper, Mrs. Joseph H. 619 State Road 67 W.
Stamper, Mrs. Robert J. 3104 Sherman St.
Stinson, Mrs. William M. 201 Longwood Ave.
Swan, Mrs. Richard C. 707 Forrest Dr.
Webb, Mrs. Harry D. 1308 Maryland
Wilder, Mrs. Gordon B. 338 W. Eighth St.
Williams, Mrs. Francis M. 1012 Park Rd.
Williams, Mrs. Robert H. 715 North Shore Blvd.
Wilkinson, Mrs. Roger L.
1525 Winding Way, Edgewood
Wishard, Mrs. Fred B. 316 E. 34th St.

Bishop, Mrs. Harry A. Frankton
Williams, Mrs. Robert D. Markleville
Hammer, Mrs. J. W. Middletown
Leahy, Mrs. H. J. P. O. Box 147, Pendleton
McLaughlin, Mrs. Calvin P.
Fall Creek Parkway, Pendleton
Van Ness, Mrs. William 216 S. Main, Summitville
Stump, Mrs. Richard L. Daleville

MARION COUNTY

Ramage, Mrs. Walter F. 244 S. First, Beech Grove

Indianapolis

A

Albertson, Mrs. Frank P. 5031 Rockville Rd.
Aldrich, Mrs. Harry D. 5805 Sherman Dr.
Allen, Mrs. Robert K. 737 Sherwood Dr.
Alvis, Mrs. Edmond O. 474 W. 92nd St.
Appel, Mrs. Richard H. 4465 Marcy Lane, No. 190
Arbuckle, Mrs. William E. 5326 E. St. Joseph St.
Avery, Mrs. George O. 5321 N. Kessler Blvd.

B

Bachmann, Mrs. Arnold J. 1615 Oles Drive
Bakemeier, Mrs. Otto H. 5535 E. St. Clair
Bakemeier, Mrs. Robert E. 1210 N. Butler Ave.
Ball, Mrs. Joseph E. 6612 E. Ninth St.
Bartley, Mrs. Max D. 5640 N. Pennsylvania St.
Batman, Mrs. Gordon W. 6906 N. Delaware
Baumeister, Mrs. Herbert E. 314 W. Hampton Dr.
Beach, Mrs. Robert R. 5810 E. Pleasant Run Pkwy,. N. Dr.
Beamer, Mrs. Parker R. 4620 Boulevard Place
Beasley, Mrs. Thos. J. 112 Berkley Rd.
Beaver, Mrs. Howard W. 303 E. Edgewood Ave.
Beck, Mrs. Evart M. 1220 Oak Ridge Dr.
Becker, Mrs. Harry G. 5641 Haverford Ave.
Beeler, Mrs. John W. 39 E. 39th St.
Benedict, Mrs. Paul 2550 Blue Grass Dr.
Bibler, Mrs. Lester D. 4360 N. Pennsylvania
Bill, Mrs. Robert O. 8750 Washington Blvd., W. Dr.
Blatt, Mrs. A. Ebner 5330 N. Illinois
Bowman, Mrs. George W. 5634 Carrollton Ave.
Boyer, Mrs. Floyd A. 136 S. Wittfield
Brady, Mrs. Thomas A. 225 Wellington Rd.
Brayton, Mrs. John R. 3128 E. Fall Creek Blvd.
Brayton, Mrs. Lee 5540 N. Illinois St.
Brickley, Mrs. Richard A. 506 W. 46th St.
Brodie, Mrs. Donald W. R. R. 13, Box 397
Brown, Mrs. Archie E. 4145 Melbourne Rd. W. Dr.
Brown, Mrs. David E. 7230 N. Lake Side Dr.
Brown, Mrs. DeWitt W., Jr. 4363 Cold Springs Rd.
Brown, Mrs. Gordon T. 6401 Park Avenue
Brown, Mrs. Wendell 3750 N. Gale
Browning, Mrs. James S. 6339 N. Keystone Ave.
Browning, Mrs. William M. 2275 Wynnedale Rd.
Brueckmann, Mrs. Robert 2356 N. Kenyon
Bunde, Mrs. Carl A. 5245 Knollton Rd.
Butler, Mrs. Robert M. 4849 N. Ritter Ave.

C

Cahn, Mrs. Hugo M. 5535 N. Pennsylvania
Call, Mrs. Herbert F. 710 E. 57th
Campbell, Mrs. John A. 5201 Grandview Dr.
Carson, Mrs. E. Wayne 7177 N. Meridian
Carter, Mrs. Larue D. 4280 N. Meridian
Carter, Mrs. Oren E. 5461 Kenwood
Chernish, Mrs. Stanley 4403 Radnor Rd.
Chivington, Mrs. Paul V. 5730 N. Parker
Chroniak, Mrs. Walter
5916 E. Pleasant Run Pkwy.
Clark, Mrs. Lawson J. 2725 E. Kessler Blvd.
Coggeshall, Mrs. Warren 3931 N. Campbell Ave.
Cohn, Mrs. A. F. 1120 Southview Dr.
Conway, Mrs. Glenn 2235 E. Garfield Dr.
Cortese, Mrs. James V. 6302 Minlo Dr.
Cortese, Mrs. Thomas A. 3240 Brill Rd.
Countryman, Mrs. F. W. 5633 Central
Cox, Mrs. Clifford E. R. R. 14, Box 811
Cross, Mrs. David G. 2801 Redfern Dr.
Culbertson, Mrs. C. G. 6060 Park Ave.
Currie, Mrs. Robert W. 512 E. 57th St.
Curry, Mrs. R. Louis 5260 Carrollton

D

Daley, Mrs. Edward H. 5118 East Dickson Road
Daly, Mrs. Joseph M. 5969 Singleton St.
Davis, Mrs. Sam J. 4545 Broadway
Dearmin, Mrs. Robert M. 5147 N. Delaware

DeArmond, Mrs. Albert M.....5401 N. Delaware
Deever, Mrs. John W.....6801 S. East St.
Dennison, Mrs. A. Dudley, Jr.
7910 Wincombe Blvd.
Denny, Mrs. James W...6633 Spring Brook, N. Dr.
Donato, Mrs. Albert M.....5915 Lawrence Dr.
Dorman, Mrs. W. Leland.6631 Spring Brook, N. Dr.
Dupes, Mrs. Lowell E.....222 West 73rd St.
Dryden, Mrs. Gale.....5835 N. Tacoma Ave.
Dyar, Mrs. Edwin W., Jr...5910 Washington Blvd.
Dyke, Mrs. Richard W.....6314 Hoover Road

E

Eastman, Mrs. Joseph Rilus....4965 Coburn Street
Eaton, Mrs. Edwin R.....5750 Allisonville Rd.
Eaton, Mrs. Lyman D.....R. R. 19, Box 487Y
Ebert, Mrs. J. Wayne.....1125 Southview Dr.
Egbert, Mrs. Herbert L.....419 W. 63rd St.
Eicher, Mrs. Palmer O.....4401 Washington Blvd.
Eldridge, Mrs. Gail E.....5746 Central Ave.
Elkins, Mrs. James P.....2045 Lick Creek Dr.
Ellis, Mrs. Bert E.....2595 N. Girls School Rd.
Ellis, Mrs. William N.....4908 E. 46th Street
Emhardt, Mrs. John T.....3305 Brill Rd.
Emhardt, Mrs. John W.....5425 Washington Blvd.
Ensminger, Mrs. Leonard A.....1321 N. Meridian
Evans, Mrs. Paul V.....7415 Dean Rd.
Everly, Mrs. Ralph V.....1105 E. 58th

F

Fausset, Mrs. C. Basil.....7757 N. Meridian
Fine, Mrs. N. J.....5481 East 19th St.
Finneran, Mrs. Joseph C.....3819 N. Delaware St.
Fischer, Mrs. A. Alan.....3230 W. 41st St.
Flanders, Mrs. Robert, Jr.....5930 N. Olney St.
Flanigan, Mrs. Meredith B.....3305 Rutledge Dr.
Flora, Mrs. Joseph O.....5604 Rockville Rd.
Folkening, Mrs. Norval C.....5501 Camden
Foster, Mrs. Lee N. Jr.....3824 Ashbourne Lane
Fouts, Mrs. Lydia M.....4046 North Webster Ave.
Fouts, Mrs. Paul J.....8393 N. Illinois
Freeman, Mrs. Leslie W.....5461 Julian Ave.
Freeman, Mrs. Max E.....4802 Thornleigh Dr.
Fry, Mrs. Robert D.....5717 Broadway

G

Gaddy, Mrs. E. T.....R. R. #2, Box 179
Gaddy, Mrs. Nelson D.....2551 Blue Grass Ct.
Garber, Mrs. J. Neill....7036 N. Pennsylvania St.
Garceau, Mrs. George J.....5539 N. Pennsylvania
Gardiner, Mrs. Sprague H.....330 W. 62nd St.
Garner, Mrs. W. Stanley.....4021 Cranbrook Dr.
Garrett, Mrs. Robert A.....1403 W. 52nd St.
Gastineau, Mrs. Frank M.....5344 N. Pennsylvania
Geider, Mrs. Roy A.....5816 Pleasant Run Pkwy.
Gick, Mrs. Herman H.....451 Eastern
Gifford, Mrs. Fred E.....5125 N. Meridian
Gillespie, Mrs. Charles F.....4530 Berkshire Rd.
Goldman, Mrs. Samuel.....428 Woodmere Dr.
Gormley, Mrs. Joseph J.....4402 Thrush Drive
Green, Mrs. Oscar.....6219 Indianola
Greist, Mrs. John H.....4343 Washington Blvd.
Griffith, Mrs. Richard S.....2002 Cunningham Road
Grisell, Mrs. Ted L.....5411 Broadway
Gustafson, Mrs. Gerald W....5768 N. Pennsylvania

H

Habegger, Mrs. E. Dale....3242 Georgetown Road
Hadley, Mrs. David.....5601 N. Pennsylvania
Haggard, Mrs. Edmund B...5914 N. Emerson Ave.
Hall, Mrs. Frank.....8633 N. Pennsylvania
Hampshire, Mrs. Donald....7979 Morningside Dr.
Harcourt, Mrs. Allan K.....4915 N. Illinois
Harding, Mrs. M. Richard.....4220 DeVon Court
Harding, Mrs. Myron S.....5410 Radnor Rd.
Harger, Mrs. Robert.....46 West 52nd Street
Harold, Mrs. Norris E.....3545 N. Denny
Hasewinkel, Mrs. Carrol W.....R. R. 2, Box 354
Haslinger, Mrs. Clarence J.....5236 Boulevard Pl.
Hatfield, Mrs. Nicholas W...4118 N. Pennsylvania
Haymond, Mrs. Joseph L...2745 Crescent Hill Lane
Haynes, Mrs. John Thomas, 4545 Marcy Lane, #273
Hays, Mrs. Everett L.....2607 Manker
Healey, Mrs. Robert J.....741 E. 53rd St.
Hedrick, Mrs. Philip W.....4808 Central Ave.
Heimburger, Mrs. R. F.....4462 Central Ave.
Helmer, Mrs. O. M.....5015 N. Illinois
Hendricks, Mrs. John W.....124 W. 64th St.
Henry, Russell S.....4367 Lincoln Rd.
Hepburn, Mrs. Charles K.....7570 Morningside Dr.
Hetherington, Mrs. A. M.....445 E. 71st St.
Heubi, Mrs. John E.....5061 N. Illinois
Hickman, Mrs. Walter F.....3535 Del Mar Rd.
Hicks, Mrs. Murwyn L.....4125 E. 61st St.
Hilldrup, Mrs. Don G.....5672 N. Illinois
Holman, Mrs. Jerome E., Sr.
4503 Kessler Blvd., E. Dr.
Hood, Mrs. Ainslee A.....1810 Rosedale Drive
Howell, Mrs. Joseph D.....4514 E. 79th St.
Howell, Mrs. Robert D.....6941 Washington Blvd.
Huddle, Mrs. John R.....4738 N. Pennsylvania
Hudson, Mrs. Foster J.....525 W. Hampton Dr.
Hughes, Mrs. William F., Sr.....4025 N. Meridian
Hull, Mrs. Ronald.....6465 Dover Rd.
Hurteau, Mrs. William W.....201 West 75th St.
Huse, Mrs. Wm. Murray....5131 N. Pennsylvania

I-J

Irwin, Mrs. Glenn W., Jr.....5022 Graceland
Iske, Mrs. Paul G.....5355 N. Delaware St.
Jaquith, Mrs. Orville S.....261 Blue Ridge Rd.
Jay, Mrs. Arthur N.....815 West 46th St.
Jennings, Mrs. Frank.....2601 Cold Springs Rd.
Jewett, Mrs. Joe H.....5803 Sherman Ave.
Johnson, Mrs. Thomas W...5735 Washington Blvd.
Jones, Mrs. David E.....646 Berkley Road
Joseph, Mrs. Rex M.....620 Hickory Lane
Jowitt, Mrs. Richard.....6021 E. 42nd St.

K

Katterjohn, Mrs. James C.....5867 Central Ave.
Keenan, Mrs. George.....2015 E. Thompson Rd.
Keenan, Mrs. Reid L.....3702 N. Delaware
Keever, Mrs. Charles H., Sr.....5226 College Ave.
Keiser, Mrs. V. D.....5709 Broadway
Kelly, Mrs. Walter F...6845 E. Pleasant Run Pkwy.
Kennedy, Mrs. Hunter.....757 N. Bolton
Kennedy, Mrs. Joseph T.....4046 Sheridan Ave.
Kenney, Mrs. David B.....5401 Eastridge Dr.
Kenzler, Mrs. Jack I.....2444 West Arlington Ct.
Kerr, Mrs. Harry R.....5774 Washington Blvd.
Kilgore, Mrs. Byron W.....2002 E. 62nd St.
King, Mrs. Harold K.....4606 Washington Blvd.
Kiser, Mrs. Edgar F.....5610 Central
Kitterman, Mrs. Harry E.....5108 Graceland
Klain, Mrs. Benjamin V.....5775 Central
Kneidel, Mrs. John H.....918 E. 57th St.
Knowles, Mrs. Robert P.....R. R. 18, Box 271
Kohlstaedt, Mrs. Kenneth G.....645 E. 80th
Kooiker, Mrs. J. E.....3540 Watson Road
Koons, Mrs. Karl M.....5767 N. Pennsylvania
Kornafel, Mrs. L. H.....6201 College
Kuntz, Mrs. Herman W.....2065 Lick Creek Drive
Kwitney, Mrs. I. J.....5774 Broadway Terrace

L

LaDine, Mrs. Clarence B.....4221 E. 35th
Lamb, Mrs. Emmett B.....1180 Golden Hill Dr.
Laramore, Mrs. Ward.....5835 N. Keystone
Leasure, Mrs. J. Kent.....3115 N. Meridian
Leff, Mrs. Abe H.....160 Pennridge Dr.
Leffel, Mrs. James M., Jr....1140 West 46th Street
Leffler, Mrs. W. T.....250 E. 70th St.
Lewis, Mrs. Robert J.....5800 Lawrence Dr.
Lichtenberg, Mrs. Melvin.....5677 N. Meridian
Lingeman, Mrs. R. E.....3845 N. Meridian
Lochry, Mrs. Ralph L.....63 Isle of Venice #11
Ft. Lauderdale, Fla.

Lord, Mrs. Glenn C. 4455 Washington Blvd.
Louden, Mrs. Robert W. 1510 Marion Dr.
Love, Mrs. George N. 5331 Washington Blvd.
Lozow, Mrs. David 7510 E. 52nd St.
Ludwig, Mrs. Oscar D. 2251 S. Ransdell, Apt. 9
Lukemeyer, Mrs. George T. 3845 N. Campbell Ave.
Lurie, Mrs. Paul R. 5 W. 79th St.
Luros, Mrs. J. Theodore 156 Fairway Dr.
Lybrook, Mrs. William B.
4585 Kessler Blvd., E. Dr.

M

McBride, Mrs. James S. 720 E. 80th St.
McCartney, Mrs. Donald H. 410 East 56th St.
McClain, Mrs. Edwin S. 550 W. 77th St., N. Dr.
McCormic, Mrs. Charles O. Jr. 4240 Glencairn Lane
McGrath, Mrs. Michael F. 6183 Washington Blvd.
McGuff, Mrs. Paul 3668 Central Ave.
McQuiston, Mrs. Ralph J. 6120 Lawrence Dr.
Mackey, Mrs. John E. 940 W. 58th St.
Madden, Mrs. Robert J. 1543 N. Euclid Ave.
Manalan, Mrs. M. M. 7807 Meadowbrook Dr.
Manders, Mrs. Karl L. 215 E. 71st Street
Manion, Mrs. Marlow W. 5132 N. New Jersey
Manning, Mrs, Randolph 5302 N. Delaware St.
Marsh, Mrs. Carl M. 4112 Marrison Place
Marshall, Mrs. Albert L., Jr. 7802 Allisonville Rd.
Martin, Mrs. Loren H. 5338 Washington Blvd.
Martz, Mrs. Carl D. 7926 Hawthorn Ct.
Masters, Mrs. John M. 34 E. 46th
Matthew, Mrs. W. Burleigh 3462 E. Fall Creek Pky., N. D.
Matthews, Mrs. William 1122 N. Bolton Ave.
Maxam, Mrs. Beverly T. 1703 Beeler St.
Megenhardt, Mrs. Dennis 3038 E. Fall Creek Blvd.
Meiks, Mrs. Lyman T. 4203 N. Pennsylvania St.
Mericle, Mrs. Earl W. 4480 N. Meridian St.
Merrell, Mrs. Paul 5367 Kenwood
Mertz, Mrs. John H. O. 6950 Central Ave.
Michael, Mrs. Isaac E. 3366 N. Kessler Blvd.
Miller, Mrs. Jerry 6050 Ewing St.
Miller, Mrs. John D. Sunnyside Sanatorium
Miller, Mrs. Roscoe E. R. R. #17, Box 503
Mitchell, Mrs. Edward O. 4807 Millersville Rd.
Molt, Mrs. William F. 2315 N. Talbot
Moore, Mrs. Ben B. 5005 N. Illinois
Moore, Mrs. Donald F. 1315 West 10th Street
Moore, Mrs. Harold T. 5802 Allisonville Rd.
Morchan, Mrs. Samuel 7007 Broadway
Morrison, Mrs. Lewis E., II 4450 Park Ave.
Morton, Mrs. Walter P.
3434 E. Fall Creek Blvd., N. Dr.
Moser, Mrs. Rollin H. 6220 Sunset Lane
Mothersill, Mrs. Mark H. 3650 College Avenue
Mouser, Mrs. Robert W. 6047 N. Meridian St.
Muller, Mrs. L. P. 5608 College Ave.
Muller, Mrs. Paul F. 4050 Washington Blvd.
Myers, Mrs. Roy V. 4450 E. Kessler Blvd.

N

Nafe, Mrs. Cleon A. 5060 N. Meridian
Nagan, Mrs. Robert F. 3902 Devon Dr.
Nay, Mrs. Richard M. 5525 N. Meridian
Need, Mrs. Louis T. 3627 Bluff Rd.
Nelson, Mrs. John W. 4132 Patricia Ave.
Nester, Miss Lena Laura 5324 N. Pennsylvania St.
Nie, Mrs. Louis W. 4305 Central
Noble, Mrs. Thomas B., Jr. 5556 N. Meridian
Nolting, Mrs. Henry F. 155 W. Hampton Dr.
Norman, Mrs. William 6416 Dean Road
Norris, Mrs. Max S. 540 E. 36th
Nourse, Mrs. Myron 8064 Morningside Dr.
Nurnberger, Mrs. John I. 5215 Washington Blvd.

O

O'Brian, Mrs. Earl J. 3425 West 57th Street
Offutt, Mrs. Andrew C. 750 N. Campbell
Olson, Mrs. John R. 6028 Winnpenny Lane
Otten, Mrs. Claude F. 5222 Washington Blvd.
Owen, Mrs. John E. 4429 N. Illinois
Owens, Mrs. Tracy 2823 N. Meridian

P

Palmer, Mrs. Harley P. 2023 East Stop 8 Rd.
Parker, Mrs. L. Burton 3525 W. 57th St.
Parr, Mrs. Robert L. 6229 Evanston Ave.
Parr, Mrs. Robert L. 5368 Winthrop Ave.
Patton, Mrs. Martin T. 3060 N. Meridian, Apt. 504
Paulissen, Mrs. George T. 741 Markwood
Paynter, Mrs. Morris B. 115 Roberts Rd.
Pearson, Mrs. Lyman R. 5215 N. Illinois
Pebworth, Mrs. A. C. 2445 East Riverside Drive
Peck, Mrs. Franklin B., Jr. 8760 Carrollton Ave.
Peirce, Mrs. James D. 3159 N. Pennsylvania St.
Pennington, Mrs. Walter E. 5727 Broadway Tr.
Permer, Mrs. Erwin 5590 Grandview
Peters, Mrs. Robert J. D. 3203 E. Michigan
Pfaff, Mrs. O. G. 4605 N. Meridian St.
Phillips, Mrs. David L.
8799 Washington Blvd., E. Dr.
Pickett, Mrs. Robert D. 4713 Millersville Rd.
Pilcher, Mrs. Jack E. 4601 Graceland Ave.
Pontius, Mrs. Edwin G. 10254 Carrollton Ave.
Popplewell, Mrs. A. G. 141 E. Southport Rd.
Price, Mrs. Francis W. 550 East Edgewood Ave.
Pryor, Mrs. Richard 6134 Carrollton

R

Raber, Mrs. Robert M. 265 Williams Ct.
Rader, Mrs. George S. 3778 E. 62nd
Ramage, Mrs. Walter F. 244 S. 1st St.
Reed, Mrs. Phillip B. 4131 N. Meridian
Rees, Mrs. Russell C.
926 Ellenberger Pkwy., W. Dr.
Reid, Mrs. Charles A. 6506 Madison Ave.
Reid, Mrs. Robert H. 1657 E. 81st St.
Rice, Mrs. Frederick A., Jr. 5802 E. 46th St.
Rice, Mrs. Raymond M. 7799 E. Holliday Drive
Richardson, Mrs. Thad T. 6126 E. St. Joseph St.
Ricketts, Mrs. Joseph W. 7447 Holliday Dr. E.
Rigg, Mrs. John F.
3540 N. Pennsylvania St., Apt. P
Robb, Mrs. John A. 5151 N. Pennsylvania
Roll, Mrs. John W. 4407 Eastbourne Drive
Roller, Mrs. Charles W. 2301 Garfield Dr.
Romberger, Mrs. Floyd T., Jr. 10 W. 64th St.
Rosenak, Mrs. Bernard D. 5254 N. Delaware
Ross, Mrs. Alexander T. 265 W. Westfield Blvd.
Row, Mrs. D. Hamilton 5214 Grandview Drive
Ruddell, Mrs. Karl R. 2626 N. Meridian
Ruddell, Mrs. Keith 1201 Golden Hill Drive
Rudesill, Mrs. Robert L. 5252 N. Capitol
Rust, Mrs. Roland B. Jr. 4458 Priscilla Ave.
Ryan, Mrs. Glenn V.
3168 E. Fall Creek Pkwy., N. Dr.

S

Sage, Mrs. Russell A. 8706 College Avenue
Salb, Mrs. Max C. 6741 Allisonville Rd.
Schaffer, Mrs. Edward V. 3785 E. 62nd St.
Schlegel, Mrs. Donald M. 6230 Dean Rd.
Schneider, Mrs. Carl J. 340 N. Kenyon
Schuchman, Mrs. Gabriel 5944 Central
Schuster, Mrs. Dwight 4503 Washington Blvd.
Scott, Mrs. George E. 3636 Layman
Scott, Mrs. John R. 7966 N. Illinois
Scott, Mrs. Robert P. 6183 River View Dr.
Seaman, Mrs. Charles F. 6017 Hillside, E. Dr.
Sedam, Mrs. Herbert L. 6931 Central
Segar, Mrs. William E. 4855 Victoria Rd.
Sexson, Mrs. Hiram T. 5455 N. Meridian
Shafer, Mrs. Marion R. 6290 Allisonville Rd.
Sheehan, Mrs. Francis G. R. R. 10, Box 257A
Shumaker, Mrs. H. B., Jr. 4330 Central Ave.
Sicks, Mrs. O. W. 607 E. 82nd St.
Sidebottom, Mrs. Earl W. 2606 W. Bluffwood Dr.
Siebe, Mrs. Jack C. 5011 E. 40th St.
Sims, Mrs. J. Lawrence 3723 N. Gale
Sluss, Mrs. David 3657 Washington Blvd.
Smith, Mrs. David L. 7979 High Dr.

Smith, Mrs. Edward B.....3322 Guilford Ave.
Smith, Mrs. E. Rogers.....160 W. 47th St.
Smith, Mrs. Roy Lee.....R. R. 6, Box 232
Solomon, Mrs. R. A.....5330 N. Pennsylvania
Sommers, Mrs. Stephens D.....1612 Cord St.
Soper, Mrs. Hunter A.....5321 Boulevard Place
Sovine, Mrs. J. W.....8182 N. Illinois
Spahr, Mrs. John F., Jr.
3014 Green Hills Lane, N. Dr.
Sparks, Mrs. Alan L.....5466 N. Pennsylvania
Speckman, Mrs. Glenn H.....5242 Park Ave.
Sputh, Mrs. C. B., Jr.....5671 Rolling Ridge Rd.
Sputh, Mrs. Carl B., Sr.....7860 Barlum Dr.
Stansbury, Mrs. Wm. E.....5610 E. 16th St.
Stayton, Mrs. Chester A., Sr.....6925 N. Delaware
Stayton, Mrs. Chester A., Jr.....7065 Central Ave.
Stephens, Mrs. Kuhrman H.....5210 Boy Scout Rd.
Stoelting, Mrs. V. K.....4706 Laurel Circle
Stone, Mrs. David F.....5603 Indianola
Storey, Mrs. D. Edmund..808 Forest Blvd., N. Dr.
Strickland, Mrs. Neil R.....5117 E. 70th St.
Stroup, Mrs. Tyler J.....5758 College
Stucky, Mrs. Elsworth K.....4528 N. Meridian
Sutton, Mrs. William E.....5670 Guilford
Swan, Mrs. John R.....320 Arden Dr.
Symmes, Mrs. Alfred T.....6445 N. Illinois St.
Szumilas, Mrs. Peter P.....1616 Cord St.

T

Talbott, Mrs. Dan E.....6470 N. Michigan Rd.
Tanner, Mrs. Henry S.....4461 N. Pennsylvania
Taylor, Mrs. Clifford.....5938 Crittenden
Taylor, Mrs. Cyril.....2936 W. 33rd St.
Taylor, Mrs. Frederick W.....40 E. 43rd
Teague, Mrs. Frank W.....R. R. #14, Box 726
Tharpe, Mrs. Ray.....6161 Sunset Lane
Thatcher, Mrs. Hugh K., Jr.....408 E. 45th St.
Thomas, Mrs. Fred A.....3914 N. New Jersey St.
Thomas, Mrs. Lowell I.....28 W. Hampton Dr.
Thomas, Mrs. Morris E.....5207 N. New Jersey
Thompson, Mrs. John V.....7899 Ridge Rd.
Thompson, Mrs. Paul D.....631 N. E. Second Ave.
Thompson, Mrs. Wayne H.....6365 Knyghton Rd.
Thornburg, Mrs. K. E.....4702 Washington Blvd.
Throop, Mrs. Frank B.....44 Meridian Place
Thurston, Mrs. A. L.....421 E. 41st
Tinsley, Mrs. Walter B.....3314 Carrollton
Tondra, Mrs. John M.....4511 Broadway
Torrella, Mrs. Jose A.....5721 W. 18th
Toumey, Mrs. F. L.....4401 Broadway
Trusler, Mrs. Harold M.....6150 N. Pennsylvania
Tuchman, Mrs. Joseph H.....1154 Hawk Lane
Tyner, Mrs. Harlan H.....3663 N. Delaware

V

Van Meter, Mrs. C. Powell....4102 Marrison Place
VanOsdol, Mrs. Harry A.....43 Hampton Dr.
Van Tassel, Mrs. C. J., Jr...5832 Washington Blvd.
Vollrath, Mrs. Victor J.....5202 N. Illinois
VonDerHaar, Mrs. Gerard...7301 East 13th Street
Vore, Mrs. Robert_____3710 Cheviot Place

W

Waldo, Mrs. J. Thayer.....420 W. 64th St.
Walker, Mrs. Frank C.....5563 N. Pennsylvania
Wallace, Mrs. Collins R.....3359 Meadows Ct., A-3
Walther, Mrs. Joseph E.....4266 N. Pennsylvania
Warriner, Mrs. James B.....990 N. Bolton
Warvel, Mrs. John H....4360 Kessler Blvd., N. Dr.
Weinland, Mrs. George C.....4341 Central Avenue
West, Mrs. Joseph L.....2110 W. 38th
Westfall, Mrs. B. Kemper, Jr.....4001 N. Meridian
Westfall, Mrs. John B.....5425 N. New Jersey St.
Wheeler, Mrs. David E.....4520 Bertrand Road
White, Mrs. Donald J.....5430 N. Delaware
White, Mrs. John B.....6425 Lawrence Dr.
White, Mrs. Philip T.....3606 Lorraine Rd.
Wilkens, Mrs. Irvin W..4820 E. Pleasant Run Pkwy.
Wilmore, Mrs. Ralph C.....6477 N. Tuxedo
Wilson, Mrs. Oliver R.....3519 Washington Blvd.
Wise, Mrs. William.....4934 N. Pennsylvania St.
Wise, Mrs. Wm. R.....4895 Knollton Rd.
Wishard, Mrs. William N., Jr.
5720 N. Pennsylvania St.
Witham, Mrs. Robert L.....4904 Staughton Drive
Wolfram, Mrs. Don J.....5716 N. Pennsylvania
Woolling, Mrs. Kenneth R.....5303 Boulevard Pl.
Wrege, Mrs. Malcolm.....6505 Riverview Dr.
Wright, Mrs. J. Wm., Jr.....4220 Knollton Rd.
Wyttenbach, Mrs. John E.....5509 Kenwood

Y-Z

Yacko, Mrs. Michael.....9740 E. 11th St.
Young, Mrs. John M.....4535 Marcy Lane, No. 261

New Augusta

Asher, Mrs. Ernest O.....Box 6
Asher, Mrs. James W.....8381 Moore Rd.

Link, Mrs. Goethe..R. R. #6, Box 152, Martinsville
Jones, Mrs. George L.....Wanamaker
Abreu, Mrs. Benedict E.
9300 Moore Rd., R. R. 2, Zionsville
Hughes, Mrs. James B.....326 Anthony St.
Glen Ellyn, Ill.

MARSHALL COUNTY

Hampton, Mrs. James.....Argos
Graham, Mrs. C. R.....Bourbon
Bowen, Mrs. Otis R.....N. Center St., Bremen
Burkett, Mrs. Cecil.....Grant St., Bremen
Stine, Mrs. Marshall.....304 W. Grant, Bremen
Norris, Mrs. Ernest B.....Culver
Reed, Mrs. Donald.....Lakefront & Mill, Culver

Plymouth

Coursey, Mrs. James.....217 N. Plum Street
Klingler, Mrs. M. O.....805 Pennsylvania Ave.
Kubley, Mrs. James.....624 E. LaPorte St.
Pomeroy, Mrs. Rex.....1400 Park Ave.
Reed, Mrs. Robert G.....235 Hogarth
Rimel, Mrs. James F.....909 Bayless
Robertson, Mrs. James.....1010 Ferndale Ave.
Vore, Mrs. Loring W.....Myers Lake, R. R. 4

MIAMI COUNTY

Line, Mrs. Homer.....Chili
Shrock, Mrs. E. E.....Amboy
Hill, Mrs. Loyd.....Denver
Rendel, Mrs. H. E.....Mexico

Peru

Barnett, Helen.....109 W. Seventh
Boone, Mrs. Max L.....301 Adams
Herd, Mrs. C. R.....105 E. 5th St.
Johnson, Mrs. Owen.....106 W. 6th
Malouf, Mrs. S. D.....359 W. Third
Snyder, Mrs. Parker S.....159 W. 6th
Wagner, Mrs. Sarah.....R. R. 4
Wildman, Mrs. R. E.....R. R. 2
Yarling, Miss Francis.....117 E. Fifth

MONTGOMERY COUNTY

Crawfordsville

Burks, Mrs. Jess E.....512 W. Wabash Ave.
Cooksey, Mrs. Thomas L.....205 Marshall
Cornell, Mrs. Robert.....1000 S. Washington
Daugherty, Mrs. Fred N.....415 W. Main
Eggers, Mrs. Richard R.....203 West

Haller, Mrs. Thomas C.....508 W. Main
Humphreys, Mrs. John W.....1309 Durham Dr.
Kinnaman, Mrs. Howard A...Branch of Darlington
Kirtley, Mrs. James N.....615 Thornwood Road
Lingeman, Mrs. Byron J.....203 Wallace
Mount, Mrs. William M.....1417 W. Main
Peacock, Mrs. Norman F.....107 Vernon Court
Pierson, Mrs. Robert H.....305 E. Main
Shannon, Mrs. Wesley E.....411 S. Walnut St.
Sharp, Mrs. John L.....1403 E. Main
Wallace, Mrs. Hawthorne C.....107 W. Jefferson

Otten, Mrs. Ralph R.....Darlington
Blix, Mrs. Fred.....Ladoga
Denny, Mrs. Frank T.....Ladoga
Wong, Mrs. Norman.....Romney
Davis, Mrs. William H.....New Market
Kindell, Mrs. Herschel D.....New Richmond
Richards, Mrs. Edgar E.....Russellville
Rusk, Mrs. Hubert M.....Wallace
Parker, Mrs. Carl B.....Wingate
Byrne, Mrs. Louis.....Roachdale

MORGAN COUNTY

Martinsville

Brubeck, Mrs. Robert D.....Martinsville
Eisenberg, Mrs. David.....340 E. Cunningham
Gray, Mrs. Leon.....260 N. Ohio
Miller, Mrs. Ray.....290 E. Washington
Pitkin, Mrs. Edward.....309 Washington
Pitkin, Mrs. McKendree C.....440 E. Washington
Sweet, Mrs. Austin.....Martinsville
Taylor, Mrs. L. F.....399 N. St. Clair
Van Wienan, Mrs. John.....439 N. Jefferson
Willan, Mrs. Horace R.....109 S. Jefferson
Winter, Mrs. William.....Martinsville

Mooresville

Bivin, Mrs. J. H.....N. Indiana Rd.
Comer, Mrs. C. W.....R. R. 2
Comer, Mrs. Kenneth.....R. R. 2
Kendrick, Mrs. William.....R. R. #1

Murphy, Mrs. M. G.....Morgantown

OWEN-MONROE COUNTIES

Bloomington

Borland, Mrs. Ray.....Moores Pike
Buckingham, Mrs. Richard E.....705 S. Fess
Creek, Mrs. Jean A.....2303 Fritz Dr.
Estes, Mrs. Ambrose.....701 Highland Ave.
Fowler, Mrs. Ross.....Pleasant Ridge Rd.
Hardtke, Mrs. Eldred F.....1400 Pickwick Place
Hepner, Mrs. H. S.....302 E. 7th St.
Holland, Mrs. D. J.....1100 Atwater
Holland, Mrs. Philip T.....1001 S. Jordon Ave.
Holtzman, Mrs. Paul W.....1203 Pickwick Pl.
Lundblad, Mrs. W. M.....400 East Side Dr.
Lyons, Mrs. Robert.....S. Walnut Rd.
Marchant, Mrs. Clarence.....350 S. College
McIntire, Mrs. C. R.....North Dunn Rd.
Middleton, Mrs. Thomas O.....210 Gilbert Ave.
Miller, Mrs. John.....1210 E. Wylie St.
Poolitsan, Mrs. George.....1217 E. First St.
Ramsey, Mrs. Hugh S.....619 E. 1st St.
Reed, Mrs. William C.....1215 Atwater Ave.
Rogers, Mrs. Floyd.....804 E. 8th St.
Rollins, Mrs. Thomas.....815 S. Rose
Smith, Mrs. Herschel.....200 Glendora Drive
Smith, Mrs. Paul.....812 N. College Ave.
Stangle, Mrs. William.....1818 E. Third
Thomas, Mrs. Harry.....129 S. Swain St.
Topolgus, Mrs. James.....1015 Atwater
Wilson, Mrs. T. L.....Bender Road
Winters, Mrs. Matthew.....407 N. Park St.

Spencer

Brown, Mrs. Marcel S.....Spencer
Austin, Mrs. D. C...1922 N. Capitol, Indianapolis 2

PARKE-VERMILLION COUNTIES

Clinton

Evans, Mrs. F. J.....1315 S. Main
Gerrish, Mrs. W. D.....125 S. 5th St.
Herzberg, Mrs. Milton.....545 S. Fourth
Kercheval, Mrs. J. M.....Box 192

Britton, Mrs. W. D.....Montezuma
DeRenne, Mrs. W. L.....190 Market St., Newport
Saunders, Mrs. J. L.....Newport
Johnson, Mrs. W. A.....Perrysville

Rockville

Bloomer, Mrs. J. R.....115 N. Market St.
Bloomer, Mrs. R. S.....502 W. York St.
Harstad, Mrs. C.....515 W. High
Kempf, Mrs. Gerald F.....Ind. State Sanitarium
Merrell, Mrs. Basil M.....516 S. Market St.
Pace, Mrs. J. V.....Indiana State Sanitarium
Pirkle, Mrs. H. B.....Indiana State Sanitarium

PERRY-SPENCER COUNTIES

Bush, Mrs. Hargis R.....Sixth St., Cannelton
Glackman, Mrs. John C...207 Center St., Rockport

Tell City

Coultas, Mrs. P. J.....809 Main
Dome, Mrs. Hardin S.....147 11th St.
Dukes, Mrs. David A.....521 Main
Glenn, Mrs. F. C.....436 Main
Herr, Mrs. John W.....Boyd Road
James, Mrs. John Mark.....24 11th St.
James, Mrs. N. A.....740 Ninth St.
Lashley, Mrs. D. L.....606 Ninth
Lohoff, Mrs. Lewis C.....425 10th St.
Neifert, Mrs. Noel L.....1118 Blum St.
Smith, Mrs. Fred, Jr.....1407 12th Street

Snyder, Mrs. E. R.....Troy

PORTER COUNTY

Chesterton

Ashmore, Mrs. Herbert C.....317 Bowser
Hall, Mrs. Thomas.....Dune Acres
Harless, Mrs. C. M.....123 W. Indiana Ave.
Reed, Mrs. John E.....Wilson St.
Robertson, Mrs. W. C.....600 E. Morgan

Valparaiso

Brown, Mrs. J. C.....458 Park Ave.
Davis, Mrs. Carl.....202 Indiana
DeGrazia, Mrs. E. J.....410 Washington
Douglas, Mrs. George R.....404 Washington
Eades, Mrs. Ralph.....203 Jefferson
Frank, Mrs. John R.....303 Indiana
Green, Mrs. Leonard.....1808 Napoleon St.
Koenig, Mrs. Robert.....601 Elmhurst
LaRocca, Mrs. Joseph.....402 Erie
Makovsky, Mrs. Theodore...1807 Beulah Vista Dr.
O'Neill, Mrs. Martin J.....301 Washington
Seipel, Mrs. Herman O.....302 Lafayette
Stoltz, Mrs. Robert.....501 Lincolnway
Vietzke, Mrs. Paul.....102 Lafayette

PUTNAM COUNTY

Veach, Mrs. Lester W.....Bainbridge
Veach, Mrs. Richard L.....Bainbridge
Gray, Mrs. Clyde.....Cloverdale

Greencastle

Dettloff, Mrs. Frederick R.....300 Highfall Ave.
Fuson, Mrs. W. J.....108 Northwood Blvd.
Johnson, Mrs. James B.....314 Highfall Ave.
Rhea, Mrs. Gilbert D.....126 E. Washington
Schauwecker, Mrs. Cleon M.....613 Ridge Ave.
Smith, Mrs. Wm.....R. F. D. 2
Steele, Mrs. Dick J.....207 Northwood Blvd.
Tennis, Mrs. George T.....605 S. Jackson
Tipton, Mrs. William R.....103 Northwood Blvd.
Wiseman, Mrs. V. Earle.....6 Durham

RANDOLPH COUNTY

Farmland

Nixon, Mrs. Byron.....312 N. Main
White, Mrs. Harvey E.....200 S. Main
Potter, Mrs. Richard M.....120 Walnut, Ridgeville

Union City

Chambers, Mrs. Leroy B.....800 N. Columbus
McClure, Mrs. Morris E.....225 N. High St.
Phipps, Mrs. Leland K.....516 N. Howard
Reid, Mrs. Robert W.....706 W. Division
Wagoner, Mrs. B. D.....701 W. Division

Harmon, Mrs. Wayne.....113 Church St., Lynn
Shallenberger, Mrs. H. R.....Modoc

Winchester

Dininger, Mrs. W. S.....303 S. Main
Engle, Mrs. Russell B.....R. R. 2
Koch, Mrs. Howard W.....208 E. Washington St.
Painter, Mrs. Lowell W.....507 S. Main
Slick, Mrs. C. R.....512 S. Oak Street
Sparks, Mrs. Paul W.....601 W. Will
Spitler, Mrs. C. A.....R. R. #4

RIPLEY COUNTY

Freeland, Mrs. Bill..714 Edgewood Rd., Batesville
Hisrich, Mrs. L. W.
Maplewood & Henry, Batesville
Lippoldt, Mrs. Chas. L. Edgewood Rd., Batesville
Aldred, Mrs. Allen W.....Milan
Conrad, Mrs. Henry W.....Milan
Frable, Mrs. Frank L., Jr.....Milan
Hunter, Mrs. G. L.....Milan
Warn, Mrs. William.....Milan
Row, Mrs. George.....Osgood
Smith, Mrs. Lee R.....Osgood
McConnell, Mrs. William C.....Sunman
Moran, Mrs. N. D.....Versailles

RUSH COUNTY

McNabb, Mrs. George B.....Carthage
McNabb, Mrs. Richard.....Carthage
Worth, Mrs. C. Willard.....Milroy

Rushville

Atkins, Mrs. C. C.....410 N. Perkins
Corpe, Mrs. Kenneth F.....R. R. 4
Deerhake, Mrs. Mabel.....501 N. Harrison
Denny, Mrs. Melvin.....R. R. #1
Ellis, Mrs. Davis.....721 N. Perkin
Green, Mrs. Frank.....516 N. Morgan
Hoover, Mrs. Eugene.....501 N. Harrison
Johnson, Mrs. Robert I.....841 N. Harrison
McKee, Mrs. Harry S.....R. R. 6
Norris, Mrs. Marvin.....1107 N. Main St.
Shanks, Mrs. Roy E.....1110 N. Morgan

SHELBY COUNTY

Nigh, Mrs. R. M.....Fairland
Davis, Mrs. John A.....Flat Rock

Shelbyville

Alden, Mrs. John O.....Spring Hill Rd.
Barnum, Mrs. Emerson.....310 Howard St.
Dalton, Mrs. Wilson L.....401 Sunset Dr.
Gehres, Mrs. Robert W.....610 Shelby
Grove, Mrs. E. G.....242 W. Broadway
Inlow, Mrs. Herbert H.....212 N. Harrison
Inlow, Mrs. W. D.....Spring Hill Rd.
McFadden, Marian.....28 W. Mechanic St.
McFadden, Mrs. Walter C.....28 W. Mechanic
Miller, Mrs. R. C.....17 W. Mechanic
Phares, Miss Frances.....408 S. Harrison
Richard, Mrs. Norman F.....45 W. Washington
Scott, Mrs. V. B.....N. Riley Hwy.
Silbert, Mrs. David B.....1100 Fairfield Drive
Spindler, Mrs. Robert D.....165 W. Mechanic
Tindall, Mrs. Paul R.....164 W. Franklin
Tindall, Mrs. W. R.....616 S. Harrison
Tower, Mrs. James H., Jr.....1018 S. West Street
Whitcomb, Mrs. Roger F.....218 W. Broadway

ST. JOSEPH COUNTY

Mishawaka

Fujawa, Mrs. M. J.....721 Lincoln Way E.
Martin, Mrs. Chas. F., Jr.....2125 Linden Ave.
Barone, Mrs. C. V.....59053 Bremen Highway
Ganser, Mrs. Ralph.....408 W. 12th St.
Ganser, Mrs. Richard A.....1020 Wilson Blvd.
Goethals, Mrs. C. J.....602 Lincolnway W.
McDonald, Mrs. R. M.....12252 E. Jefferson Road
Reed, Mrs. Robert.....213 Downey Street
Rosenwasser, Mrs. Jacob.....415 Indiana Avenue
Sirlin, Mrs. Edward M.....1473 Jefferson Rd.
Spalding, Mrs. Wendell L.....60100 So. Fir Road
Templeton, Mrs. Ames R.....522 Calhoun
Walerko, Mrs. Frank M.....515 N. Clay St.
Walters, Mrs. Charles E.....16166 Ireland Rd.
Whitlock, Mrs. Francis.....304 Lincoln Way E.
Whitlock, Mrs. Merle E.....16146 Chandler Blvd.
Wurster, Mrs. H. C.....221 E. Third
Wygant, Mrs. M. D.....Beatty Memorial Hospital, Westville
Wyland, Mrs. B. J.....510 Calhoun
Zimmer, Mrs. H. J.....333 Edgewater Dr.

Houser, Mrs. D. S.
24751 N. Riley Rd., North Liberty
Smith, Mrs. Lee.....R. R. 1, Lakeville

South Bend

A

Acker, Mrs. Robert B.....103 S. Ironwood Dr.
Arisman, Mrs. R. K.....1615 E. Colfax

B

Backs, Mrs. Alton J.....1953 Inglewood Place
Balla, Mrs. Morris.....1516 E. Wayne
Baran, Mrs. Charles.....1430 E. Wayne
Bartsch, Mrs. Harvey L.....1330 E. Victoria
Bechtold, Mrs. S. E.....313 Pendle
Bell, Mrs. H. D.....1357 Champeau St.
Bennett, Mrs. Jene R.....1826 E. Jefferson Blvd.
Berke, Mrs. Robert D.....2510 Erskine Blvd.
Biasini, Mrs. B. A.....19585 Glendale Road
Bickel, Mrs. David A.....1335 E. Wayne St.
Birmingham, Mrs. P. J.....1126 E. Irvington
Bishop, Mrs. C. Allen.....1301 Garland Rd.
Bixler, Mrs. Louis C.....1817 Portage
Blackburn, Mrs. Erwin.....1340 E. Madison Ave.
Bodnar, Mrs. Leslie M.....1843 Portage Ave.
Borough, Mrs. Lester D.....816 E. Woodside
Buchanan, Mrs. Wallace D..1326 E. Wayne St., N.
Buechner, Mrs. Fred W.....603 W. Marion
Bussard, Mrs. C. F.....719 W. North Shore Drive
Bussard, Mrs. Frank.....1311 Sunnymede
Butts, Mrs. Milton.....118 N. Walnut St.

C

Carter, Mrs. F. R. N.....2000 E. Jefferson Blvd.
Cassaday, Mrs. John R.....1805 Marquette Blvd.
Cassaday, Mrs. J. V.....2216 E. Madison
Chamblee, Mrs. R. W.....1435 Corby Blvd.
Clark, Mrs. W. H.....1227 Garland Rd.
Colip, Mrs. George D.....260 David
Condit, Mrs. D. H.....1521 E. Wayne
Cook, Mrs. Gordon C.....1620 Southwood Ave.
Crowley, Mrs. J. B.....17821 Ponader Dr.
Custer, Mrs. Edward W.....52383 Laurel Road

D

Denham, Mrs. Robert H.....1429 E. Wayne
DeVoe, Mrs. K. R.....621 Woodcliff Dr.
Dodd, Mrs. Robert D.....1510 Tudor Lane
Dolezal, Mrs. Bernard J.....815 Park Ave.
Duggan, Mrs. James A.....110 Peashway
Dunlap, Mrs. D. Logan.....123 North Shore Dr.

E

Eades, Mrs. R. Charles.....232 Marquette Ave.
Ebin, Mrs. J. L.....1223 N. Lawrence
Edwards, Mrs. Bernard E.....1341 E. Wayne
Egan, Mrs. Sherman L.....944 Riverside Dr.
English, Mrs. J. Paul.....3116 Robinhood Lane
Erickson, Mrs. G. Walter....3012 Robinhood Lane
Ericksen, Mrs. L. G.....1212 E. Woodside

F

Farner, Mrs. James.....1335 Leeper Ave.
Feferman, Mrs. Martin E.....1914 Rockne Dr.
Feldman, Mrs. Max.....702 N. Lafayette Blvd.
Filipek, Mrs. Walter.....2513 Lincoln Way West
Firestein, Mrs. Ben Z.....125 W. Marion Street
Firestein, Mrs. Ray.....502 N. Ironwood Drive
Fish, Mrs. Edson C.....19054 Summers Drive
Frank, Mrs. Herbert....2616 S. Twyckenham Dr.
Frank, Mrs. L. L.....534 N. Lafayette Blvd.
Frash, Mrs. D. W.....1912 Miami Street
Friedman, Mrs. Morris S...1617 E. Jefferson Blvd.

G

Gaffney, Mrs. R. A.....534 Peashway
Gates, Mrs. George E.....411 W. North Shore Dr.
Gilman, Mrs. Marcus.....1925 E. Jefferson Blvd.
Giordano, Mrs. A. S.....1518 E. Colfax Ave.
Godersky, Mrs. George.....2744 Sampson
Goraczewski, Mrs. T. C.....1016 W. Washington
Graf, Mrs. John P.....424 Peashway
Green, Mrs. George F.....1515 E. Wayne
Green, Mrs. Norvel E.....1726 E. LaSalle
Grove, Mrs. James H.....60268 Mayflower Rd.

H

Hamilton, Mrs. Charles O.
1418 E. Washington Ave.
Haugseth, Mrs. E. K.....820 N. Ironwood
Helmer, Mrs. John.....1825 Wilbur
Hilbert, Mrs. John W.....410 W. Washington
Hildebrand, Mrs. J. O.....1637 Southbrook Dr.
Hill, Mrs. Theodore.....107 N. Eddy St.
Hill, Mrs. Wallace C.....1221 Sunnymede Ave.
Hillman, Mrs. Marion W.....1516 Marquette Blvd.
Holdeman, Mrs. Lillian S....615 W. Colfax Avenue
Holtzman, Mrs. Norman.....3322 Whitcomb
Hyde, Mrs. C. C.....1521 E. Colfax

J

Johns, Mrs. N. C.....1329 N. St. Joseph St.

K

Kamm, Mrs. Bernard.....125 W. Marion St.
Karn, Mrs. John W.....1535 Wall St.
Krueger, Mrs. John E.....1206 N. Lawrence
Kuhn, Mrs. Frederick L.....1215 S. Michigan St.

L

Lamb, Mrs. Leonard_____1321 E. Wayne
Lane, Mrs. William H.....845 Park
Lang, Mrs. Joseph E.....505 Dixie Hwy., No.
Levatin, Mrs. B. J.....1814 E. Churchill Dr.
Levkoff, Mrs. Abner.....3239 Essex Dr.
Lionberger, Mrs. John R...1419 E. Jefferson Blvd.
Liss, Mrs. Emanuel.....1612 E. Madison
Lockhart, Mrs. Philip.....1311 E. Monroe St.

M

MacLeod, Mrs. John K.....930 Simmon Ct.
Mahank, Mrs. Camiel C.....1804 E. Jefferson
Marquis, Mrs. Gordon.....329 Wakewa
Mason, Mrs. Bernard A.....2719 Marine St.
McCraley, Mrs. W. J.....1737 Belmont
Metcalfe, Mrs. G. E.....1209 E. Wayne, No.
Miller, Mrs. Milo K.....1018 E. Oakside
Mott, Mrs. C. A.....2733 Lincolnway West
Mueller, Mrs. H. M.....3525 Windingwood Dr.
Murphy, Mrs. Eugene C.....1411 Sunnymede

N-O

Nelson, Mrs. F. D.....58244 S. Ironwood Dr.
Nelson, Mrs. Raymond E.....1909 E. Madison
Olson, Mrs. Donald T.....127 S. Ellsworth Pl.
Olson, Mrs. Kenneth.....1228 E. Woodside
Oren, Mrs. William.....1149 E. Belmont

P

Parsons, Mrs. Robert.....1464 Ridgedale Rd.
Pauszek, Mrs. Thomas B.....916 Riverside Dr.
Petrass, Mrs. Andrew.....22027 Liberty Highway
Plain, Mrs. George.....17836 Ponader Drive
Pyle, Mrs. H. Dale.....115 N. Sunnyside

R

Rigley, Mrs. Edward L.....1704 Ridgedale Rd.
Rosenheimer, Mrs. George M.....1425 E. Woodside
Rubens, Mrs. Eli.....1240 E. Irvington
Rudolph, Mrs. Carl.....2016 E. Madison Street

S

Sanderson, Mrs. Robert B...1331 Sunnymede Ave.
Sandock, Mrs. I.....1203 N. Notre Dame Ave.
Sandock, Mrs. Louis E.....235 S. Esther St.
Sandoz, Mrs. H. H.....239 S. Hawthorne Dr.
Sandoz, Mrs. Louis A.....304 S. Twyckenham Dr.
Schiller, Mrs. Herbert A.....1813 E. Cedar
Scott, Mrs. Frank M.....1220 E. Woodside
Selby, Mrs. K. E.....1327 E. Wayne, No.
Sensenich, Mrs. R. L.....128 S. Scott
Sharp, Mrs. Merle C.....17772 Woodthrush Lane
Shelley, Mrs. Edward S.....207 S. Taylor St.
Shriner, Mrs. Richard L.....53362 Juniper Road
Sisson, Mrs. Norval D.....1614 Oak Park Dr.
Skillern, Mrs. Scott.....1553 Southbrook Dr.
Slominski, Mrs. Harry H.....1862 College St.
Spenner, Mrs. R. W.....125 S. Esther St.
Stiver, Mrs. Dan D.....1127 E. Wayne St. N.
Stogdill, Mrs. William.....102 S. Coquillard
Stratigos, Mrs. Joseph S.....17788 State Rd. 23

T

Thompson, Mrs. John M.....1618 Cedar
Thornton, Mrs. M. J.....R. R. #2, Miami Rd.
Tirman, Mrs. Wallace,....1224 E. Wayne St., No.

V-W-Z

Vagner, Mrs. S. Bernard...53190 Willow Run Road
Vurpillat, Mrs. F. J.....2102 E. Cedar
Walker, Mrs. Edwin M., Jr.....1114 Stanfield
Weiss, Mrs. Eugene.....1605 E. Washington Ave.
Wilson, Mrs. James M.....1416 E. Monroe St.
Zeiger, Mrs. Irwin L.....1205 E. Irvington

TIPPECANOE-WHITE COUNTIES

Lafayette

Babb, Mrs. Forrest J. 2106 South 9th St.
Baker, Mrs. John R. 1603 Potomac
Bayley, Mrs. Richard D. 725 S. 11th St.
Canganelli, Mrs. Vincent G. Rd. 43 South
Carpenter, Mrs. John B. 1720 Scott
Dubois, Mrs. Ramon 519 Calvert Lane
Fields, Mrs. Donald C. 1010 Highland Ave.
Flack, Mrs. R. A. 3600 Cypress Lane
Frey, Mrs. Harley 927 Highland
Graham, Mrs. Thomas 1213 Wea
Gripe, Mrs. Richard 1623 S. Fifth
Harter, Mrs. Eli B. 918 King
Holladay, Mrs. L. J. 1403 S. 14th St.
Johnson, Mrs. Herbert 712 Cherokee
Jones, Mrs. David 2055 S. Ninth
Karberg, Mrs. Richard J. 1212 El Prado
Klepinger, Mrs. Harry E. 909 N. 21st
Kohne, Mrs. Robert 1001 Pontiac
Martin, Mrs. Joe M. 822 So. 18th St.
Marvel, Mrs. Howard 1106 Hedgewood
McAdams, Mrs. Hugh 2110 Birch Lane
McClelland, Mrs. D. C. 1021 Highland
McKinley, Mrs. Joseph 610 Lingle Terrace
Neumann, Mrs. Kenneth 1410 S. 18th
Onorato, Mrs. Joseph 2606 South St.
Ratcliff, Mrs. Frank W. 1000 Wea
Rothrock, Mrs. Philip 605 Lingle Ave.
Shively, Mrs. John L. 1615 S. 5th St.
Sholty, Mrs. William M. Shadeland Farm Rd.
Trout, Mrs. Carl J. 800 State
Underwood, Mrs. George M. 2800 Longlois Dr.
VanReed, Mrs. Lula C. 806 S. 9th St.
Vermilya, Mrs. R. W. Cedar Bluff Rd.
Williams, Mrs. Robert E. 403 Asher

West Lafayette

Bayley, Mrs. William 622 Rose
Bolin, Mrs. Robert C. 908 Windsor Dr.
Burns, Mrs. John T. 2201 N. Salisbury
Calvert, Mrs. R. R. 308 Park Lane
Davis, Mrs. Howard B. 833 Hillcrest Rd.
Eaton, Mrs. Marion J. 425 Forest Hill Dr.
Engeler, Mrs. James E. 1316 N. Grant
Ferguson, Mrs. William B. 430 Forest Hill Dr.
Harden, Mrs. Murray 610 Carrolton
Hughes, Mrs. Richard R. 908 Carrolton Blvd.
Hull, Mrs. James 605 Carrolton
Johnson, Mrs. Lowell 1601 Woodland
Klatch, Mrs. Ben Z. 1504 N. Grant
Loop, Mrs. Frederick A. 119 Leslie Dr.
Marsh, Mrs. George W. 2121 Happy Hollow Rd.
McAdams, Mrs. Robert 625 Ridgewood
McFadden, Mrs. James M. 1424 N. Salisbury
Mather, Mrs. Charles R. 1815 Ravinia Rd.
Miller, Mrs. Roland 600 Ridgewood Dr.
Peyton, Mrs. Frank W. 612 Ridgewood Dr.
Stahl, Mrs. E. T. 324 Park Lane
Steele, Mrs. Hugh H. 118 Sunset Lane
VanDen Bosch, Mrs. W. R. 715 Princess Dr.
Washburn, Mrs. W. W. 209 Forest Hill Dr.

Henderson, Mrs. Robert N. Box 397, Brookston
Lind, Mrs. Jaap Mulberry
Weller, Mrs. Robert Rossville

VANDERBURGH COUNTY

(Southwestern)

Stover, Mrs. Wendell C.
20 Lake Shore Dr., Boonville

Evansville

A

Acre, Mrs. Robert R. 2311 Lincoln
Adler, Mrs. Ray N. 1660 Lincoln
Adye, Mrs. Wallace H. 124 Fairway Dr.
Anderson, Mrs. Milton H. Woodmere
Antes, Mrs. Earl H. 1201 Bonnieview Dr.
Antonetti, Mrs. John 211 Inwood Drive
Arendell, Mrs. Robert 710 S. Weinbach Ave.
Austin, Mrs. Eugene W. 2163 Bayard Park Dr.

B

Baker, Mrs. Mason 900 Bellemeade Ave.
Barnhart, Mrs. Willard T. 507 Boeke Rd.
Beck, Mrs. Robert E. 301 Inwood Drive
Begley, Mrs. Joseph W. 700 Blue Ridge Rd.
Bender, Mrs. M. J. 2716 Capitol Blvd.
Bennett, Mrs. Abner P. 961 Blue Ridge Rd.
Bissonette, Mrs. Roger P. 911 Colony Rd.
Britt, Mrs. Robert 6416 Arcadian Hwy.
Brown, Mrs. George W. 2051 E. Florida St.
Bryan, Mrs. Stanton L. 3211 E. Mulberry
Buehner, Mrs. Donald 1200 Bonnieview Dr.
Buikstra, Mrs. C. R. R. R. 5, Box 215
Burger, Mrs. Thomas C. 2331 Washington Ave.
Burnikel, Mrs. Ray H. 960 S. Rotherwood Ave.
Burress, Mrs. Clyde R. R. #8, McCutchanville

C

Cacia, Mrs. John J. 420 S. Boeke Rd.
Caldwell, Mrs. William C. 643 College Hwy.
Carlson, Mrs. Ralph F. 1350 Bayard Park Dr.
Clark, Mrs. Thomas W. 810 Plasa Dr.
Clements, Mrs. A. F. 3315 Lincoln
Clouse, Mrs. Paul A. 2066 Bayard Park Dr.
Cockrum, Mrs. William M. 1414 Parkside Dr.
Cole, Mrs. W. L. 18 Johnson Place
Coleman, Mrs. Joseph E. 2831 Wayside Dr.
Combs, Mrs. Herman 915 S. Red Bank Rd.
Corcoran, Mrs. P. J. V. 2412 E. Chandler
Crawford, Mrs. James 631 Blue Ridge Dr. North
Crevello, Mrs. Albert J. 1664 Lincoln
Crimm, Mrs. Paul D. Boehne Hospital
Crudden, Mrs. Charles H. 2511 E. Powell
Cullnane, Mrs. Chris W. 3020 Mt. Vernon Rd.
Cymbala, Mrs. Bohden 1141 Bayard Pk. Dr.

D

Daves, Mrs. W. Lawrence 708 College Hwy.
Davidson, Mrs. Harold H. 800 Blue Ridge Rd.
Deems, Mrs. Myers 6830 Arcadian Highway
Denzer, Mrs. Edward K. 540 Scenic Dr.
Denzer, Mrs. W. O. 923 Bellemeade
Dieckman, Mrs. Herbert S. Johnson Place
Dodd, Mrs. R. K. 1705 S. New Green River Rd.
Drake, Mrs. Dale W. Little Schaefer Rd.
Dunham, Mrs. Howard 3215 Ridge Top Rd.
Dycus, Mrs. Walter A. 3400 Koring Rd.
Dyer, Mrs. Wallace K. 812 St. James Blvd.

E

Ehrich, Mrs. William S. 1500 S. Kentucky
Engel, Mrs. Edgar L. 1411 E. Park Dr.

F

Faith, Mrs. Ira L., Jr. 950 Blue Ridge Road
Faul, Mrs. Henry 725 S. Willow Rd.
Faw, Mrs. Melvin L. 3105 E. Oak Street
Fenneman, Mrs. Robert J. 1468 Bonnieview Ct.
Fisher, Mrs. William C. 1319 S. Kentucky
FitzGerald, Mrs. Maurice D. 924 Bayard Park Dr.
Fitzsimmons, Mrs. E. L. 500 S. Boeke Rd.
Fleming, Mrs. Thomas C. 5417 Stringtown Rd.

G

Garland, Mrs. E. A. 719 Plaza Dr.
Gaul, Mrs. L. Edward 508 S. Boeke Rd.
Getty, Mrs. William 1810 Mt. Auburn Road
Giorgio, Mrs. Douglas J. 916 S. Burkhart Road
Griep, Mrs. Arthur H. 5414 Madison Ave.
Guckien, Mrs. Joseph 2054 Bayard Park Dr.

H

Hammond, Mrs. R. Case.....6820 Arcadian Hwy.
Hare, Mrs. Daniel M.....2112 Lincoln
Harned, Mrs. Ben King, Jr.....8232 Maple Lane
Hart, Mrs. Paul L.....1436 Lincoln
Hawk, Mrs. Edgar A,..R. R. 3, Outer Lincoln Ave.
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Hoover, Mrs. Guy.....864 Lodge Ave.
Hovda, Mrs. Richard.....800 St. James Blvd.
Huggins,, Mrs. Victor.....520 S. Alvord Blvd.
Hyatt, Mrs. G. T.....1616 Mt. Auburn Rd.

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Johnson, Mrs. Stephen L.....2215 Lincoln Ave.
Johnson, Mrs. Victor.....1303 Masker Pk. Dr.
Karn, Mrs. William N.....4 Woodmere Dr.
Kessler, Mrs. R. B.....1200 Harrelton Ct.
Kiechle, Mrs. Fred.....726 S. E. First St.
Kincaid, Mrs. Robert S.....1000 N. Spring St.

L

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Leibundguth, Mrs. Henry.....5206 Lincoln Ave.
Leslie, Mrs. Ermil T.....3214 E. Mulberry St.
Logan, Mrs. J. R.....503 First Ave.
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M

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Mayberry, Mrs. Alton.....6125 Washington Ave.
McCool, Mrs. J. H.....6314 Old State Rd.
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Mehl, Mrs. Rudolph.....631 Blue Ridge Dr.
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Miller, Mrs. Minor.....701 S. Weinbach Ave.
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O

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Wilson, Mrs. David.....1709 S. E. Blvd.
Wilson, Mrs. Ralph.....1522 Audubon Dr.
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Bopp, Mrs. Henry W., Jr.....2237 Poplar
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Mattox, Mrs. Ernest.....240 Hamilton Dr.
Miklozek, Mrs. J. E.....2204 Ohio Blvd.
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Musselman, Mrs. Glenn.....7222 Wabash Avenue

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Buche, Mrs. Frederick P.....2408 S. "E" St.
Coble, Mrs. Frank.....Liberty Pike
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Cox, Mrs. Leon.....10 Clifton Rd.
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Guthrie, Mrs. James R.....636 S. 19th St.
Hagie, Mrs. Franklin.....Backmeyer Rd.
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Hoffman, Mrs. Curtis.....204 S. 21st St.
Hunt, Mrs. Gayle.....425 S. 19th St.
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Kime, Mrs. Charles E.....501 S. 19th St.
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Laird, Mrs. Leslie.....Richmond State Hospital
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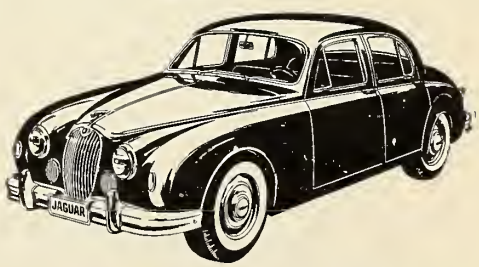
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Protestant Deaconess	Evansville	Miss Irma M. Bolte, R.N., Dir. of Nsg. Education	283.56
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Lutheran	Fort Wayne	Miss Marie E. Moehring, R.N.	289
Parkview-Methodist	Fort Wayne	Miss Marie Kolter, R.N.	235.53
St. Joseph's	Fort Wayne	Sister M. Theodorita, R.N.	248.5
Methodist	Gary	Mrs. Dorothy M. Damewood, R.N.	240
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410 N. Notre Dame Avenue, South Bend 22			
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St. John's Hospital	Anderson		253
St. Joseph Memorial	Kokomo		148
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Union	Terre Haute	Miss Prudence Appelman, R.N.	212
** Good Samaritan	Vincennes	Miss Grace A. Sease, R.N.	190.6
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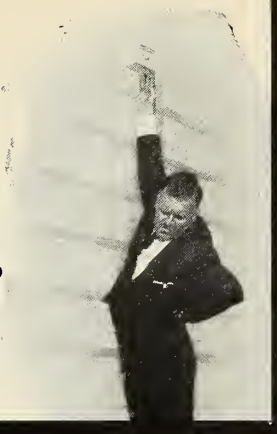
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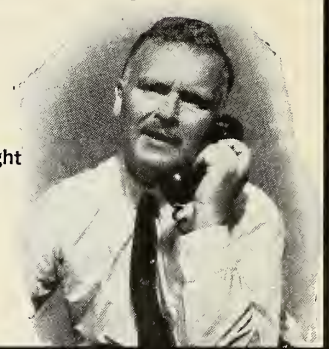
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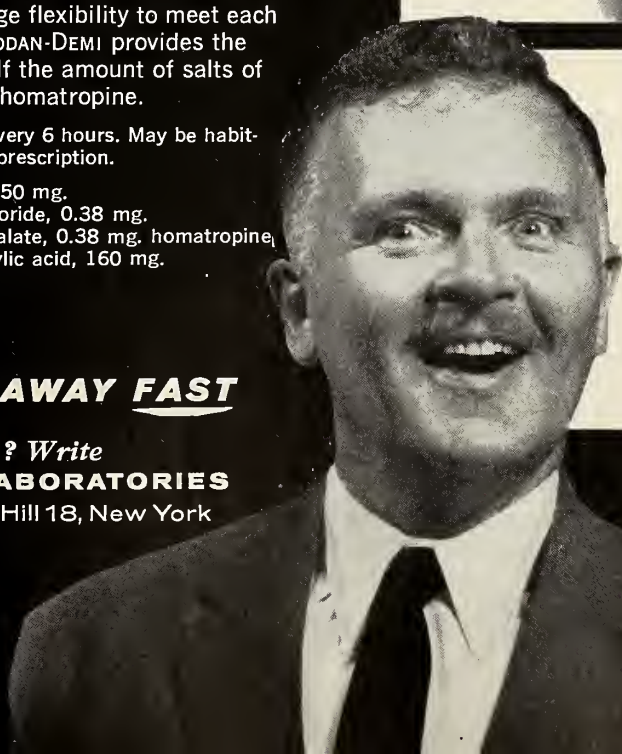
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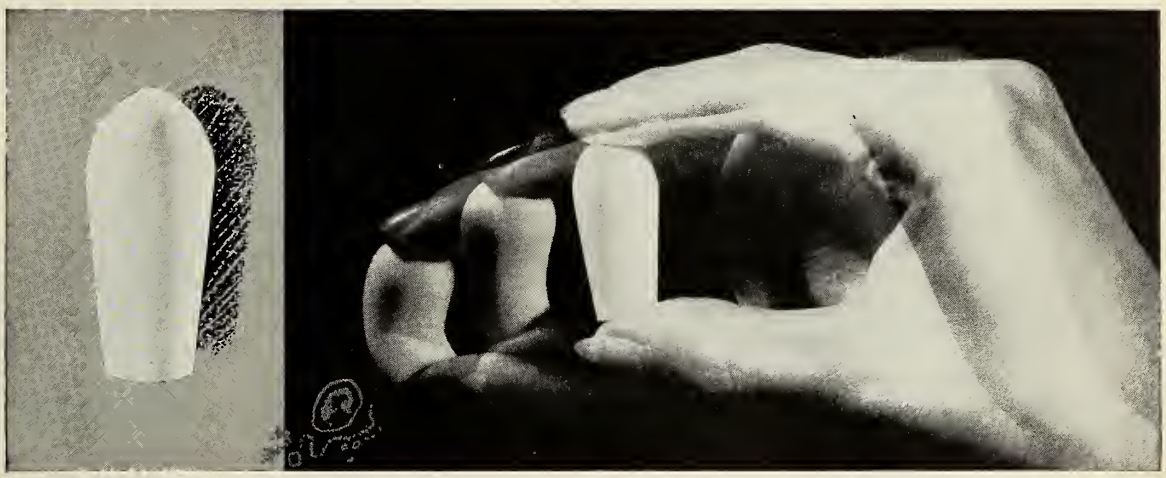
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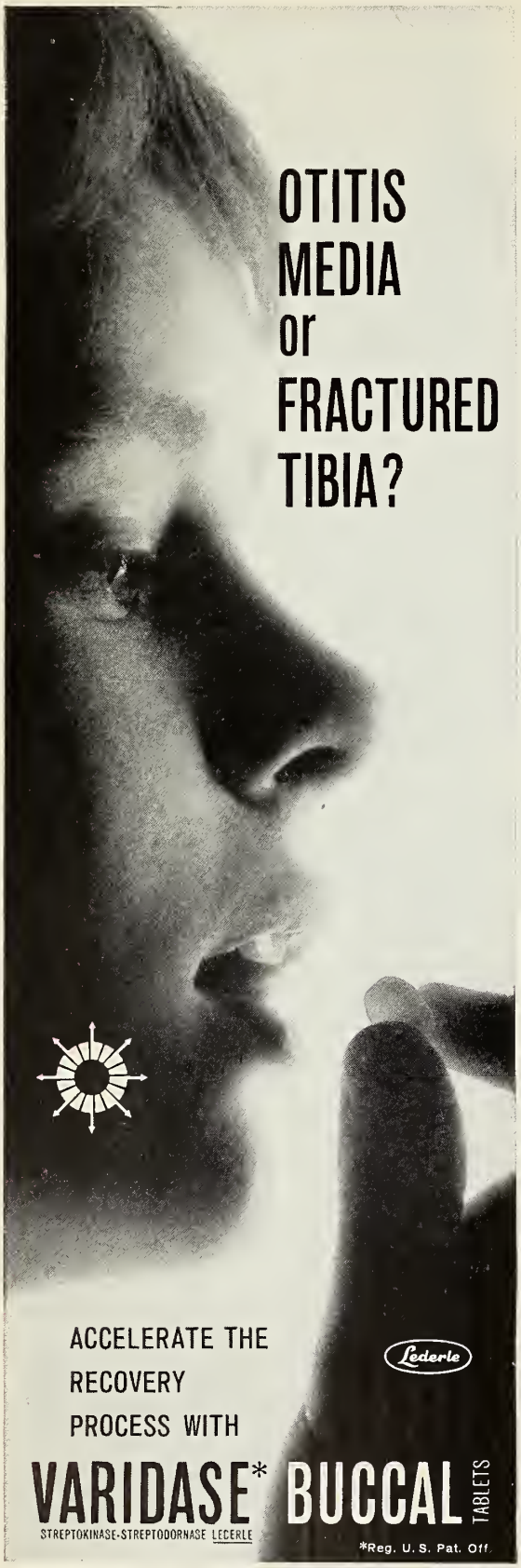
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Mrs. Mabel Brown, Adm.

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Mr. William B. Robinson, Adm.

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1101-1115 Michigan Ave., Logansport.
Howard R. Jones, Jr., Adm.

St. Joseph Hospital.
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Sister M. Geranda, Adm.

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Mr. William McAlexander, Adm.

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Mr. Karl J. Dickerson.

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Clinton County Hospital.
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William Russell, Adm.

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Mr. Lawrence Trousdale, Adm.

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Mr. James Mitchell, Adm.

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Bonnell M. Souder, M.D., Adm.

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Sister Mary James, Adm.

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Warren Hospital, Inc.
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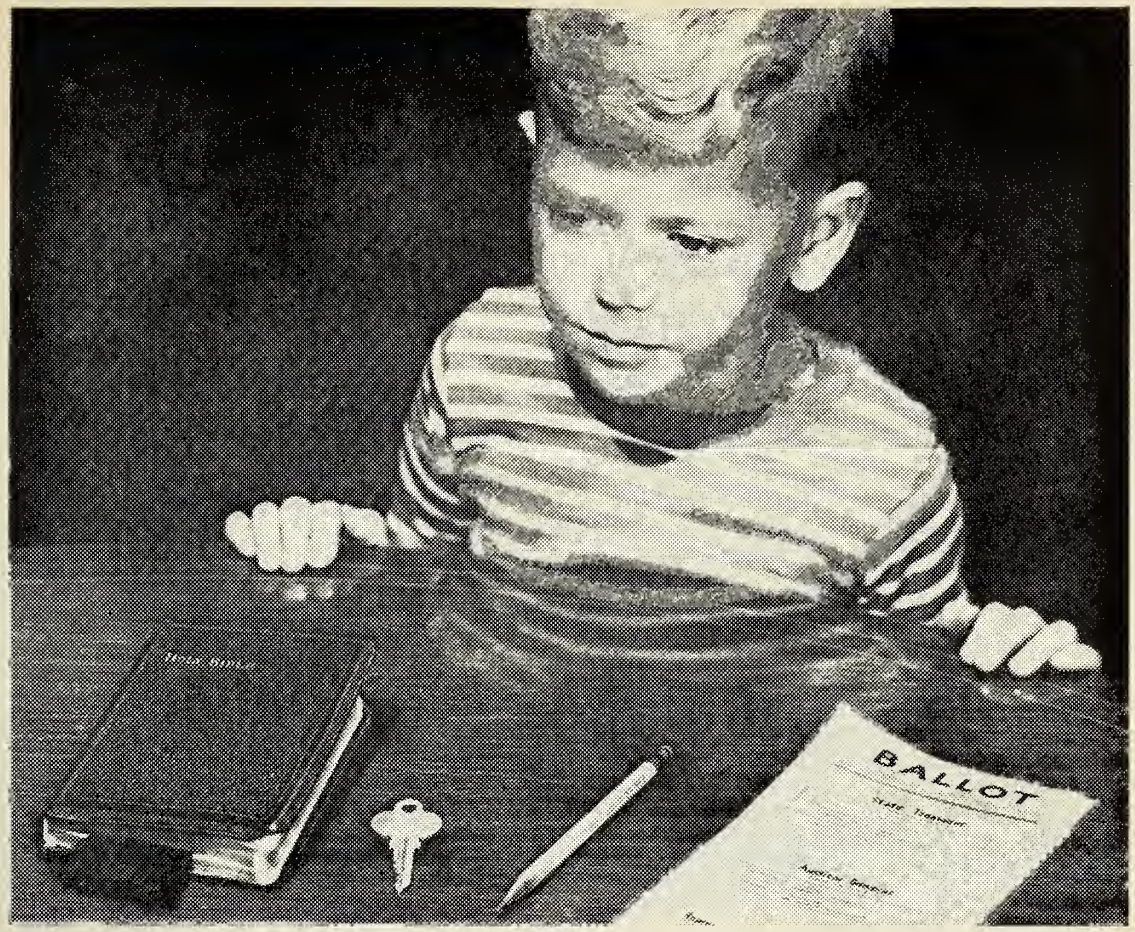
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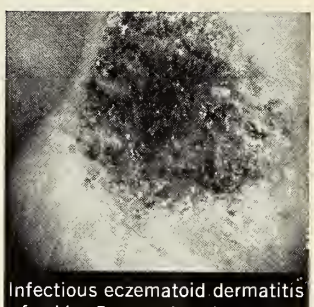
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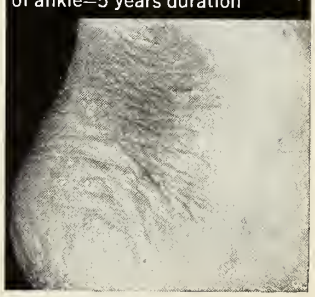
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References: 1. Shelmire, J.B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Oerbes, V.J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R.C.V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T.H.: Newcomer, V.D., and Reisner, R.M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: Monographs on Therapy, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr., Zawisza, R.J., and Blank, H.: Monographs on Therapy, 3:111 (Nov.) 1958. • 7. Monographs on Therapy, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: North Carolina M.J. 19:449 (Oct.) 1958. • 9. Bereston, E.S.: South. M.J. 50:547 (April) 1957.

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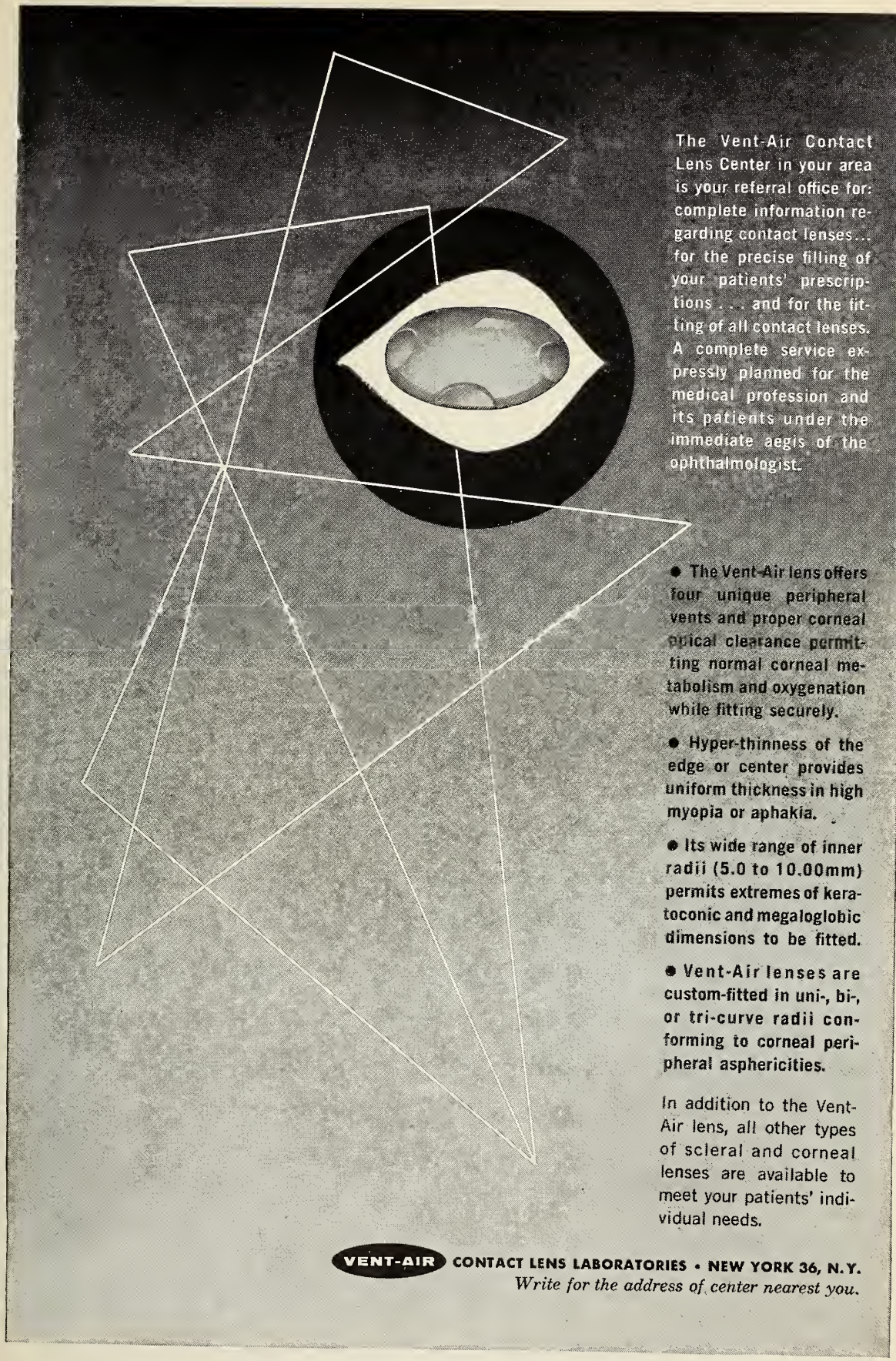
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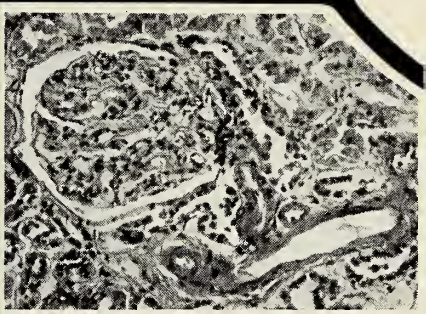


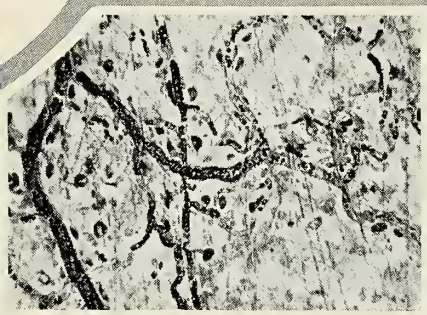
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References: 1. Moyer, J. H., and others: Am. J. Cardiol., 3:113 (Jan.) 1959. • 2. Bodi, T., and others: To be published, Am. J. Cardiol., (April) 1959. • 3. Fuchs, M., and others: Monographs on Therapy, 4:43 (April) 1959. • 4. Montero, A. C.; Rochelle, J. B., III, and Ford, R. V.: To be published. • 5. Rochelle, J. B., III; Montero, A. C., and Ford, R. V.: To be published.

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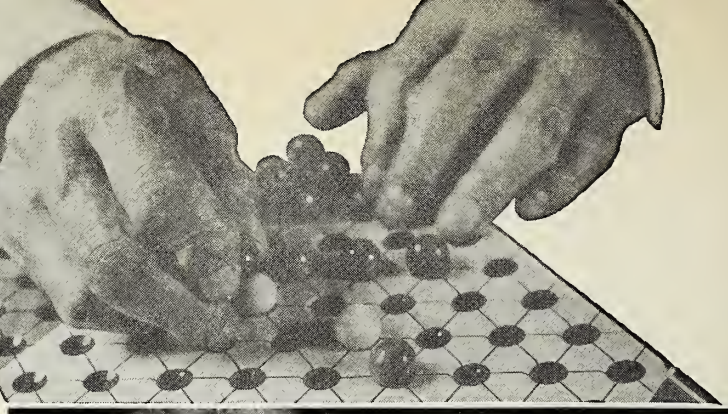
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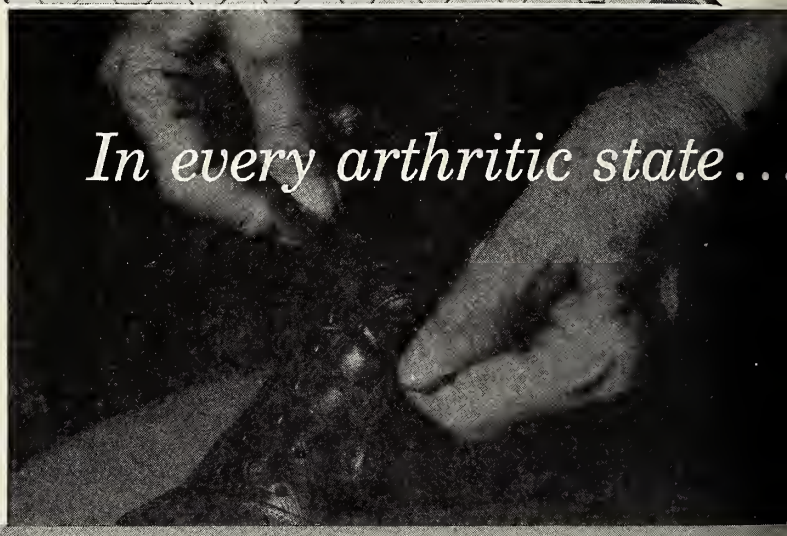
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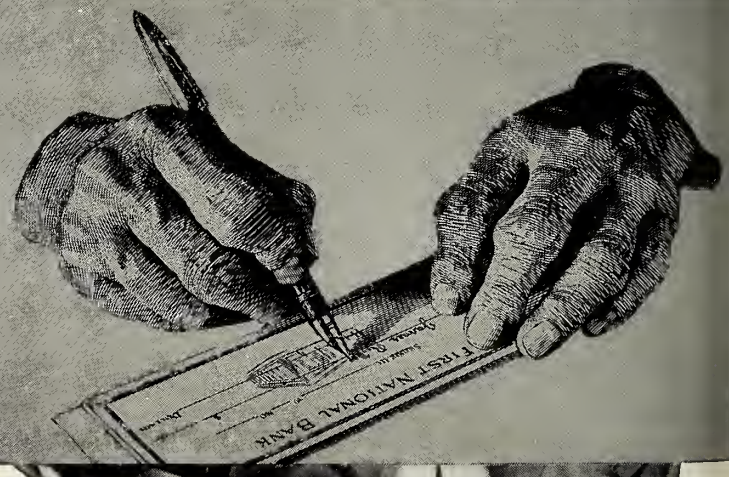
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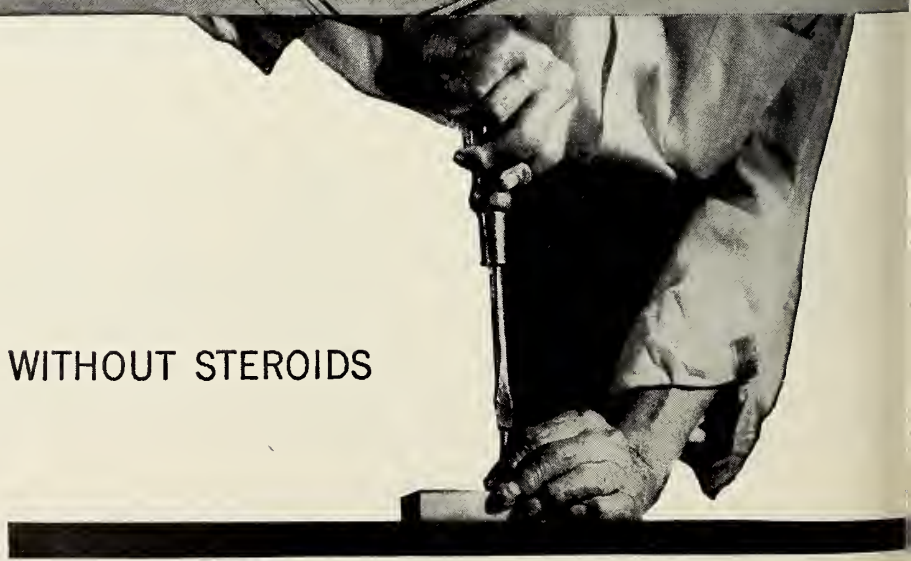
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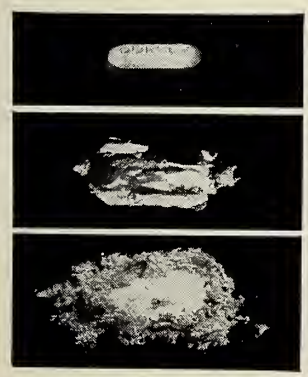
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Deaths of Indiana Physicians in 1958

(Compiled by James B. Maple, M.D., Necrologist)

(M) Member I.S.M.A.; (S) Senior Member; (R) Retired

Name	Age	Age Date of Death	Address	Cause of Death
Singleton, Dennis E.	75	Jan. 11	Marion	Bronchopneumonia, passive congestion of heart
Molt, William F. (S) (R)	82	Jan. 12	Indianapolis	Arteriosclerosis
Bitler, Clyde C. (M)	70	Jan. 14	New Castle	Cerebral hemorrhage. Hypertensive cardiovascular disease
Fritsch, Louis E. (S) (R)	78	Jan. 20	Evansville	Accidental burns
Kiser, Edgar F. (S) (R)	77	Jan. 23	Indianapolis	Coronary occlusion. Hypertensive heart disease
Rawlings, James V. (R)	99	Jan. 27	Indianapolis	Congestive heart failure. Bronchopneumonia
McArthur, Rutherford B.	73	Jan. 31	Indianapolis	Bronchopneumonia. Passive congestion of heart
Werner, George C.	30	Feb. 1	Indianapolis	Suffocation from bedding while unconscious from self administered trilene for sleep
Burroughs, Carroll A. (M) (R)	56	Feb. 9	Frankfort	Cerebral embolism. Ventricular tachycardia. Coronary thrombosis
Meek, Marquis L. (R)	101	Feb. 10	Abington	Arteriosclerotic heart disease
Gilkinson, Wm. L. (S) (R)	84	Feb. 11	Loogootee, R. #4	Coronary occlusion, thrombosis and generalized arteriosclerosis
Wilhelmus, William M. (S)	76	Feb. 13	Evansville, R.R.	Pneumonia
Winters, Matthew (M) (R)	67	Feb. 14	Bloomington	Cerebral hemorrhage. Generalized arteriosclerosis
Robertson, David W. (S)	96	Feb. 14	Deputy	Arterionephrosclerosis
Norby, Charles	78	Feb. 14	Rensselear	Bilateral bronchopneumonia
Geordano, Alfred S. (M)	65	Feb. 15	South Bend	Coronary thrombosis. Arteriosclerotic heart disease
Logan, Jesse R. (M)	57	Feb. 16	Evansville	Malignant brain tumor
Kramer, Albert A. (S)	78	Feb. 20	South Bend	Acute coronary occlusion. Arteriosclerotic heart disease
Alexander, Oliver O. (M)	70	Feb. 23	Terre Haute	Cerebral thrombosis. Generalized arteriosclerosis
Arnold, Marion F., Jr. (M)	40	Feb. 27	New Palestine	Cerebral hemorrhage. Malignant hypertension
Turner, Robert D. (M)	54	Feb. 28	Muncie	Hypertensive cardiovascular disease
Wilkins, Robert W. (M)	56	Mar. 8	Ft. Wayne	Coronary occlusion. Arteriosclerotic heart disease
Loop, Floyd A. (S)	81	Mar. 10	Lafayette	Arteriosclerotic heart disease. Generalized arteriosclerosis
Titus, Charles R. (S)	88	Mar. 11	Wilkinson	Cerebral thrombosis. Generalized arteriosclerosis
Jinks, Clifford H. (M)	61	Mar. 14	Indianapolis	Glioblastoma multiforme. Carcinoma of brain
Lynn, Frank M. (S)	88	Mar. 17	Peru	Cardiovascular renal disease
Ramsey, George (R)	89	Mar. 19	Richmond	Arteriosclerotic heart disease. Thrombosis left leg. Gastric ulcer
Tallman, Ralph L.	59	Mar. 20	Hammond	Coronary thrombosis
Asbury, Wm. D. (S) (R)	83	Mar. 29	Terre Haute	Auto accident
Byrne, John M. (M)	42	Mar. 31	Delphi	Auto accident
Munk, Cleorie E. (M)	73	Apr. 4	Kendallville	Coronary sclerosis. Generalized arteriosclerosis
Harris, C. N.	83	Apr. 6	Indianapolis	Cerebral thrombosis. Cerebral arteriosclerosis

Name	Age	Age Date of Death	Address	Cause of Death
Miller, William T. (R)	65	Apr. 9	Indianapolis	Congestive heart failure. Generalized arteriosclerosis
Kuhn, Hugh A. (M)	62	Apr. 17	Hammond	Coronary occlusion
Bruggeman, Henry O. (S)	77	Apr. 17	Ft. Wayne	Coronary occlusion
Daniels, Erle O. (S) (R)	76	Apr. 17	Marion	Cerebral thrombosis. Hypostatic pneumonia
Galbreath, Russell S. (M)	70	Apr. 20	Huntington	Abdominal cancer
Lansford, John (M)	64	Apr. 20	Redkey	Myocardial infarction
Garner, William H. (S)	83	Apr. 22	Indianapolis	Coronary infarction
Cochran, Ralph B.	52	Apr. 26	Washington	Congestive heart failure following fall off house
Hall, Emory H. (M)	58	Apr. 28	Dunkirk	Acute coronary occlusion. Coronary arteriosclerosis
Bowles, John H.	59	May 3	Muncie	Fracture of spine in a fall
Gilliott, James P. (M)	57	May 7	Salem	Hepatic coma. Metastatic carcinoma liver. Bronchogenic carcinoma
Baxter, James W., Jr. (M)	52	May 7	New Albany	Self inflicted gunshot wound
Bradfield, John C. (S) (R)	79	May 9	Logansport	Chronic myocarditis
Eifert, Elmer E. (M)	73	May 13	Alfordsville	Pernicious anemia
Damiana, P. G. (M)	58	May 19	Peru	Coronary infarction
Scott, Garland D. (M)	74	May 22	Sullivan	Cerebrovascular accident. Osteoporosis of spine
Adkins, Onan C. (S) (R)	81	May 22	Indianapolis	Arteriosclerotic heart disease
Johnson, Frank D. (M) (R)	48	June 2	Waynetown	Acute cor pulmonale, emphysema
Cook, Elbert C. (R)	81	June 5	Madison	Coronary occlusion
Gage, James W.	76	June 7	Indianapolis	Pneumonia. Hypertensive heart disease
Harmon, Vachelle E. (M)	72	June 8	South Bend	Coronary occlusion
Krueger, Frederick W. (S)	79	June 15	Richmond	Acute myocardial infarction. Arteriosclerotic heart disease
Bond, Charles S. (S) (R)	102	June 16	Richmond	Arteriosclerotic heart disease and gangrene of left foot
MacDonald, John A. (S) (R)	91	June 17	Indianapolis	Dissecting aneurysm of abdominal aorta
Leedy, Gladys June (M)	39	June 30	Indianapolis	Acute barbiturate intoxication
Ballard, Robert J.	42	July 9	Michigan City	Auto train accident
Moore, Ben B. (M)	62	July 13	Indianapolis	Acute coronary occlusion
Swank, L. Forrest (M) (R)	60	July 16	Elkhart	Coronary occlusion
O'Dell, Harry C. (M)	73	July 18	Farmersburg	Myocardial infarction. Arteriosclerotic coronary thrombosis
Nickel, Allen C. (M)	63	July 31	Bluffton	Pulmonary embolism, thrombus illiac vein
Fallin, Ladislaus (M)	62	Aug. 17	South Bend	Cerebral hemorrhage
Kolettis, George J. (M)	64	Aug. 27	Gary	Acute posterior myocardial infarction. Acute coronary occlusion
Long, William H. (S)	76	Sept. 4	Indianapolis	Cerebrovascular thrombosis
Terflinger, Fred W. (S) (R)	84	Sept. 5	Logansport	Coronary thrombosis. Arteriosclerotic heart disease
Groves, John W. (M)	57	Sept. 6	Indianapolis	Coronary thrombosis. Arteriosclerotic heart disease
Smith, Wilbur F. (M)	68	Sept. 10	Indianapolis	Bleeding duodenal ulcer
Cornell, Beaumont S. (M)	66	Sept. 16	Huntington	Acute coronary occlusion
Niles, Edward H.	76	Sept. 23	Indianapolis	Metastatic carcinoma of the bile duct
Jewett, Earl B. (S)	78	Sept. 25	St. Paul	Coronary occlusion. Arteriosclerosis
Stayton, Chester A., Sr. (M)	69	Oct. 8	Indianapolis	Cerebral hemorrhage
Coulson, Sewell B. (S)	80	Oct. 22	Waldron	Coronary occlusion

Name	Age	Date of Death	Address	Cause of Death
Reitz, Thomas F. (M)	62	Oct. 24	Evansville	Intestinal occlusion, carcinoma ceacum
Younkin, J. Noble	83	Oct. 26	Chesterfield	Cardio nephritis. Cerebral accident
Forsyth, David H. (S)	81	Oct. 28	Terre Haute	Cerebral hemorrhage. Cerebral arteriosclerosis
Tindel, Edward F. (S)	89	Oct. 28	Muncie	Renal insufficiency. Generalized arteriosclerosis
Shortridge, Wilbur H. (M)	52	Oct. 28	Seymour	Coronary occlusion. Generalized arteriosclerosis
Langsdon, Fred R. (M)	65	Nov. 2	Gaston	Emphysema, advanced bilateral
Bondoc, Jose M.	40	Nov. 3	Richmond	Convulsive seizures, hypoglycemia, etiology of both undetermined
Yarling, John E. (S)	89	Nov. 8	Peru	Coronary thrombosis. Cardiovascular disease. Diabetes mellitus
DuPuy, Charles M. (S)	91	Nov. 18	Riley	Coronary occlusion
Fox, Maurice S. (M)	57	Nov. 21	Vincennes	Coronary thrombosis
Freeman, Floyd M. (S)	75	Nov. 24	Goshen	Coronary thrombosis
Henning, Carl (S)	79	Nov. 24	Hanover	Myocardial infarction, Coronary arteriosclerosis
Foreman, Harry L. (S)	75	Dec. 3	Indianapolis	Coronary thrombosis
Noble, Thomas B. (M)	62	Dec. 9	Indianapolis	Coronary occlusion
Smith, Lester A. (M)	68	Dec. 15	Indianapolis	Carcinoma of the throat
Carlisle, Patrick G.	80	Dec. 27	Connersville	Pneumonia following a fall
Beasley, Thomas J. (S)	78	Dec. 30	Indianapolis	Ventricular fibrillation. Coronary artery disease
Linton, Charles D. (M)	54	Dec. 30	Walkerton	Coronary occlusion

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Medical Convention	Elected	Served
*Livingston Dunlap, Indianapolis	1849	1849
Medical Society		
*William T. S. Cornett, Versailles	1849	1850
*Ashahel Clapp, New Albany	1850	1851
*George W. Mears, Indianapolis	1851	1852
*Jeremiah H. Brower, Lawrenceburg	1852	1853
*Elizur H. Deming, Lafayette	1853	1854
*Madison J. Bray, Evansville	1854	1855
*William Lomax, Marion	1855	1856
*Daniel Meeker, LaPorte	1856	1857
*Talbot Bullard, Indianapolis	1857	1858
*Nathan Johnson, Cambridge City	1858	1859
*David Hutchinson, Mooresville	1859	1860
*Benjamin S. Woodworth, Ft. Wayne	1860	1861
*Theophilus Parvin, Indianapolis	1861	1862
*James F. Hibberd, Richmond	1862	1863
*John Sloan, New Albany	1863	----
*John Moffet (acting), Rushville	1863	1864
*Samuel L. Linton, Columbus	1864	----
*Wilson Lockhart (acting), Danville	1864	1865
*Myron H. Harding, Lawrenceburg	1865	1866
*Vierling Kersey, Richmond	1866	1867
*John S. Bobbs, Indianapolis	1867	1868
*Nathaniel Field, Jeffersonville	1868	1869
*George Sutton, Aurora	1869	1870
*Robert N. Todd, Indianapolis	1870	1871
*Henry P. Ayres, Ft. Wayne	1871	1872
*Joel Pennington, Milton	1872	1873
*Isaac Casselberry, Evansville	1873	----
*Wilson Hobbs (acting), Knightstown	1873	1874
*Richard E. Houghton, Richmond	1874	1875
*John H. Helm, Peru	1875	1876
*Samuel S. Boyd, Dublin	1876	1877
*Luther D. Waterman, Indianapolis	1877	1878
*Louis Humphreys, South Bend	1878	----
*Benj. Newland (acting), Bedford (v.p.)	1878	1879
*Jacob R. Weist, Richmond	1879	1880
*Thomas B. Harvey, Indianapolis	1880	1881
*Marshall Sexton, Rushville	1881	1882
*William H. Bell, Logansport	1882	1883
*Samuel E. Mumford, Princeton	1883	1884
*James H. Woodburn, Indianapolis	1884	1885
*James S. Gregg, Ft. Wayne	1885	1886
*General W. H. Kemper, Muncie	1886	1887
*Samuel H. Charlton, Seymour	1887	1888
*William H. Wishard, Indianapolis	1888	1889
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*Gonsolvo C. Smythe, Greencastle	1890	1891
*Edwin Walker, Evansville	1891	1892
*George F. Beasley, Lafayette	1892	1893
*Charles A. Daugherty, South Bend	1893	1894
*Elijah S. Elder, Indianapolis	1894	----
*Charles S. Bond (acting), Richmond	1894	1895
*Miles F. Porter, Ft. Wayne	1895	1896
*James H. Ford, Wabash	1896	1897
*William N. Wishard, Indianapolis	1897	1898
*John C. Sexton, Rushville	1898	1899
*Walker Schell, Terre Haute	1899	1900
*George W. McCaskey, Ft. Wayne	1900	1901

Medical Association	Elected	Served
*Alembert W. Brayton, Indianapolis	1901	1902
*John B. Berteling, South Bend	1902	1903
*Jonas Stewart, Anderson	1903	1904
*George T. MacCoy, Columbus	1904	1905
*George H. Grant, Richmond	1905	1906
*George J. Cook, Indianapolis	1906	1907
*David C. Peyton, Jeffersonville	1907	1908
*George D. Kahlo, French Lick	1908	1909
*Thomas C. Kennedy, Shelbyville	1909	1910
*Frederick C. Heath, Indianapolis	1910	1911
*William F. Howat, Hammond	1911	1912
*A. C. Kimberlin, Indianapolis	1912	1913
*John P. Salb, Jasper	1913	1914
*Frank B. Wynn, Indianapolis	1914	1915
*George F. Keiper, Lafayette	1915	1916
*John H. Oliver, Indianapolis	1916	1917
*Joseph Rilus Eastman, Indianapolis	1917	1918
*William H. Stemm, North Vernon	1918	1919
*Charles H. McCully, Logansport	1919	1920
*David Ross, Indianapolis	1920	1921
*William R. Davidson, Evansville	1921	1922
*Charles H. Good, Huntington	1922	1923
*Samuel E. Earp, Indianapolis	1923	1924
*Eldridge M. Shanklin, Hammond	1924	1925
Charles N. Combs, Terre Haute	1925	1926
*Frank W. Cregor, Indianapolis	1926	1927
George R. Daniels, Marion	1926	1928
*Charles E. Gillespie, Seymour	1927	1929
*Angus C. McDonald, Warsaw	1928	1930
*Alois B. Graham, Indianapolis	1929	1931
Franklin S. Crockett, Lafayette	1930	1932
*Joseph H. Weinstein, Terre Haute	1931	1932
*Everett E. Padgett, Indianapolis	1932	1934
*Walter J. Leach, New Albany	1933	1935
Roscoe L. Sensenich, South Bend	1934	1936
*Edmund D. Clark, Indianapolis	1935	1937
Herman M. Baker, Evansville	1936	1938
*Edmund M. Van Buskirk, Ft. Wayne	1937	1939
Karl R. Ruddell, Indianapolis	1938	1940
*Albert M. Mitchell, Terre Haute	1939	1941
Maynard A. Austin, Anderson	1940	1942
Carl H. McCaskey, Indianapolis	1941	1943
*Jacob T. Oliphant, Farmersburg	1942	1944
*Neslen K. Forster, Hammond	1943	1945
*Jesse E. Ferrell, Fortville	1944	1946
*Floyd T. Romberger, Lafayette	1945	1947
Cleon A. Nafe, Indianapolis	1946	1948
Augustus P. Hauss, New Albany	1947	1949
*C. S. Black, Warren	1948	1950
Alfred Ellison, South Bend	1949	1951
*J. William Wright, Indianapolis	1950	1952
Paul D. Crimm, Evansville	1951	1953
Wm. Harry Howard, Hammond	1952	1954
Walter L. Portteus, Franklin	1953	1955
Walter U. Kennedy, New Castle	1954	1956
Elton R. Clarke, Kokomo	1955	1957
M. C. Topping, Terre Haute	1956	1958
Kenneth L. Olson, South Bend	1957	1959

* **Deceased.**

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Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy
64% of 42 pregnancies were salvaged by progesterone
83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.
108 (76%) of 142 babies of this birth weight survived without progestational therapy.
16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.
A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

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References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

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Constitution and Bylaws of the Indiana State Medical Association

CONSTITUTION

ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

ARTICLE II.—PURPOSES OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

Section 1.—This Association shall consist of Active Members, Associate Members, Senior Members and Honorary Members.

Sec. 2.—*Active Members.*—The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the Indiana State Medical Association.

Sec. 3.—*Associate Members.*—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

Sec. 4.—*Senior Members.*—Senior members shall be physicians of the State of Indiana who have attained the age of seventy years and have held membership in the Indiana State Medical Association for twenty years or more, and who, upon their application, have been certified to the executive secretary as eligible for such membership by the county societies of which they are members. Eligibility to senior status shall begin the year after the member reaches the age of seventy.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members.

Sec. 5.—*Honorary Members.*—Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Sec. 6.—*Rights and Privileges of Members.*—Active members and senior members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

c. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold office. They shall not be required to pay membership dues in the State Association.

ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be *ex officio* members: the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

ARTICLE VI.—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, and Treasurer with power to vote. Besides its duties mentioned in the Bylaws, it shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the Bylaws, and at all times

shall be the finance committee of the Association. Seven Councilors shall constitute a quorum.

ARTICLE VII.—SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Councilor districts shall be defined by the House of Delegates.

ARTICLE VIII.—CONVENTION AND MEETINGS

Section 1.—The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Sec. 2.—The House of Delegates shall select the place two years in advance for holding the annual convention. The time for the convention shall be fixed by the Council, and the Council shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Sec. 3.—Special meetings of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members.

ARTICLE IX.—OFFICERS

Section 1.—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

Sec. 2.—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. No Councilor shall be eligible to serve longer than two consecutive three-year terms, effective with the beginning of his next election following the adoption of this amendment.

All of these officers shall serve until their successors are elected and installed. Provided, that if any elected Councilor fails, without reason acceptable to the Council, in any one calendar year to attend a majority of the meetings of the Council, he shall thereby cease to be a Councilor, and the Executive Secretary shall thereupon take action in accordance with Section 4 of this article.

Sec. 3.—The officers of this Association with the exception of the Executive Secretary shall be elected by the House of Delegates as the first order of business of the last day of the Annual Convention, and no person shall be elected to any such office who is not in attendance on that Annual Convention and who has not been a member of the Association for the preceding two years.

Sec. 4.—The Councilors shall be elected by the respective district societies. If any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Sec. 5.—Each Councilor district shall elect an alternate Councilor whose term of office shall be the same as the Councilor, namely three years. The alternate Councilor shall be elected in a year during which there is no Councilor elected.

The duties of the alternate Councilor shall be:

1. To represent the Councilor district in the absence of the regularly elected Councilor.
2. To vote only in the absence of the regularly elected Councilor either in the House of Delegates or in Council meetings where he represents the regularly elected Councilor.
3. The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present.

Sec. 6.—Any officer may be removed from office after a hearing before the Council, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Council.

Sec. 7.—In event of the death, resignation, removal, or disability of the President, the President-elect shall succeed to the presidency. In the event of the death, disability, resignation or removal of both the President and the President-elect, the chairman of the Council shall become President pro tem and as such shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-elect shall be elected, both of whom shall take office immediately upon their election.

Sec. 8.—A vacancy in the office of Treasurer shall be filled by an election by the Councilors at the next regular meeting of the Council following the occurrence of such vacancy.

Sec. 9.—In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any district councilor, the duly elected alternate councilor from the same district shall succeed to the office of councilor in that district for the unexpired term of said councilor.

In the event vacancies occur in any councilor district in the offices of both councilor and alternate councilor, the vacancies shall be filled by an election by the members of the association within the councilor district in which such vacancies occur. A call for such elections shall be issued by the executive secretary of the State Association following conference with the officers of the district organization. The call shall state the time and place of holding the election and shall be sent reg-

istered mail to the county secretary as filed in the State secretary's office of each component society within the district. Such call shall be mailed within ten days after the State secretary has learned of the vacancies. The election may be held at a special or regular meeting in which other business than the election may be transacted. Such election shall be held within fifteen days after the secretary of the State Association shall have mailed such call.

Sec. 10.—None of the officers shall receive compensation except the Executive Secretary, who shall be employed by the Council, and the Council shall fill any vacancy in that office.

ARTICLE X.—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

ARTICLE XI.—INCOME AND EXPENSES

Funds for carrying on the activities of this Association shall be raised by the following means:

a. Membership dues to be collected by the component county societies in connection with the dues for such component societies. The amount of the dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

b. Voluntary contributions.

c. Revenues derived from the Association's publications.

d. Any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.

ARTICLE XII.—REFERENDUM

Section 1.—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all the members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2.—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII.—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XIV.—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association.

BY-LAWS

CHAPTER I.—MEMBERSHIP

Section 1.—The term "Member" as used in these Bylaws unless otherwise indicated shall mean both active and senior members of component county medical societies who hold either the Degree of Doctor of Medicine or Bachelor of Medicine.

Sec. 2.—Any physician who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Sec. 3.—No person who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Sec. 4.—Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

CHAPTER II.—GENERAL MEETINGS

Section 1.—General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President may be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Committee on Scientific Work, with the sanction and approval of the officers.

Sec. 2.—The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific

investigation of special interest and importance to the profession and public.

Sec. 3.—All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Secretary when read.

Sec. 4.—The Council shall appropriate from the funds of the Association for such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Committee on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the Association.

CHAPTER III.—SECTIONS

Section 1.—During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

a. Surgical.
b. Medical.
c. Eye, Ear, Nose, and Throat.
d. Anesthesia.
e. General Practice.
f. Obstetrics and Gynecology.
g. Preventive Medicine and Public Health.
h. Radiology.
i. Any other sections that hereafter may be provided for by the House of Delegates.

Sec. 2.—The officers of each section shall be a Chairman, a Vice-Chairman, and a Secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Sec. 3.—The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Sec. 4.—No section meeting shall be allowed to conflict with a general meeting.

CHAPTER IV.—HOUSE OF DELEGATES

Section 1.—The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General or Section Meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program.

Sec. 2.—Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and Bylaws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who shall be selected by the physicians residing in such county.

The number of Delegates to which each Component Society is entitled shall be based upon the number of members on record in the office of the Executive Secretary in good standing with current dues fully paid as of December 31 of the preceding year.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association annually on or before December first prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credentials as a delegate or alternate, properly signed by the secretary of his county society, be presented to the Committee on Credentials at the time of the Annual Convention.

Sec. 3.—Fifty delegates shall constitute a quorum.

Sec. 4.—The House of Delegates shall:

a. Elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

b. Divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

c. Have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

d. Approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 5. — Funds may be appropriated by the House of Delegates, subject to approval by the Council, for such purposes as will promote the welfare of the Association and the profession.

Sec. 6.—At the first meeting the President shall announce the membership of the reference committees, as hereinafter provided for, and any other

committees considered by him necessary to expedite the business of the Association.

Sec. 7.—All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Secretary of the Association so that he will receive them not later than forty-five days prior to the meeting of the House of Delegates to which the resolutions will be presented for action.

Provided, that this sub-section of the Bylaws may be suspended with respect to any resolution upon a two-thirds majority vote of the House of Delegates.

CHAPTER V.—ELECTION OF OFFICERS

Section 1.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

Sec. 2.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Sec. 3.—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years.

Sec. 4.—The President, President-elect, and the Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect and Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

CHAPTER VI.—DUTIES OF OFFICERS

Section 1.—The President, or a member designated by him, shall preside at all general meetings of the Association and of the House of Delegates. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2.—The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties.

Sec. 3.—The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Council. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the Chairman of the Council. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

Sec. 4.—The Executive Secretary shall be the directing manager of the Association's headquarters and Journal offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Council, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.

Sec. 5.—The necessary expenses of the above officers incurred in the line of duty herein imposed may be allowed by the Council, but excepting the Executive Secretary, this shall not include the expenses of attending the Annual Convention.

CHAPTER VII.—COUNCIL

Section 1.—The Council shall meet as follows: 1. January, April, and July of each year on dates and at places fixed by the Council. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the Chairman, or on petition of three Councilors. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a Chairman, and a Clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates. It shall organize itself at the meeting following the final session of the House of Delegates by electing its chairman who shall serve for one year. The chairman of the Council shall be elected by secret ballot. The number of terms of the chairman shall be limited to not more than three in succession.

Terms of councilors shall begin with the first meeting of the Council following the final session of the House of Delegates at the Annual Session.

Sec. 2. — Each Councilor shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the Council on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

Sec. 3.—The Council shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

Sec. 4.—The Council shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Sec. 5.—The Council shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Sec. 6.—The Council shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 7.—The Council shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and Bylaws.

Sec. 8.—In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 9.—The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Sec. 10.—The Council shall provide for and superintend all publications of the Association, and shall have authority to appoint an editor and such assistants as it deems necessary, and fix the amounts of their salaries. The proceedings of the Council for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediately precedes the Annual Convention.

Sec. 11.—In the interim between the meetings of this Association the Council shall be the executive body of the Association with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require.

Sec. 12.—The Council shall at its meeting following the close of the House of Delegates elect two members of the Association, at large, or of the Council, who, with the President, the President-elect, the Treasurer, and the Chairman of the Council, shall constitute and be known as the Executive Committee. If such members of the Executive Committee be not members of the Council they shall not have the power of vote in the Council.

CHAPTER VIII.—ORGANIZATION OF ACTIVITIES AND RESPONSIBILITIES

Section 1.—The work of the Association, the performance of which is not provided for elsewhere in the Constitution or Bylaws, and is not carried on in the meetings of the Council or of the House of Delegates, or by Special Committees created by the Executive Committee, the Council, or the House of Delegates, shall be performed by the following standing committees and commissions:

The Executive Committee
The Grievance Committee
The Student Loan Committee
The Medical-Legal Review Committee
The Commission on Convention Arrangements
The Commission on Constitution and Bylaws
The Commission on Legislation
The Commission on Public Information

The Commission on Govermental Medical Services
The Commission on Public Health
The Commission on Voluntary Health Agencies
The Commission on Medical Economics and Insurance
The Commission on Inter-Professional Relations
The Commission on Medical Education and Licensure
The Commission on Special Activities

The difference between committees and commissions is shown in the provision of these Bylaws pertaining to their work and composition.

Sec. 2.—Unless otherwise provided in these Bylaws, the committees shall be appointed by the President with the chairman of each committee designated by him, and the number constituting each committee shall be as indicated in the section of these Bylaws pertaining to each particular committee.

Sec. 3.—Each commission will consist of fifteen members appointed by the President, with at least one member from each councilor district. The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming president shall appoint five members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise.

Sec. 4.—The President shall have the power, with the approval of the Council, to remove any member of any committee or commission where such member, for any reason, does not or cannot work at attempting to perform the duties pertaining to membership on such committee or commission.

Sec. 5.—Unless otherwise provided in these Bylaws, no member of either a committee or a commission shall serve on the same committee or commission more than two consecutive terms, but this shall not prevent him serving more than two terms if the term of another member intervenes. The time given to the serving of an unexpired term shall not be considered in determining the period within which a member may serve consecutively.

Sec. 6.—Within sixty days after the meeting of the State Convention, the President will call all commissions and committees into a joint meeting in which he will give a statement of the duties and responsibilities of all committees and commissions, call special attention to any immediate problems confronting the Association, and assign such problems or parts thereof to appropriate committees and commissions. Then this joint meeting will divide into meetings of the separate commissions, at which time the commissions and committees will organize by the election of chairman, vice-chairman and secretary, unless otherwise provided for in these Bylaws. In these meetings the commissions may provide for such subcommittees within the separate commissions as they may deem advisable. Each committee or commission shall have the right to call upon other committees, commissions or members of the profession for counsel and advice with respect to its work.

Sec. 7.—Each committee and commission shall have the privilege and is encouraged to have joint meetings with any like committee or commission of the Auxiliary where such like committee or commission exists, for the purpose of coordinating their activities to make them more effective in the medical service of the public and the intent of the Association.

Sec. 8.—Each committee and commission shall have the duty and responsibility of keeping constantly and currently informed on the matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities of improvement; of finding the best solutions it can to the specific problems referred to it; of contributing in its area to the achievements of the Association as a whole in the protection and improvement of the health of the whole human family; and finally of making all its efforts useful by passing on to the Association in the most effective manner possible the results of its studies and activities in its own area of special interests.

Sec. 9.—The President and Executive Secretary shall be ex officio members of all the foregoing committees and commissions without voting rights where their inclusion on the committee or commission is not otherwise provided for in these Bylaws.

CHAPTER IX.—THE EXECUTIVE COMMITTEE.

Section 1.—The Executive Committee, constituted as provided in Section 12 of Chapter VII of these Bylaws, shall hold its first meeting immediately following the meeting of the Council held at the close of the last meeting of the House of Delegates in the annual convention, and shall organize by electing its chairman. Its secretary shall be the Executive Secretary of the Association. It shall meet with the Executive Secretary on the call of the Chairman, or of any three members, to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office. It shall have all jurisdiction with respect to medical defense activities of the Association and shall be governed by the rules it adopts concerning that activity and by the Bylaws of this Association. It shall make decisions for the Association, including matters pertaining to THE JOURNAL, during the intervals between the meetings of the Council, and shall report its actions to the Council.

Sec. 8.—It shall prepare a budget for the ensuing calendar year; and all expenditures of the Association, except those otherwise provided for under the Constitution and Bylaws, shall be gov-

erned by the budget. No expense not provided for in the budget or otherwise under the Constitution and Bylaws shall be incurred by any officer, commission or committee. A committee, commission or officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

CHAPTER X.—THE GRIEVANCE COMMITTEE.

Section 1.—The Grievance Committee shall be composed of nine physicians, three of whom may be past presidents of the Association, and all of whom shall be appointed by the President. Not more than two physicians shall be appointed from any one councilor district. No member shall hold any elective office in the State Association during tenure on this committee. Of the nine physicians first appointed, three shall serve for a period of one year; three for two years; and three for three years. Thereafter, three shall be appointed each year for a three-year term to fill the vacancies caused by the expiration of terms. Any vacancy occurring in this committee, other than by expiration of term, shall be filled by an interim appointee to serve the balance of the unexpired term. This committee shall organize itself by electing a chairman, a vice-chairman and a secretary.

Sec. 2.—This provision regarding the constitution of the Grievance committee shall be construed to mean that the present committee of that name is continued in that position with the terms of its members expiring and new members to be appointed on the basis of this provision being operative and effective as of the dates of their respective original appointments; and it is not to be construed as having the effect of creating a new committee, all of whose members are to be appointed upon this amendment being adopted and becoming effective.

Sec. 3.—In addition to the above provided organization and membership of the committee, the President of the Association shall appoint an accredited psychiatrist as a consultant for the committee, whose tenure of office shall be on an annual basis. The appointment of the psychiatrist may be made from any councilor district of the Association, irrespective of the membership of the committee including another member or members from the same councilor district. He shall have the same rights and privileges as other members of the committee except that he shall not have the right to vote.

Sec. 4.—The duties of this committee shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians, and between physicians. It may, if it believes the facts justify such action, cite a member of the Association to the Council of the State Association. It shall, subject to the approval of the Council, draw up a set of rules and regulations governing its procedure and official actions.

CHAPTER XI.—THE COMMISSION ON CONVENTION ARRANGEMENTS.

Section 1.—The Commission on Convention Arrangements, with the advice and assistance of the Executive Secretary, shall provide suitable accommodations for meetings of the Association, including the House of Delegates, Council, and of their respective committees, the scientific and technical exhibits, and in conjunction with the Executive Secretary, shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Executive Secretary of the Association for publication in THE JOURNAL and in the official programs, and shall make additional announcements during the session as occasion may require. The arrangements and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

Sec. 2.—It shall, with the approval of the Excutive Committee, prepare a program for scientific work for the annual convention in which shall be included the respective programs for section meetings which shall be prepared through cooperation with the officers of the various sections; and it shall, with the approval of the Executive Committee, arrange for scientific exhibits as a part of the annual convention.

Sec. 3.—The general, scientific and sectional programs, and the financial arrangements to provide for them must be approved by the Executive Committee before being officially announced.

CHAPTER XII.—THE STUDENT LOAN COMMITTEE.

Section 1.—The Student Loan Committee shall be constituted as follows:

(a) The President of Indiana State Medical Association
(b) One Councilor of the Association to be appointed by the President
(c) One general practitioner to be appointed by the President
(d) One specialist to be appointed by the President
(e) The Treasurer of Indiana State Medical Association
(f) The Dean of Indiana University School of Medicine
(g) One of the attorneys of Indiana State Medical Association to be appointed by the President

Sec. 2.—This committee shall have authority to make loans to medical students in accordance with the terms and conditions under which funds are made available for that purpose. The committee shall organize itself at its first meeting following the annual convention of the Association, by the

election of a chairman and a secretary. The committee shall adopt its own rules and regulations, subject to the approval of the Council. The secretary shall have the duty and responsibility of keeping minutes of all transactions of the committee, and shall file a copy of such minutes, as well as a copy of all papers pertaining to any application or loans, in the Headquarters Office of the Association.

CHAPTER XIII.—THE MEDICAL-LEGAL REVIEW COMMITTEE.

Section 1.—The Medical-Legal Review Committee shall consist of three members whose duty it shall be to meet in joint session and work with a similar committee to be appointed by the President of the State Bar Association. This committee of the Medical Association shall function as the medical representatives provided for in the Joint Inter-Professional Code of the State Medical Association and the State Bar Association to carry out the purposes of that Code. Its duties shall be as stated in that Code in the form in effect from time to time as approved by the Association.

CHAPTER XIV.—THE COMMISSION ON CONSTITUTION AND BYLAWS.

Section 1.—The Commission on Constitution and Bylaws shall keep in contact with the developments and changes in procedures in carrying on the work of this Association; shall suggest revisions necessary to keep the Constitution and Bylaws always in accord with the practices and procedures best adapted to the functioning of the Association; and shall keep the practices and procedures of the Association consistent with the provisions from time to time contained in the Constitution and Bylaws—to the end that all members of the profession, by reference to the Constitution and Bylaws, may be able to obtain accurate information regarding procedure and practice within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and Bylaws may be avoided.

CHAPTER XV.—THE COMMISSION ON LEGISLATION.

Section 1.—The Commission on Legislation shall study all legislation, both state and national, and all local legislative trends and movements, as to their effect upon the practice of medicine and the protection of the public health; shall keep the profession informed at all times concerning the matters within its area of responsibility; shall conduct investigations of legislative proposals; and shall maintain liaison with members of the State Legislature and of the United States Congress, and with the legislative activities of the American Medical Association. It shall strive to implement and make effective the legislative proposals adopted by the Association.

CHAPTER XVI.—THE COMMISSION ON PUBLIC INFORMATION.

Section 1.—The Commission on Public Information shall collect and organize for dissemination to the public all matters of public interest within the field of medicine, including the activities of other commissions in which the public interest would be involved, and including also the achievements in the advancement of medicine which would be of interest to the public; shall disseminate all such information through the use of whatever media the Commission may find adaptable to that purpose so that such information may be brought to the public in the most effective and convincing manner; and shall develop and maintain the relations of the medical profession with the public in such a way as to give the lay public a better knowledge and understanding of the aims, objects and value of the profession to the public.

CHAPTER XVII.—THE COMMISSION ON GOVERNMENTAL MEDICAL SERVICES.

Section 1.—The Commission on Governmental Medical Services shall concern itself and assume special responsibility in obtaining information and giving counsel and advice to the Association with respect to all matters in which medical service comes into contact with any existing or proposed functions of government, including civil defense, rehabilitation of persons handicapped by abnormality or disease, medical service in welfare departments, maternal and child health programs sponsored through governmental agencies, medical care of military manpower, plans and programs for medical care of veterans, medical care for dependents of those in uniformed services of the Government, plans and programs of the Government for medical care now existing or which may hereafter be adopted by any special group, government programs for elimination of venereal disease and other communicable diseases, and all programs and plans for medical care to be provided through municipal, state or federal governments.

CHAPTER XVIII.—THE COMMISSION ON PUBLIC HEALTH.

Section 1.—The Commission on Public Health shall assemble and study information regarding industrial medical practice, rural health, preventive medicine, placement of physicians, traffic safety, conservation of hearing and vision; and shall bring such information, and the possibility of progress and advancement in such fields, to the attention of the medical profession, with suggestions for improvements as the commission finds such possibilities.

CHAPTER XIX.—THE COMMISSION ON VOLUNTARY HEALTH AGENCIES.

Section 1.—The Commission on Voluntary Health Agencies shall maintain liaison between all voluntary health agencies and the Association; shall study and counsel in regard to planning all educational and other activities of such agencies; and shall keep the Association fully informed at all times regarding present and contemplated programs of these agencies.

CHAPTER XX.—THE COMMISSION ON MEDICAL ECONOMICS AND INSURANCE.

Section 1.—The Commission on Medical Economics and Insurance shall study and improve forms used in medical and hospital insurance; shall continuously be interested in all types of plans for prepayment of medical and hospital expense, and for provision for medical and hospital service through all types of group activity; shall maintain liaison with labor with respect to labor's problems involving medical and hospital care, and Workmen's Compensation problems; and shall seek improved solutions of professional liability or malpractice problems, tax problems in relation to medical practice, and problems involving physician retirement plans.

CHAPTER XXI.—THE COMMISSION ON INTER-PROFESSIONAL RELATIONS.

Section 1.—The Commission on Inter-Professional Relations shall study to find all the best methods of maintaining on the highest and most satisfactory levels physicians' professional relations with hospitals, nurses, dentists, pharmacists, pharmaceutical manufacturers, veterinarians, nursing homes, and all other professional groups with which the practice of medicine comes into contact.

CHAPTER XXII.—THE COMMISSION ON MEDICAL EDUCATION AND LICENSURE.

Section 1.—The Commission on Medical Education and Licensure shall maintain liaison with, and try to be of assistance to, medical schools and the licensing board; and shall keep in contact with, and endeavor to assist in improving, undergraduate education, postgraduate education, intern training, resident training, preceptor instruction, and public school health education.

CHAPTER XXIII.—THE COMMISSION ON SPECIAL ACTIVITIES.

Section 1.—The Commission on Special Activities shall organize and promote support for the American Medical Education Fund, assistance to physicians, blood banks, and all miscellaneous activities not falling within the area of responsibilities of other commissions or committees.

CHAPTER XXIV.—REFERENCE COMMITTEES.

Section 1.—Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the President in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention.

The President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of five members, the chairman to be specified by the President. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

Sec. 2.—The following Reference Committees are hereby constituted to which shall be referred all matters as indicated by the titles of the committees:

(1) Sections and Section Work
(2) Rules and Order of Business
(3) Medical Education and Hospitals
(4) Legislation
(5) Public Relations
(6) Hygiene and Public Health
(7) Amendments to the Constitution and Bylaws
(8) Reports of Officers
(9) Credentials
(10) Insurance
(11) Miscellaneous Business

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the President, be made (a) to as many reference Committees as are necessary to cover all subjects included therein; or (b) to only one Reference Committee which the President deems has within the scope of its reference the most important part of the matter referred.

No report of any Reference Committee shall be rejected on the ground that it covers something not included in the matters which such Committee was created to consider.

Sec. 3.—The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

CHAPTER XXV.—COUNTY SOCIETIES.

Section 1.—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application, receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and Bylaws and other rules and resolutions of this Association.

Sec. 2.—Charters shall be issued only upon approval of the Council and shall be signed by the President and Executive Secretary of this Association. The Council shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Sec. 3.—Only one component medical society

shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 4.—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Sec. 5.—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

Sec. 6.—In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 7.—When a member in good standing in a component society moves to another county in this state his name, on request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the membership is proposed.

Sec. 8.—A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice.

Sec. 9.—Each component society, shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Sec. 10.—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before August first.

Sec. 11.—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Councilor of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Councilor shall also be sent to the Executive Secretary of the State Association. The State Association shall supply each county secretary a form for these reports.

Sec. 12.—The fiscal year of the Association shall be the calendar year, and all dues shall be for the year and *payable in advance.*

The secretary of each component society shall forward the dues for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Secretary of this Association the dues for such new members.

The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only. Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay $10.00 as dues for the remainder of that year. Interns and residents shall pay $10.00 a year annual dues during their term of service in the hospital.

In the event the county society remits a member's dues for good cause, the secretary of the county medical society shall recommend in writing to the councilor of his district the remission of the state association dues of said member of the society, showing good cause why such recommendation should be granted. The councilor in turn may present the recommendation to the Council, which shall have the power to remit such dues.

Sec. 13.—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Asso-

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ciation or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 14.—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Sec. 15.—Each component society shall have its own Constitution and Bylaws, not in conflict with the Constitution and Bylaws either of this Association or of the American Medical Association, a copy of which shall be filed with the Executive Secretary of this Association; and furthermore, the Executive Secretary shall be notified at once of any changes or amendments that may be made from time to time.

CHAPTER XXVI.—COUNCILOR DISTRICT MEDICAL SOCIETIES.

Section 1.—A Councilor District Medical Society, hereinafter called the District Society, shall be a society whose members consist of the members of the County Medical Societies in the Counties which constitute the Councilor District, provided such members of County Medical Societies have paid their membership dues in the District Society.

Sec. 2.—The State shall be divided into thirteen (13) Councilor Districts with the boundary lines and numbers of each District to be as follows:

First District—Posey, Vanderburgh, Warrick, Spencer, Perry, Pike and Gibson Counties.

Second District—Knox, Daviess, Martin, Monroe, Owen, Greene and Sullivan Counties.

Third District—Dubois, Crawford, Harrison, Floyd, Clark, Scott, Washington, Orange and Lawrence Counties.

Fourth District—Jackson, Jennings, Jefferson, Switzerland, Ohio, Dearborn, Ripley, Decatur, Bartholomew and Brown Counties.

Fifth District—Clay, Vigo, Vermillion, Parke and Putnam Counties.

Sixth District—Shelby, Rush, Fayette, Franklin, Union, Wayne, Henry and Hancock Counties.

Seventh District—Morgan, Johnson, Marion and Hendricks Counties.

Eighth District—Madison, Delaware, Randolph, Jay and Blackford Counties.

Ninth District—Fountain, Montgomery, Boone, Hamilton, Tipton, Clinton, Tippecanoe, Warren, Benton and White Counties.

Tenth District — Newton, Jasper, Porter and Lake Counties.

Eleventh District — Carroll, Howard, Grant, Huntington, Wabash, Miami and Cass Counties.

Twelfth District—Wells, Adams, Whitley, Allen, Noble, DeKalb, LaGrange and Steuben Counties.

Thirteenth District—Pulaski, Fulton, Kosciusko, Marshall, Starke, LaPorte, St. Joseph and Elkhart Counties.

Sec. 3.—Each District Society shall adopt a Constitution and Bylaws, which shall not conflict with the Constitution and Bylaws of the State Association, and only one District Society shall exist within any one Councilor District. The authorized District Society in each Concilor District shall receive a charter from the State Association, and the Secretary of the District Society shall have custody of the charter.

Sec. 4.—Each District Society shall organize by electing a President, a Secretary, and a Treasurer and a Councilor and Alternate Councilor as the current Councilor term and Alternate Councilor term for the district expires, and such others as may be provided for in its Constitution and Bylaws. The office of Secretary and Treasurer may be held by the same physician. The Councilor shall continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association.

Sec. 5.—The dues of the District Society, in an amount fixed by the District Society to meet the District Society needs, shall be collected by the Secretaries of the component County Societies and delivered to the Treasurer of the District Society. The Secretary of each District Society shall report to the office of the State Association the names and addresses of the members of his District Society, together with a copy of the minutes of each meeting of the District Society.

Sec. 6.—Each District Society shall meet at least once each year at a time and place to be fixed by the District Society. On or before January 1st of each year each District Society shall notify the headquarters of the State Association of the time and place of the annual District meeting for that year; but if no such notification has been received in the headquarters on or before the January meeting of the Council, the Councilor shall fix the time and place of the District meeting, and notice of such meeting shall be sent to the members of the County Medical Societies in such District.

Sec. 7.—Whenever a District Society is to elect a Councilor and/or Alternate, the headquarters office of the State Association shall so notify the individual members of such District Society not later than the first of March of the year in which the election is to occur.

Sec. 8.—The District Society shall send to the headquarters office of the State Association a copy of its program showing the time and place of its meetings, early enough that the headquarters office may notify all members within the District of the meeting at least thirty (30) days prior to the date thereof.

CHAPTER XXVII.—MISCELLANEOUS.

Section 1.—The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and Bylaws.

Sec. 2.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

CHAPTER XXVIII.—MEDICAL DEFENSE.

Section 1.—One dollar and twenty-five cents out of the annual dues of each member of the Asso-

ciation shall be set aside as a special fund for medical defense.

Sec. 2.—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Sec. 3.—This Committee shall have full authority governing all matters pertaining to this Chapter. In order to secure to any physician sued or against whom claim is made a fair and full presentation on his defense, the Committee shall have power to enter into an agreement with such physician to furnish to him funds with which to employ and pay one attorney of his choice and such other expenses as the Committee may approve as necessary to a fair and full presentation of his defense. Provided, always, that the attorney selected by the physician must be of good reputation and standing in his profession and the terms of employment, including the fees to be paid, must be approved by the Committee in each case in advance of such agreement. Provided, further, that the Executive Committee shall set a limit to the amount which may be so expended in connection with any one claim or case.

Sec. 4.—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the Chairman of the Council.

Sec. 5.—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Sec. 6.—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these Bylaws.

Sec. 7.—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.

Sec. 8.—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive Secretary of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the President, Secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Sec. 9.—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Sec. 10.—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Sec. 11.—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Sec. 12.—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Sec. 13.—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Sec. 14.—Medical defense as provided for by this Association shall be available to members under the terms stated in these Bylaws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

CHAPTER XXIX.—DIVISION OF FEES.

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XXX.—INVESTMENT OF SURPLUS FUNDS.

Section 1.—The investment of all surplus funds of this Association shall be under the direct control and management of the Executive Committee subject to instructions in regard thereto which may be given by the Council at its option. The Executive Committee shall have the right and is encouraged to obtain the advice and counsel of the investment departments of any bank or trust company of Indianapolis in regard to the discharge of the duties covered by this chapter of the Bylaws.

CHAPTER XXXI.—AMENDMENTS.

Section 1.—These Bylaws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and Bylaws all previous Constitutions and Bylaws are hereby repealed.

Poison Control Centers in Indiana

City	Name and Address	Telephone	Director
East Chicago	Poison Control Center St. Catherine Hospital 4321 Fir St.	EXport 7-3080	Jack Troy, M.D.
Elkhart	Poison Control Center Elkhart General Hospital 600 East Blvd.	3-5350 Ext. 224	C. Richard Yoder, M.D.
Gary	Poison Control Center Methodist Hospital 1600 W. 6th Avenue	Turner 3-0491	Glen T. Dreher, R.N.
Hammond	Poison Control Center St. Margaret Hospital 25 Douglas Street	Westmore 2-2300	Herbert I. Arbeiter, M.D.
Indianapolis	Poison Control Center General Hospital 960 Locke Street	Melrose 6-6331 Ext. 211 or 212	Richard W. Dyke, M.D.
Indianapolis	*Poison Control Center Indiana State Board of Health 1330 W. Michigan St.	Melrose 4-8433 Ext. 226	
Whiting	Poison Control Center Whiting Clinic 1900 Indianapolis Blvd.	Whiting 2075	Jack M. Troy, M.D.

*Informational services only.

(Supplied by Ind. State Board of Health, Poison Control Center, Indianapolis.)

What's Available For Your Patients' Protection Through Your *Blue Shield Plan*

BLUE SHIELD PROGRAMS

Blue Shield has four basic types of surgical schedules. These schedules are:

Type of Program	Rates Single	Family
A. The Standard Schedule or $200 Schedule	$.90	$2.40
B. The Preferred or $300 Schedule	1.40	4.00
C. A Special County Schedule		
D. A Special Steel Schedule	1.20	3.90

Basically, Blue Shield offers the following varieties of In-hospital medical care programs.

Type of Program	Rates Single	Family
A. 30-day In-hospital medical	$.25	$.50
B. 70-day Program	.30	.60
C. 120-day Program	.35	.75

(All three of the above programs provide benefits in the amount of $10.00 for the first day, $3.00 for succeeding days for the maximum number of days indicated. This program includes an allowance up to $15.00 per Certificate year on a schedule basis for x-rays for possible fractures or dislocations when taken in a physician's office.)

D. 30-day In-hospital medical	$.25	$.60
E. 120-day In-hospital medical	.30	.65

(The above two endorsements allow $15.00 for the first day, $10.00 for the second day, $4.00 for the next 8 days and $3.00 for each day thereafter up to the maximum specified. This program does not include any allowance for x-rays for fractures or dislocations taken in the doctor's office.)

F. 30-day In-hospital medical	$.50	$1.00
G. 120-day In-hospital medical	.55	1.10

(The two above programs cover our members at the rate of $15.00 for the first day, $10.00 for the second day, $4.00 for the next 8 days and $3.00 each day thereafter. They each also provide up to $15.00 for one bedside consultation per hospital admission when the condition warrants such service and when such consultation is requested in writing by the doctor in charge of the case. There is an additional allowance

not to exceed $25.00 per hospital admission for intensive medical care which might require continuous attention for not less than four repeated visits during a single 24-hour period. X-rays for possible fractures or dislocations taken in a physician's office are excluded from this program also.)

H. 30-day In-hospital medical program—Non-Group Certificate.

(This program makes no allowance for the first medical visit but picks up the patient from the second day for a maximum of 30 days per condition per Certificate year.)

At the present time, none of the above programs provide benefits for In-hospital medical care in conjunction with the same condition for which the patient was operated upon. In other words, in none of the programs outlined would we cover medical care for appendicitis, for example, when the appendectomy was performed at the same time. Each one of the above, however, will cover our member for medical visits made for a condition unrelated to the surgery. For example, we will pay for any surgery, plus medical care for a diabetic, or we would pay for medical care for a patient operated on for one condition, and who develops pneumonia or a cardiac condition. These are approved by the Executive Committee.

The other major programs offered by Blue Shield include a Home and Office call program which pays $3.00 for office calls and $5.00 for home visits with not more than 30 per year for fees of .75 for a single policy and $1.75 for a family per month. This is a pilot study covering about 6,000 members.

We also have an endorsement covering diagnostic x-ray as well as pathology services up to a maximum of $50.00 per person per Certificate year. This program covers these services whether they are performed in a doctor's office or a hospital, for a monthly rate of .30 for a single and .70 for a family. This program is for the sick and does not cover physical examinations.

Of course we also have the very special program for In-hospital medical care which increases the number of days per admission to 365 and changes our limitations for pulmonary tuberculosis, venereal disease or mental and nervous disorders.

Any account which has our surgical schedule automatically has provision for anesthesia payments up to a maximum of $40.00 under the Standard Schedule or a maximum of $60.00 under the Preferred Schedule. The surgical schedule also covers radiation therapy for neoplastic diseases.

In addition to the programs outlined above, Blue Shield has several special programs which have been developed to be sold upon request or in specific areas. Such programs would include our Extended Benefits program, the special U. S. Steel program and the special County Schedule programs.

Blue Shield

Mutual Medical Insurance, Inc.

110 No. Illinois St.

Indianapolis 9, Indiana

DISEASE PREVENTION by Immunization and Chemoprophylaxis*

Disease	*Agent Used*	*Recommended For*	*Method of Administration*	*Type of Immunity*	*Duration of Protection*	*Booster Injection*
Cholera	Cholera Vaccine	Adults	—0.5 cc. subcutaneously followed by 1.0 cc. in 7 doys.	Active	6 months	0.12-1.0 cc. according to oge every six months in endemic oreas.
		Children: 6 months to 2 years 3-6 yeors 7-10 yeors 11 yeors ond older	Three subcutoneous injections given 7-10 doys intervol. (1) 0.06 cc.; (2) 0.12 cc.; (3) 0.12 cc. (1) 0.12 cc.; (2) 0.25 cc.; (3) 0.25 cc. (1) 0.25 cc.; (2) 0.5 cc.; (3) 0.5 cc. Adult schedule			
Diphtheria	Diphtherio Antitoxin	All eorly coses	Usually intromusculor if seen within 48 hours of onset. *Warning:* Test for sensitivity to horse serum. May be used introvenously in severe nosophorynx coses. Dosage dependent on degree of toxicity rother than age and weight. 10,000 units to 75,000 units.	Possive	Short	Additionol ontitoxin given dependent upon illness and toxicity.
Diphtheria	Diphtheria Toxoid (fluid or olum precipitoted or oluminum phosphate odsorbed, for odult use)	Children older thon 11 years ond odults	Two intramuscular injections of 0.5 cc. each, four to six weeks opart for primary immunization or if individuol hos not hod a booster dose of voccine for 3 years.	(If toxoid is given then octive immunity develops.)	Indefinite	0.5 cc. every year.
Diphtheria	Diphtherio-Pertussis-Tetanus olum precipitated or oluminum hydroxide (or aluminum phosphote) adsorbed diphtherio ond tetanus toxoids; contoining 12 protective ontigenic units of vaccine per 1.5 cc. (DPT)	Children under 5 years	(1) First dose of 0.5 cc. deep intramusculorly—follow injection with 0.1-0.2 cc. oir. Given 1-3 months oge. (2) Second dose of 0.5 cc. deep intromusculorly one month ofter first dose. (3) Third dose of 0.5 cc. deep intramuscularly one month after 2nd dose. (4) If 1st dose given eorlier than 3 months of oge, then give fourth dose 2-3 months after series completed.	Active	Indefinite	D. P. T. booster of 0.5 cc. ot 12 to 18 months ond 4-5 yeors. After 5 yeors booster dose of 0.5 cc. Diphtherio Tetanus Toxoid every 3 years to oge 11 yeors.
Diphtherio	Diphtherio Tetonus Toxoid olum precipitoted or oluminum hydroxide (or oluminum phosphote) odsorbed.	Children over 5 yeors and up to 10 years	(1) First dose of 0.5 cc. deep intromuscularly, follow injection with 0.1-0.2 cc. oir. (2) Second dose of 0.5 cc. deep intromusculorly—follow injection with 0.1-0.2 cc. oir.	Active	Indefinite	Diphtherio Tetonus booster 0.25 cc. to 0.5 cc. *Caution:* Do not give to children past 10 years of oge.
Diphtheria	Diphtheria Toxoid Pertussis Vaccine	Rapid immunization of children under	Three doses of 0.5 cc. given subcutaneously ot intervals of 3-4 weeks. In face of epidemic	Active	Antigenic response lower than with the	0.5 cc. every 2 yeors.

	Tetanus Toxoid Fluid	under 10 years	intervals of 3-4 weeks. In face of epidemic injections may be given at intervals of one week.		lower than with alum preparations and does not last as long.	
Hepatitis, Infectious (Epidemic)	Immune Serum Globulin (Gamma Globulin)	All exposed in household, institution, etc.	Dosage: 0.01 cc. per pound of body weight. Given intramuscularly.	Passive	Brief	Repeat each exposure.
Influenza	Polyvalent Vaccine	Use during epidemics		Active (in 70% + immunized)	Short: 3-4 months	Repeat primary injection.
		Children	Give total of 1.0 cc. in the course of one week.			
		Adults	1.0 cc. subcutaneously. *Warning:* Precautions must be taken in individuals sensitive to egg protein. *(Note:* There is less chance of local or systemic reaction if only 0.1 cc. is given intradermally.)			
Measles (Rubeola)	Immune Serum Globulin (Gamma Globulin)	Complete passive immunity children under one year; children ill with chronic disease or healthy child whose siblings are ill with chronic disease	Dosage 0.2 cc. per pound of body weight given prior to 6th day after exposure. Given intramuscularly.	Passive	Very brief	Repeat each exposure.
		Incomplete immunity or modification in all other children	Dosage 0.05 cc. per pound of body weight before 6th day after exposure; if given after 6th day use dose of 0.1 cc. per pound of body weight. Given intramuscularly.	Partial passive. Child has modified disease and develops active immunity	For life if disease was modified and not prevented.	
Measles, German (Rubella)	Immune Serum Globulin (Gamma Globulin)	Pregnant females exposed during the first trimester	Dosage: 0.1 cc. per pound of body weight. Given intramuscularly.	Passive	Very brief	Repeat each exposure if pregnant.
Meningococcic Meningitis	Sulfadiazine	Control of exposed persons in community groups Children up to 11 yrs.	0.5 m. twice daily for 2 days.	None Chemical prophylaxis only	Very brief—for one exposure only.	Repeat following each exposure.
		Adults (and children 12 yrs. or over)	1.0 gm. twice daily for 2 days.			
Mumps	Mumps Vaccine	Adults exposed to case and with negative history of having had mumps	*Warning:* Check on sensitivity to egg protein. Two injections given 5 to 10 days apart of 1.0 cc. each subcutaneously.	Active	Brief	Previously immunized persons may be given booster dose of 0.5 to 1.0 cc. subcutaneously.

Disease	Agent Used	Recommended For	Method of Administration	Type of Immunity	Duration of Protection	Booster Injection
Pertussis	Pertussis Vaccine saline suspended (See Double and Triple antigens under "Diphtheria")	Children during epidemic	A total of 12 N. I. H. units divided into 3 equal doses of 4 N. I. H. units (0.5 cc.) given subcutaneously at intervols of one week.	Active	Indefinite	1 yeor ofter primary series, 2 years after primary series and then every three years to 6 or 7 years of age.
	Pertussis Voccine alum precipitated or aluminum hydroxide adsorbed (See Double and Triple antigens under "Diphtheria")	Routine immunizotion of infants when DPT is contraindicoted	A total of 12 N. I. H. units divided into 3 equol doses of 4 N. I. H. units each (0.5 cc.) injected intromuscularly at intervals of 4 to 6 weeks.	Active	Indefinite	18 months—3-4 years. 6-7 yeors usually given as DPT.
		Exposure Recall		Active	Indefinite	4 NIH units (0.5 cc.) saline suspension subcutoneously if child hos not had immunization post 2 years.
Plogue	Plague Vaccine—a suspension of 2000 million killed Posteurella per milliliter	Epidemics and areas with high endemic rote. Adults: Children: 6 months-2 years 2 yeors-6 years 6 yeors-10 years	Two injections subcutaneously 7-10 days apart. First injection 0.5 cc.; second, 1.0 cc. 0.06 cc.; 0.12 cc; 0.12 cc. 0.12 cc.; 0.25 cc.; 0.25 cc. 0.25 cc.; 0.50 cc.; 0.50 cc.	Active Active	Partial protection for period of 4-6 mos. Partiol protection for period of 4-6 mos.	1.0 cc. every 4 months as long os danger of epidemic exists. Booster dose for children is same as first dose of initial series.
Poliomyelitis	Poliomyelitis (Salk) Vaccine	All Ages	Two injections each 1.0 cc. given intramuscularly at interval of 1 month. Third injection of 1.0 cc. given 7 months after second.	Active	Not known	Booster dose of 1.0 cc. recommended 8 to 12 months ofter 3rd dose.
Robies	Robies—hyperimmune serum 1000 units per pound of body weight Rabies Vaccine 7-14 doses	Licks of obroded skin or mucosa by proven rabid, suspicious, escoped, killed or unknown animal	Hyperimmune serum within 24-72 hours of exposure. Follow within 24 hours with Rabies Voccine.	Passive immunity from hyperimmune serum	Few weeks	Repeat initial dose hyperimmune serum.
		Bites of healthy animal, multiple, or face or head bites	Hyperimmune serum. Stort vaccine but stop if onimol remains normol for 3 doys.	Active immunity from rabies vaccine	Indefinite	Robies vaccine prepared according to Semple method—should not repeat full course—one to 3 injections probably sufficient. More hazardous Egg embryo vaccine—give one injection.
		Bite of healthy animal, other than head or	No treatment. If animal becomes suspicious during 14 days observation give serum and			

		escaped, killed, unknown or any bites by any wild animal	mune serum followed by 7-14 doses vaccine, depending upon whether single or multiple bites and location.			
Rocky Mountain Spotted Fever	Rocky Mountain Spotted Fever Vaccine	Not routinely recommended since advent of specific antibiotic therapy. May be used in areas of high incidence among persons of high risk.	Adults: 3 injections each 1.0 cc. subcutaneously or intramuscularly at intervals of one week. Children—under 10 years three injections each 0.5 cc. subcutaneously or intramuscularly at intervals of one week.	Active	One year	1.0 cc. booster annually
Smallpox	Smallpox Vaccine (Vaccinia virus)	Children and adults	Begin at 5-12 months. Administered by multiple pressure technique skin over insertion of left deltoid.	Active	Indefinite, average 3 years	Repeat every 4th year.
Tetanus	Tetanus Antitoxin	All cases of puncture wounds and animal bites when person has not been immunized or more than 2 years since last booster.	*Caution:* Skin test first for serum sensitivity. Intramuscular injection of 10,000 units antitoxin.	Passive	10 days	Repeat with each injury. Because of hazard to horse serum active immunization with toxoid preferred.
	Tetanus Toxoid, depot (alum precipitated or adsorbed) (See Double and Triple antigens under "Diphtheria")	All	Two doses, each 0.5 cc. given intramuscularly, at least one and preferably 2-3 months interval.	Active	At least 4 years	0.5 cc. end first year, then—booster every 2-4 years. Satisfactory recall response after 10 years but is too slow in case of injury. Emergency booster if injured.
	Tetanus Toxoid, Fluid (See Double and Triple antigens under "Diphtheria")	All	Three doses, each 0.5 cc., subcutaneoulsy or intramuscularly at one month and preferably 2-3 months between doses.	Active	At least 4 years	0.5 cc. end first year, then—booster every 2-4 years. Satisfactory recall response after 10 years but is too slow in case of injury. Emergency booster if injured.
Typhoid Fever	Typhoid Vaccine Triple vaccine containing 1000 million S. typhosa and 250 million each of paratyphoid A and B per cc.	All persons living in or traveling to areas where disease is endemic or insanitary conditions exist.	*Adults* Three doses, each 0.5 cc. subcutaneously not less than 7 days or more than 28 day intervals between doses. An alternate method is: 0.1 cc.; 0.15 cc. and 0.2 cc. given intradermally not less than 7 nor more than 28 days between doses. *Children* 6 mo.-2 yr.—(1) 0.06 cc.; (2) 0.12 cc.; (3) 0.12 cc. 2 yr.- 6 yr.—(1) 0.12 cc.; (2) 0.25 cc.; (3) 0.25 cc. 6 yr.-10 yr.—(1) 0.25 cc.; (2) 0.50 cc.; (3) 0.50 cc.	Active	Indefinite—usually at least one year	Persons traveling or living in insanitary areas should receive booster of 0.1 cc. intradermally or 0.5 cc. subcutaneously annually. Children's annual booster the same dose as initial dose of each series.

Disease	Agent Used	Recommended For	Method of Administration	Type of Immunity	Duration of Protection	Booster Injection
Typhus Fever	Typhus Fever Vaccine	All persons traveling to or living in areas where epidemic typhus exists.	*Adults* Two doses, each 1.0 cc. at intervals of 7-10 days given subcutaneously. Allergy to egg or chicken protein only contraindication. *Children* Three doses each: 6 mos.-2 yrs.: 0.12 cc. 2 yrs.- 6 yrs.: 0.25 cc. 6 yrs.-10 yrs.: 0.50 cc.	Active	Relative 3-6 months	*Adults* Routine every 6 months dose of 1.0 cc. given subcutaneously or whenever threat of outbreak occurs. *Children* Same dose as in initial series.
Yellow Fever	Yellow Fever Vaccine* (Obtainable only at U. S. P. H. S. Hospital or Yellow Fever Immunization Depots. See footnote where obtainable in Indiana.)	All persons traveling in or through or living in endemic areas. Should receive vaccine 10 days before arrival in area.	One dose 0.5 cc. of a 1:10 dilution of concentrated vaccine, freshly prepared. Given subcutaneously. Should not be given to person ill with virus disease or at same time cowpox virus is given. Children's dose—same as adult.	Active	6 years or longer	As required at present every 6 years repeat immunization. In presence of epidemic repeat primary immunization.

*While many contraindications are listed for various biologicals it should be recognized that in the interest of brevity it was impossible to give all details. In case of doubt consult standard reference for detailed description of biological in question and/or pharmaceutical company's circular accompanying original package of biological.

All of the biologicals listed may be obtained through normal supply channels with the exception of Yellow Fever Vaccine. Because of hazards if yellow fever vaccine is improperly handled it can only be obtained from U. S. P. H. S. depots. In Indiana this depot is:

Elkhart County Health Department
200 Harrison Street
Elkhart, Indiana

1st or 3rd Wednesday each month 2 p.m.
Telephone 26525

Physicians having patients requiring yellow fever immunization should advise person to call or write the above, as inoculations are given by appointment only on one day a week. There is a fee to cover vaccine and administration.

(Revised)

A. L. Marshall, Jr., M.D., *Director*
Division of Communicable Disease Control
Indiana State Board of Health

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Medical Panorama—

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HUMAN ENIGMA: SELF-DESTRUCTION

The average physician (not in psychiatry) confronted by a patient who threatens suicide, is apt to soliloquize something like this: "What to do? H'm! Well, let's see — h'm — what to do?" Of course, we all know some precautions which must be taken, but what, really, can you do for the patient?

This problem has been posed (and ventilated somewhat) in an article by Ralph B. Elias, M.D., of La Jolla, in *California Medicine,* February, 1959. It was presented before the California Medical Association in April, 1958. Excerpts follow:

Although statistics on suicide are particularly unreliable, it can be definitely stated that the incidence currently is not declining. In this country in 1955 the number of deaths attributed to suicide was 16,755—more than from all forms of tuberculosis, from all diseases of the central nervous system except for cerebral vascular accidents, and over twice the number for homicide.

* * *

Should the individual attempt or act of self-destruction be considered a manifestation of psychological disease? Most observers believe so, although there are exceptional situations in which suicide appears admirable if not rational. Most suicides, and especially those within the ken of the physician, are not of this order. They are reactions either patently or implicity distorted and inappropriate to the circumstances, at least to the observer. They are in essence the final do-it-yourself treatment; the ultimate examples of the cure's being worse than the disease. But the sick individuals cannot understand this at the time.

A psychiatric study was reported by Ettlinger and Flordh[2] of 500 cases of attempted suicide at a general hospital in Stockholm. Five % of the patients did not manifest abnormality; the remainder ran the gamut of psychiatric diseases. Neurotic depression in 24% and psychotic depression in 7% accounted for fewer than a third of the cases; it is now well recognized that persons may have neither the clinical nor the dynamic features of depression yet be suicidal, and conversely many depressive patients never attempt suicide.

Nevertheless, a person suffering from depression remains the most dangerous risk.

* * *

Is there anything more that should be done about suicide in this country? Two concomitant approaches are suggested:

The first is the organization of centers, particularly in cities, where trained personnel would provide emergency care and continued treatment of suicidal patients. As previously described, such a unit is part of a general hospital in Stockholm. In Vienna, there is a religious group described by Ringel,[3] its psychiatric director, which devotes itself to care of those who are tired of life. Social workers, priests and other volunteers participate. Individual psychotherapy is the basic treatment. Ringel's reported results are impressive. In the years 1948 through 1950, 2,879 persons were treated who had made attempts at suicide. By August of 1951, 42 had made another attempt, but only one committed suicide. All patients who were treated before an attempt had not since tried.

The other part of the approach is an extensive educational program, which seems at least as worthwhile as the elaborate campaigns to combat cerebral palsy and muscular dystrophy. But it will not be an easy task to communicate awareness to individuals, their families and neighbors

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'Hospitals, Physicians and Government Domination'

F. J. L. BLASINGAME, M.D.*

Chicago

AS MY old patron saint, Benjamin Franklin, once said, "We must all hang together, or assuredly we shall all hang separately."

The AHA and the AMA are passing through a critical period which requires cooperation, intelligent long-range planning and courageous leadership in the health field.

In recent years, our associations have never been so cleverly challenged. I refer, of course, to the political proposal for a radical change in Social Security whereby eligible, retired aged would receive hospital, nursing home, surgical, medical and ancillary services, or a part thereof, under the Social Security program.

In reviewing together our association's policies relating to this serious problem—and it is vital that we make such a review—it is important that we bear in mind the relationship which must exist between hospitals and medicine.

The need for a team approach has always been clear. The list of examples of cooperation between us would be endless.

Such a list would include such major projects in the public interest as Blue Cross and Blue Shield, the Hill-Burton construction program, the Joint Accreditation program and—last year—the creation of the Joint Council to Improve the Health Care of the Aged.

As to the latter, it is a going concern. It will hold its first national conference in Washington, D. C., June 12, 13 and 14. To me the primary significance of the Joint Council effort is the close cooperation between our two associations which it reflects.

A more recent instance of how hospitals and medicine must work together was occasioned by an article in *Look* magazine, dated February 3. This story appeared under the headline, "A Searing Report on Hospitals Suppressed by Doctors Who Found It Too Hot to Handle."

It began by saying: "A hospital is not a fit place in which to be sick." The balance of the article was based on half-truths and distortions which would serve to destroy public confidence in hospitals.

Although hospitals were the object of this attack, medicine acted at once. There was immediate consultation between the AHA and the AMA. The result was a joint news release which gave the lie to the *Look* article.

This is but one of hundreds of examples of how we have acted in concert.

Our past partnership in service to the public is something of which we should both be proud. It should be preserved.

It is in this spirit that I speak today, on behalf of the AMA, regarding the issues involved in proposals for sickness benefits for the aged under the Social Security system.

The conflicting statements by the AHA and the AMA on this issue are a serious threat to the splendid relationship between hospitals and physicians.

I am impelled to unusual candor today because tomorrow may be too late. I speak frankly in the hope that the differences can be resolved before an open breach at the grass roots level develops.

As you know, these legislative proposals provide compulsory health insurance through the Social Security system for some 13 million Americans. The items of illness expense which may be covered vary from one proposal to an-

Delivered before the American Hospital Association, Mid-year Conference of State Presidents and Secretaries, Feb. 4, 1959, AHA Headquarters, Chicago.

* Executive vice president, American Medical Association.

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Continued

other. The principle remains. To physicians there is little difference between these proposals and the old Wagner-Murray-Dingell bills, except in initial services covered. I repeat, the difference is only in initial services covered and in the portion of the population affected at the start.

We are disturbed at the possibility AHA may end up supporting proposals of this type.

We are alarmed at the prospect of the cleavage between hospitals and physicians which will be inevitable should our policies on this issue be in basic conflict.

The position of the AMA is clear.

We oppose National Compulsory Health Insurance—whether across the board, or limited in scope—because we believe voluntary enterprise can do the job.

The AMA recognizes that, at the moment, there is a special need for action on behalf of the senior citizen. The precise extent and character of such need has not been clearly defined, but certainly it exists. The AMA and its state societies have, therefore, undertaken a broad positive program.

We have faith in Blue Cross-Blue Shield and private insurance as methods of financing the cost of illness.

We are encouraging them to accelerate the availability of coverage for persons over 65. We are convinced that the dynamic record of these mechanisms, especially during the past 5 or 6 years, clearly shows their ability to meet the need.

The AMA took a big step when, in December, its House of Delegates called for reduced fees for older persons with low incomes and limited resources in order to make this growth even faster.

We must, however, go beyond financing mechanisms. AMA has recommended that construction of additional nursing homes, convalescent wings in hospitals and similar facilities be given emphasis under Hill-Burton. We have cooperated with AHA and ANHA in efforts to improve standards in nonhospital institutions now serving aged patients. We support further experimentation with progressive hospital care as a means of lightening burdens on individual, community and financing mechanisms such as Blue Cross.

The AMA's positive health program for older citizens calls for an all-out approach to the needs of all the aged, sick or well, so that special needs will be less in the future—not greater.

The six objectives of the AMA program are:

1. Creation of a realistic attitude toward aging.
2. Promotion of health maintenance programs and wider use of restorative and rehabilitative services.
3. Extension of effective methods of financing health care for persons over 65.
4. Expansion of skilled personnel training programs and improvement of medical and related facilities for older people.
5. Amplification of medical and socio-economic research in problems of the aging.
6. Leadership and cooperation in community activities for senior citizens.

We are determined to work positively on behalf of older Americans through voluntary programs of all types. We are equally determined to fight proposals for compulsory health insurance in any form.

No issue will arouse the vast majority of physicians as will proposals for nationalized medicine, *in toto* or piecemeal.

I have reviewed the physician attitude, the AMA's positive program, and our position on compulsory federal schemes, so you may understand our deep concern over the statement on

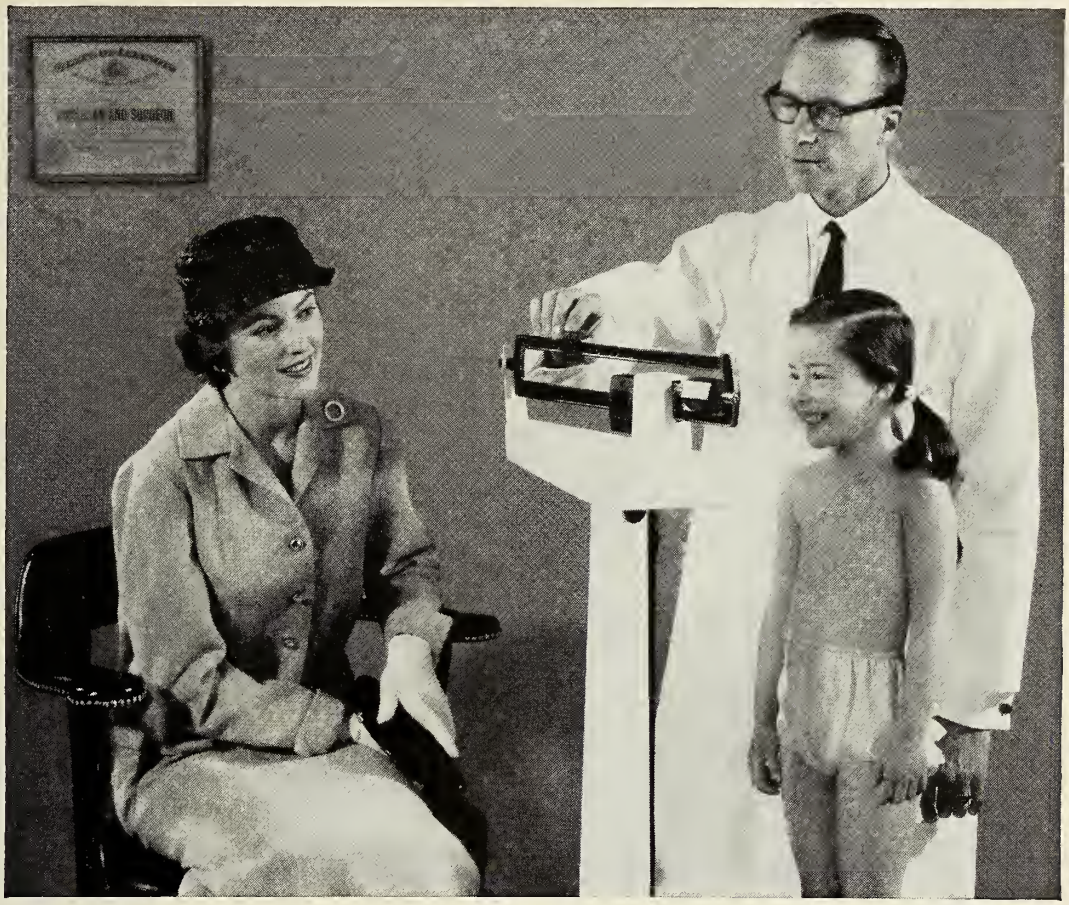
Medical Panorama

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that suicide is practically always the result of illness which can be cured.

Finally, returning to the question, "Is suicide preventable?" It is appropriate to recall an observation by the anthropologist Benedict[1] of the Zuni Indians, among whom sobriety and moderation are valued above all things: "To talk to these people of suicide is to court polite incredulity."

Old-time American doctors learned a good deal from the Indians. Perhaps it is time for another lesson, but this time the lesson would be good for the general public as well.



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Research in the Service of Medicine.

*Brawn, S. S.; Liba, H. W., and Nussbaum, A. H.: Norethandralane in the Successful Management of Anarexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

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hospitalization of the aged which was adopted by the AHA House of Delegates, Aug. 20, 1958.

Our views are presented here because this forum represents a cross-section of the nation's hospitals somewhat comparable to your House of Delegates. I speak with the frankness that our long friendship demands.

Stating it simply, and without reservation, the AHA statement confuses and alarms medicine. Examination of the proceedings of your House of Delegates indicates we are not alone—that there was likewise confusion and concern within your own membership.

Let's take the statement paragraph by paragraph:

Paragraph one of the August 20 statement says:

"The American Hospital Association is convinced that retired aged persons face a pressing problem in financing their hospital care."

Paragraph 2 of the August 20 statement says that AHA "believes federal legislation will be necessary to solve the problem satisfactorily. It has, however, serious misgivings with respect to the use of compulsory health insurance for financing."

Paragraph 3 of the August 20 statement says: "All possible solutions must be vigorously explored, including methods by which the dangers inherent in the Social Security approach can be avoided."

We, too, believe that all possible solutions must be explored by which the dangers inherent in the Social Security approach can be avoided.

Paragraph 4 of the August 20 statement says, first: "Every realistic effort should be made to meet the hospital needs of the retired aged promptly through mechanisms utilizing existing systems of voluntary prepayment."

With this we agree. We believe such "realistic" effort can succeed. The paragraph, however, does not stop there.

It goes on as follows: "It is conceivable, however, that the use of Social Security to provide the mechanism to assist in the solution of the problem . . . may be necessary ultimately."

As this portion of paragraph 4 stands, however, it vitiates what has been said earlier in



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the statement. If you and we agree that the voluntary mechanisms are best, if we agree that the posibilities they afford should be pursued vigorously, why even discuss failure? To do so is to invite failure. To do so is to encourage the enemies of voluntary methods.

American medicine recognizes the conflict between its position and this portion of the AHA statement. We hope the differences can be resolved.

The fifth and last paragraph conflicts even more with the rest of the August 20 statement. It begins as follows: "Any legislation developed to provide for government participation to meet the hospital needs of the retired aged should be so devised as to strengthen the voluntary prepayment system and should conform to the following principles:"

The paragraph then goes on to enumerate 10 principles to be applied to a government program.

This paragraph is an exercise in semantics which tries to mix oil and water. The two key characteristics of voluntary prepayment systems are (1) Their freedom from government domination, and (2) Their insistence on the right of the individual to choose whether or not he participates and how he participates. Neither of these is provided for in the 10 principles, nor can they be while retaining the paragraph's obvious intent.

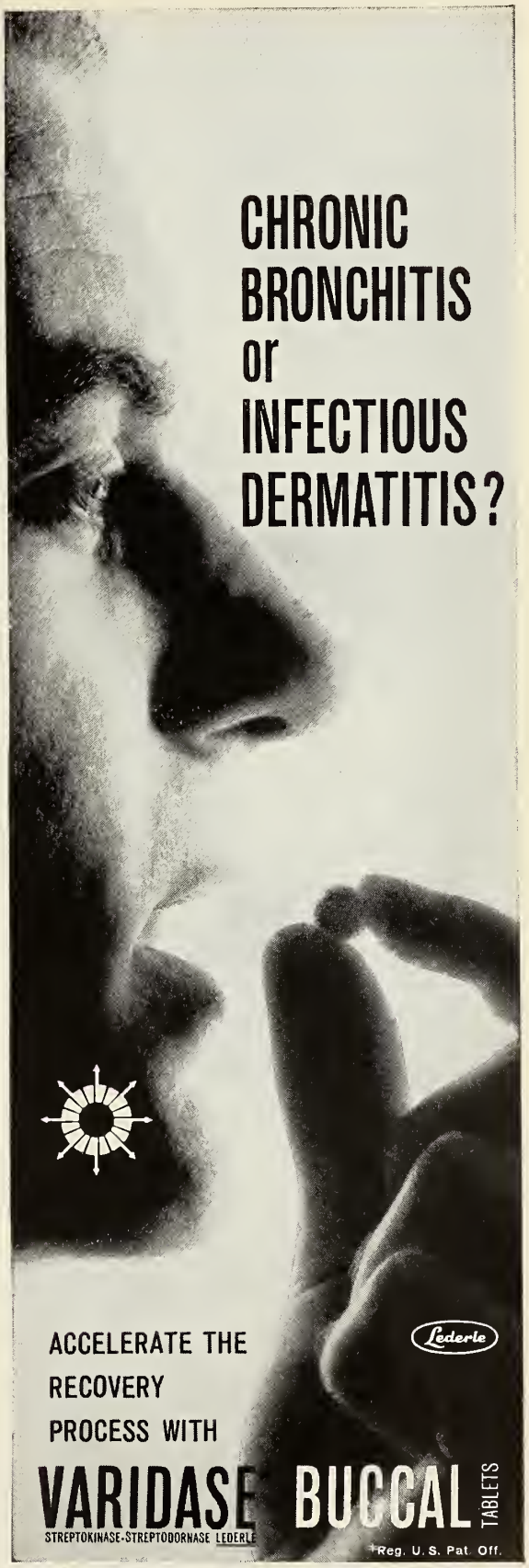
The fact is that the principles outlined under paragraph 5 are consistent with the basic principles of the proposed Wilbur Cohen amendment to Old Age Survivors and Disability Insurance:

1. Comprehensive hospital services,
2. Restriction of services to the aged only,
3. Elimination of a means test and
4. Utilization of Blue Cross as the fiscal agent.

Other principles as enunciated in paragraph 5 are also compatible with the proposed OASDI amendment.

Paragraph 5 is, therefore, unacceptable to American medicine.

The statement has been made by some that paragraph 5 does not provide a basis for support of such proposals as the Forand Bill intro-



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duced in the last session of Congress. We suggest that it can be readily interpreted as support for such legislation. As a matter of fact, it has been used to develop support for Forand-type bills.

The promulgators of these schemes for socialized medicine are perfectly willing, at the start, to tailor initial legislation to fit the 10 principles set forth in the statement.

They are masters at calculated fogging of the issues.

Wilbur Cohen, in a speech November 18, indicated the possible lines such proposals will take at this time. He recommended "hospital care of perhaps 50 to 60 days a year and a limited amount of nursing service, including visiting nursing service in the home . . .

"Other aspects which might be considered," he said, "are: that, initially, benefits be payable only to persons age 70 or over.

"Administratively," he continued, "consideration might be given to placing the responsibility for putting this plan into operation by a 3-man board . . . which, in effect, would enroll the Social Security beneficiaries under Blue Cross plans."

Is the AHA willing to support or accept this type of proposal?

It would be tragic if we permitted the designers of state medicine to "divide and conquer." The answer to their "divide and conquer" tactics must be a resounding enunciation that we stand together.

Paragraph 5 encourages those who would have government take over voluntary mechanisms. The adoption of legislation such as it suggests would, in fact, be a first step in the destruction of Blue Cross-Blue Shield and private health insurance.

American medicine holds that the principles under which voluntary prepayment plans, independent hospitals and private practice of medicine operate are too important, too valuable to throw away. On the contrary, we believe that every avenue should be exhausted in defense of the inherent freedoms on which they are based.

The AMA, therefore, urges you and the AHA, of which you are a part, to reconsider the August 20 statement.

It would be extremely regrettable if our united front were destroyed and our principles deserted because of a special situation which probably presents no significant burden for either hospitals or physicians.

The financial impact of hospitalization of the aged needs considerable further research. Recent studies certainly suggest that such hospitalization is a relatively small financial burden to most hospitals.

Certainly whatever need does exist is not so urgent as to require a drastic departure from fundamental principle, a departure which ultimately would be of doubtful benefit to the senior citizen.

The need which exists is one which should be met through creative thinking by the best minds in hospital, medical and related fields—and positive voluntary programs based on such thinking.

When we turn to the federal government in this area, we are running away from the problem. Instead of running, we should recapture the pioneering spirit, the willingness to assume risks ourselves, which was the foundation on which Blue Cross and Blue Shield were built.

When Blue Cross and Blue Shield began, many said "it can't be done." But we refused to accept these predictions. The results, in which you played such a magnificent role, are history.

We must join together in a similar crusade today. This crusade calls for a re-examination of technics for financing hospital and medical service, for thorough study of ways in which costs of adequate care for our older citizens may be lowered, for promotion of programs which will reduce demands on hospitals and other medical facilities, and the wide variety of other positive activities which get to the heart of the patient's needs.

Nothing shows AMA's determination more clearly than the December action of our House of Delegates which recommended reduced physician fees for persons past 65 with low income and modest resources.

The speed with which state medical associations have responded clearly demonstrates that medicine is willing to accept its responsibility.

In some areas, as you know, Blue Cross and Blue Shield already are permitting original en-

rollment for persons over 65 on a non-group basis. It is interesting that where one plan has taken this step, so has the other. This underscores our common interest. It also shows that together we can help voluntary mechanisms solve the major financing problem.

We believe that indigent care programs in which the hospital is compensated adequately for the care rendered, should be developed at state and local levels where they can be tailored most accurately to the people's needs. We are prepared to continue and to accelerate our campaign on their behalf. It is the indigent, the majority of whom are ineligible for Social Security benefits, that present a major problem for hospitals in care of the aged.

From the days of Wagner-Murray-Dingell to the present, the state medicine planners have been in retreat. Mr. Cohen's suggestion that physicians' services be deleted from the new proposals shows the desperation with which they are seeking a soft spot in the dike. We hope that hospitals do not intend to become the soft spot in the dike of voluntary financing mechanicsms.

Let's not yield to the cult of inevitability and defeatism. Let's unite in realistic, positive approaches to these and all other phases of health care among our people, young and old. We must work as a team, within the framework of independent hospitals, voluntary prepayment methods and private medicine to create a health record for America of which we have not yet dreamed.

We can do this, however, only if we take the long view, only if we avoid being stampeded into precipitate action, only if we stand on principle, and only if we work together.

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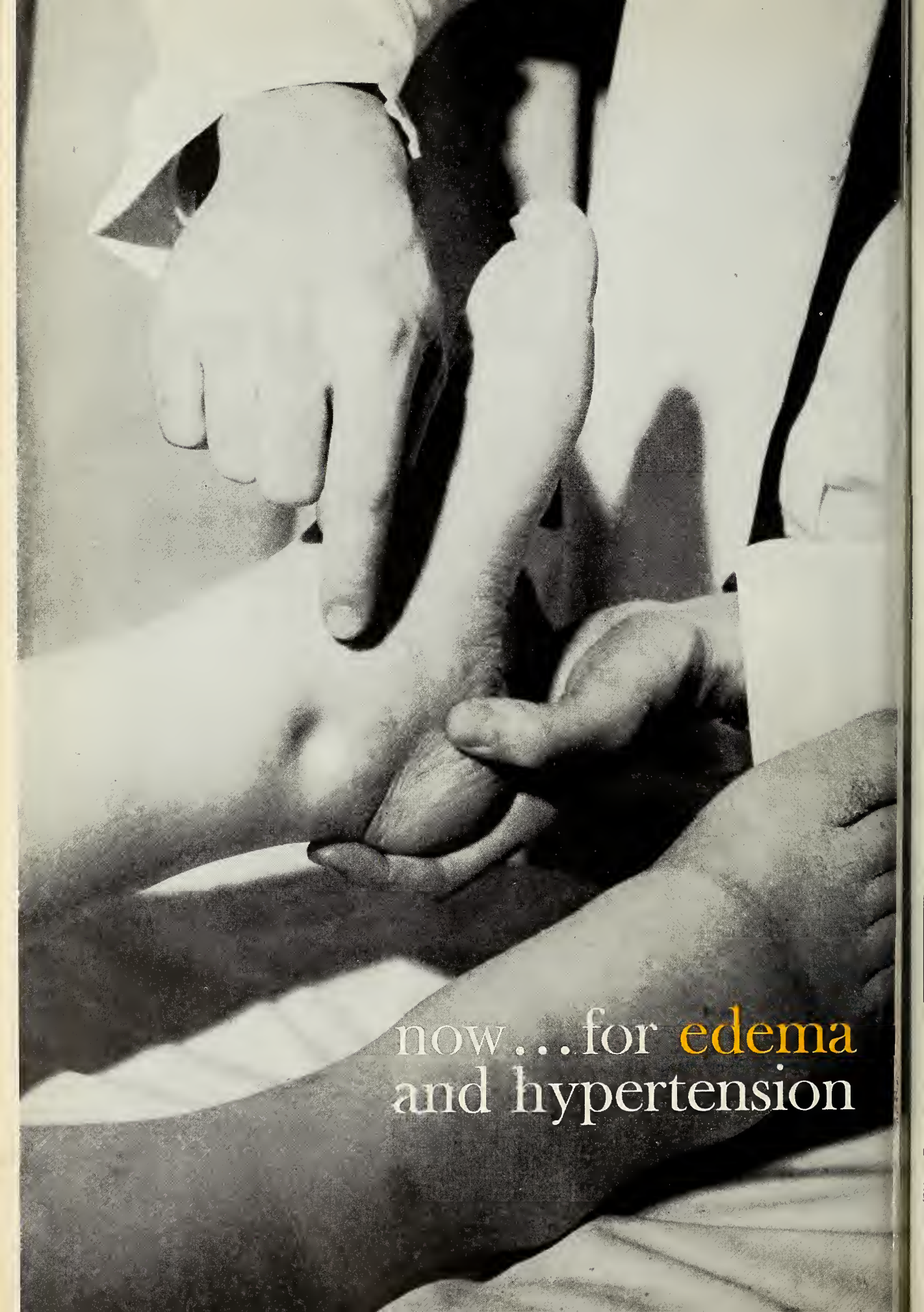
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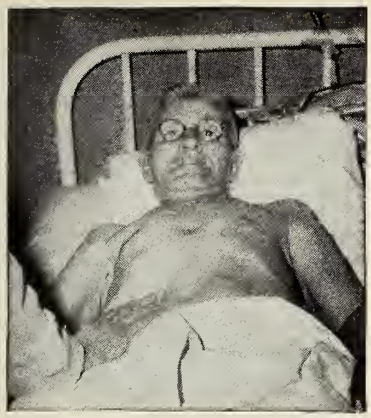
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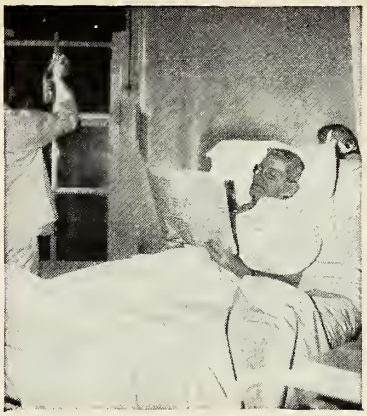
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now...for edema
and hypertension



L.S., 81-year-old patient with complaint of painless hematuria admitted to hospital on 3/3/59. Past history included congestive heart failure of 15 years' duration. **Clinically significant symptoms:** expiratory wheezes over entire chest; bilateral coarse rales of both bases; slight abdominal distention (without evidence of ascites); palpable liver 2-3 fingerbreadths below rib cage; bilateral pitting edema (4+) of pretibial and ankle area. **Admission diagnosis:** hematuria of unknown origin; arteriosclerotic cardiovascular disease; poorly compensated heart failure; and chronic pulmonary fibrosis with pulmonary insufficiency.



Patient was put on regimen of bed rest, moderate salt restriction, digitalis and pulmonary decongestants. When ankle edema, hepatic congestion and rales failed to clear by 3/6, Esidrix 50 mg. b.i.d. was ordered. By 3/8 L.S. had lost 3 pounds. Rales decreased; there was 1+ pitting edema of ankle area only. He felt more comfortable, was able to enjoy reading newspapers and magazines in bed.



By 3/11, patient's weight had dropped 2 more pounds. Ankle edema and lung rales were gone. Patient tolerated cystoscopy and fulguration of a small bleeding polyp in his bladder on 3/12 very well. Ambulatory on the 4th day of Esidrix therapy, L.S. visited his neighbors down the hall, played checkers with another patient. On 3/14 he was discharged.

Patient L.S. Date	3/4	3/5	3/6	3/7	3/8	3/9	3/10	3/11	3/12	3/13
Urinary Output (ml.)	840	690	960	2140	1230	660	1220	1350	--	--
Weight (lbs.)	139	--	--	--	136	--	--	134	--	--
Esidrix Dosage (mg./day)	0	0	50	100	100	100	100	100	50	100

Esidrix T.M.

(hydrochlorothiazide CIBA)

- **relieves edema in many patients refractory to other diuretics[1]**
- **often produces greater weight loss than parenteral mercurials or chlorothiazide[2]**
- **provides a greater average reduction in blood pressure than chlorothiazide[3]**
- **is exceptionally safe . . . reduces the likelihood of electrolyte imbalance**

1. Brest, A. N., and Likoff, W.: Am. J. Cardiol. *3*:144 (Feb.) 1959. 2. Clark, G. M.: Clinical report to CIBA.
3. Dennis, E. W.: Clinical report to CIBA.

2/2684MK-2

Help for the Alcoholic

The Problem

ALCOHOLISM is said to be the nation's No. 4 public health problem, now afflicting about 5,000,000 Americans, of whom fully 120,000 are residents of the State of Indiana. Indirectly, the disease affects many other millions, relatives, employers, friends, etc.; in fact, there is scarcely a family in all the United States untouched by the illness.

The Legislation

Having long recognized the extent of the scourge, the Indiana Medical Society arranged for introduction of a bill in the 1953 State Legislature to provide relief for sufferers. In its final form, it passed without a dissenting vote and became Chapter 194, effective in August of the same year. The 1955 Legislature arranged for permanent financial support of the program by providing a $30 addition to all license fees for sale of alcoholic beverages, retailer or dealer, as Chapter 335, and the 1957 Assembly revised the original measure, as Chapter 213, effective July 1, 1957, setting up the Section on Alcoholism of the Division of Mental Health. Its main purpose is to develop and carry on a program for the rehabilitation of alcoholics.

The Section is also empowered to conduct an educational program, to engage in research activities and to accept gifts.

Who Is An Alcoholic?

The measure defines an alcoholic as any person who chronically and habitually uses alcoholic beverages to the extent that he has lost the power of self-control with respect to the use thereof or becomes a menace to the public morals, health, safety or welfare, under the judicial determination of one of several designated courts. Commonly accepted symptoms of the disease include:

1. You can't control your drinking.
2. Your drinking causes unhappiness in your home.
3. You lose time from work, possibly lose your job, your business or your health, due to drinking.
4. You drink because of worry or trouble, or to face a problem.
5. You drink because you are shy or afraid of people.
6. You drink alone.
7. You have a partial or complete loss of memory as a result of drinking.
8. You need a drink in the morning.
9. You crave a drink at a certain time of day.
10. You feel remorse after drinking.
11. Your drinking affects your reputation.

Treatment

Any resident of the State of Indiana, who believes himself to be an alcoholic and who can support his petition with a medical statement made by a licensed physician, may voluntarily ask the judge of a circuit, criminal, superior, probate or juvenile court in the county of his residence for treatment under the act. If the judge agrees, the applicant shall be committed for any period to a state institution which has facilities for treatment. Unless the superintendent and the judge decide that the period shall be shortened, the patient remains for length of the commitment.

The 1957 Act added a provision whereby a resident may file a written application with the superintendent of any qualified state institution for admission and treatment, but also gives the superintendent the right to refer the applicant to an appropriate court, as provided above.

The Section will determine the ability of the patient or of a person responsible for his care and support to meet cost of treatment. The rate has been fixed at $10 per week. If it is determined that the applicant is indigent, there are no

Published by State of Indiana Section on Alcoholism, Room 1005, 145 West Washington Street, Indianapolis 4, where further information may be obtained. Reprinted in the *Journal* as information to ISMA members who may not be aware of this service.

court costs and the expense is borne by the Section.

Suggested commitment forms have been supplied to all qualified courts, in order to simplify procedure. Persons desiring treatment should apply through an attorney, if possible; if not, ask advice of the court regarding steps to be taken. In an emergency, the Section will render assistance to applicants.

Patients are treated at Logansport, Madison, Evansville, Richmond, Central (Indianapolis) and Beatty (Westville) hospitals, but only at Logansport and Beatty are there hospital wards occupied solely by alcoholics and they are all males. The Section has also established the Nash Rehabilitation Center on the grounds of the New Castle State Hospital, at which male patients only are treated.

Medical, psychiatric and other rehabilitative treatment is given at every institution where the Section program is operated. Especially valuable is the opportunity afforded the patients to affiliate with Alcoholics Anonymous, which operates at all treatment places. It should also be pointed out that there is no loss of citizenship rights because of commitment.

Unauthorized absence, exceeding 48 hours, of any patient committed by a court, is termed a misdemeanor by Chapter 213, and may be punishable, upon conviction, by a fine or sentence or both.

Out-Patient Clinic

The Central Indiana Alcoholism Clinic, Room 1005, 145 West Washington Street, Indianapolis 4, provides out-patient treatment, consultation and diagnostic services to alcoholics and their families. The professional staff includes a psychiatrist, psychologist, two psychiatric social workers and a social group worker. Office hours: 8:15 a.m. to 4:45 p.m. Monday thru Friday. The clinic is open Tuesday and Wednesday evenings until 8 p.m. for clients unable to arrange daytime visits. Patients, who desire to utilize the evening hours, are asked to make appointments ahead of time.

For therapy and information, alcoholic and family groups are meeting separately at the clinic on Tuesday (7 p.m.) and Wednesday (8 p.m.), respectively. Due to possibility of time changes, it is suggested that newcomers check before attending. No invitation to either group is necessary.

The Section on Alcoholism plans to establish other out-patient clinics at some of the hospitals and to cooperate with local organizations in setting up similar centers in other areas of the state.

Education

The Section is required to promote and encourage educational activities which will develop, in the public generally and among students in the grade and high schools, particularly, an attitude consistent with scientific facts regarding alcoholism and the use of alcoholic beverages. It is prepared to furnish speakers, sound pictures, recordings, necessary mechanical equipment (in emergencies) and literature for interested groups, as well as information to sick persons or others interested.

Research

Much basic research in the field of alcoholism, both as to its causes and its effective treatment, remains to be done. The Section on Alcoholism has already begun the sponsorship of research projects in this area and plans to expand the activity.

Remember

1. Once one becomes an alcoholic, he will always be an alcoholic. He may recover, but he may never safely drink again.
2. Alcoholics are sick people, but they can be helped if they wish to get well.
3. Recovery is possible only through total abstinence. A cure permitting the alcoholic to return to controlled drinking has not been found.
4. Section help can be extended only to those who personally ask for it.

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NEWS NOTES—from State and Nation

Smadel Award:

Knox County Doctors Honor Senator Welsh

Senator Matthew E. Welsh, a distinguished member of the state legislature for a number of years, was honored by Knox County Medical Society April 8 as recipient of the third annual J. E. Smadel Award.

The Smadel Award was established in 1957 to be given annually by the medical society to some outstanding citizen in the Knox County community. Joseph Smadel, M.D., U.S.P.H.S., was first recipient. Last year his son, Director of the National Institute of Health, Bethesda, won the award.

Senator Welsh, an attorney, was selected for his interest in the development of the local high school and his general interest in education.

Guest speaker at the banquet honoring Senator Welsh was Dr. John D. VanNuys, dean of I. U. Medical School. Other speakers included, Dr. Earl W. Mericle, ISMA president-elect, Dr. N. D. Ewing, Knox County Medical Society president, and James Waggoner, ISMA executive secretary. Invocation was by Rev. Henry Doll and benediction by Rev. Charles M. Johnson. Dr. Herbert Chattin was master of ceremonies.

Explanation of the award, as given in the program, tells that "The Knox County Medical Society desires to recognize individuals who through the years have by their contributions made our community a better place in which to live.

"The Society believes that commendation is deserved when an individual does his duties in a manner evident to be above personal desire and financial gain. The recipients of the award are selected by the Society whose members themselves are not eligible."

"How much longer," the small boy inquired, "will I have to eat spinach to be able to lick anybody who tries to make me eat spinach?"—*Woodmen of the World Mag.*

Dr. Glock I.U. Trustee Candidate

Dr. Maurice Glock of Fort Wayne has been announced as a candidate for trustee of Indiana University, subject to the alumni ballots this spring. Dr. Glock is a graduate of Indiana University School of Medicine, has been a member of the Alumni Council of the Medical School, and represents the medical school on the Council of the Alumni Association of the University. He has served the State Medical Association in many capacities: delegate, state chairman for the American Medical Education Foundation, and is now Councilor for the 12th District.



Dr. Glock

New Ohio Editor Named

New editor of the *Ohio State Medical Journal* is Perry R. Ayres, M.D. He succeeded Dr. Jonathan Forman who resigned.

Mail for Dr. Ayres on *Journal* business should be addressed to the *Ohio State Medical Journal,* 79 East State St., Rm. 1005, Columbus 15, Ohio.



"Frankly, sir, you need more exercise. Get rid of your remote-control TV set."



in the depressed, unhappy patient

PROMPTLY IMPROVES MOOD

without excitation

- **Acts fast to relieve depression and its common symptoms:** sadness, crying, anorexia, listlessness, irritability, rumination, and insomnia.
- **Restores normal sleep**—without hang-over or depressive aftereffects. Usually eliminates need for sedative-hypnotics.

EFFICACY AND SAFETY CONFIRMED IN OVER 3,000 DOCUMENTED CASE HISTORIES.[1, 2, 3]



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References:
1. Alexander, L.: J.A.M.A. 166:1019, March 1, 1958.
2. Current personal communications; in the files of Wallace Laboratories.
3. Pennington, V.M.: Am. J. Psychiat. 115:250, Sept. 1958.

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National Hospital Week, May 10-16, To Emphasize 'More Roads to Recovery'

AMA Headquarters, Chicago—The nation's hospitals, through the American Hospital Association, have invited their closest ally, the medical procession, to help them develop greater understanding and appreciation of their services and contributions to the American people.



This year's program, centered in a seven-day observance of National Hospital Week, May 10-16, will emphasize the theme of "More Roads to Recovery." An explanation of these "roads"—better care, improved technics and skills, greater numbers of personnel to apply the dramatic successes of medical science—will help offset a growing myth that hospital costs are greater than the services received.

Such distorted stories not only jeopardize public regard for the hospital but for the entire medical team, including the practicing physician. Consequently, it is to our mutual advantage to work together toward overcoming these detrimental impressions which are gaining some acceptance.

Kits and other working tools, prepared by the American Hospital Association, have been sent by the AMA to the excutive secretaries of each state and metropolitan medical society, together with the names of the contacts of state hospital associations and metropolitan hospital councils, so that the medical profession may better coordinate its promotional efforts on behalf of the Week.

Through the use of public forums, tours of hospital facilities, talks to community groups, and radio, television, and newspaper facilities, the story of the unprecedented hospital services now available—resulting in shorter hospital stays, employment of all the medical advances, and healthier and longer lives—can be told convincingly.

"More Roads to Recovery" are the patient's reward for the close harmony and utilizations of the tools and skills of both the hospital personnel and the medical profession. These rewards can be made more meaningful by your participation in National Hospital Week.

Each physician in the community has a role and responsibility to win public support for the hospital in which he practices, and we urge you to offer your help to your hospital administrator and to your hospital association inasmuch as National Hospital Week, May 10-16, is an exceptional opportunity for creating greater appreciation of the entire medical team.

Camp Riley to Open Again

Opportunity for outdoor camping will be available for some 200 physically handicapped boys and girls again this summer for the fifth year in Camp Riley at Bradford Woods, 2,300-acre children's recreational area 6 miles north of Martinsville.

The non-profit camps, which are sponsored by the Riley Memorial Association, offer a full program of outdoor activity, tailored to the capability of the child. Especially-trained counselors, under supervision of a nationally known director, are assigned to every two or three children.

Full time physicians and nurses work from a modern, fully-equipped infirmary. Trained dietitians direct the menu planning and preparation of food. No child is accepted for camp without the written approval of the family physician.

There will be 3, 12-day sessions: July 5-17; July 19-31 and August 2-14, the latter session being reserved for cerebral palsied children.

Basic gift funds administered by Riley Memorial Association, plus annual gifts from many organizations and individuals, finance the camp's operation. Full information may be obtained from: Riley Memorial Association, Room 917, 129 East Market Street, Indianapolis 4.

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108th ANNUAL MEETING *OF THE* AMERICAN MEDICAL ASSOCIATION

June 8-12, 1959, Atlantic City, New Jersey



. . . over 300 scientific exhibits . . . 57 seminars and sectional meetings . . . 60 medical motion pictures . . . daily closed-circuit telecasts.

Childbirth featured in largest combined session ever offered by A.M.A. Seven sections—Obstetrics and Gynecology; Anesthesiology; Pediatrics; Preventive Medicine; General Practice; Diseases of the Chest and Nervous and Mental Diseases present a morning long symposium.

Liver diseases presented in a combined symposium and panel session with six sections participating: Internal Medicine, General Practice, Experimental Medicine and Therapeutics, Pathology, Radiology and Gastroenterology.

Typical of the hundreds of speakers and topics scheduled for presentation:

SYMPOSIUM ON HEPATIC DISEASES

"Newer Concepts of Bilirubin Metabolism"
David Schachter, New York City, New York

"Hepatic Coma: Its Physiologic and Chemical Basis"
S. P. Bessman, Baltimore, Maryland

"Current Problems in Hepatic Pathology"
I. N. Dubin, Philadelphia, Pennsylvania

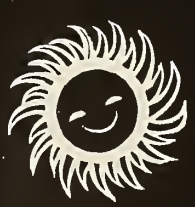
"Current Knowledge of Viral Hepatitis"
Joseph Stokes, Jr., Philadelphia, Pennsylvania

"Radiography in the Diagnosis of Hepatic Disease"
John R. Hodgson, Rochester, Minnesota

"Newer Concepts of Cirrhosis"
Gerald Klatskin, New Haven, Connecticut

PANEL DISCUSSION ON HEPATIC DISEASES
Moderator—Cecil Watson, Minneapolis, Minnesota

Atlantic City is an ideal family playground. The fabulous Boardwalk and world renowned Steel Pier are focal points of interest at this famous ocean side resort.



For advance hotel and meeting registration information write: Convention Services, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois

Army Mass Casualty Care Training Program Scheduled

CHICAGO—Military and medical preparedness for the management and care of mass casualties in case of war will feature the seventh annual National Civil Defense Conference which will be held in Atlantic City on Saturday, June 6, immediately prior to the opening of the annual American Medical Association convention.

"The one-day program will highlight medical problems involved in nuclear warfare," said Dr. Harold C. Lueth, Evanston, Ill., chairman of the AMA Committee on Disaster Medical Care. "The program, unique since it will be presented entirely by the Army Medical Service, will dramatize the important fact that the medical and health professions can take positive action to minimize the impact of mass casualties if properly trained and organized," Dr. Lueth said.

Dr. Louis M. Orr, Orlando, Fla., who will be inducted as president of the American Medical Association at the Atlantic City meeting, will open the conference at the Traymore Hotel.

Physicians attending the meeting, sponsored by the AMA and its Council on National Defense, will get a one-day version of the Army's one-week education and training program dealing with mass casualty concepts and treatment technics.

The general method of instruction for these courses, already attended by 6,000 students, military personnel and civilians, include lectures, student participation through practical exercises, group and panel discussions, visual aids and manikin demonstrations.

Currently, the courses are being given at Walter Reed Army Medical Center in Washington, D. C., and Brooke Army Medical Center in San Antonio, Texas. The courses embrace both the short and long term expected injuries. Counter medical and health measures are stressed to combat the nuclear effects of blast, burn and radiation injuries, both from the preventive and curative standpoint.

Title topics to be discussed on the AMA program include: Casualty Estimation; First Aid, Self Aid, Rescue and Evacuation; Management of Burns Resulting From Nuclear Disaster; Chemical and Biological Warfare, and Psychological Aspects of Disaster.

Maj. Gen. James P. Cooney, Deputy Surgeon General of the Army, said that the AMA Conference, like the courses, will be "directed to a positive approach in order to instill a feeling of hope in the resolution of foreseeable problems."

After the various presentations are given at the AMA meeting, there will be a panel discussion and question period.

All information pertaining to registration may be obtained from Frank W. Barton, Secretary, Council on National Defense, American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Joint Blood Council Publishes First Directory of Blood Facilities

The first comprehensive directory and description of blood facilities and services ever compiled in this country was released recently by the Joint Blood Council, a nonprofit national organization with headquarters in Washington, D. C.

It shows the location of facilities, the extent of their operations, how they are organized, what specific services they offer and other information of importance to physicians, hospitals and any person or organization interested in blood and its derivatives.

The directory will be distributed free by the council to all institutions and organizations that participated in its preparation. Others may obtain it at the cost price of $1.50 each from the Joint Blood Council headquarters, 1832 M Street, N. W., Washington 6, D. C.

The council was formed 3 years ago by the American Association of Blood Banks, the American Hospital Association, the American Medical Association, the American National Red Cross and the American Society of Clinical Pathologists. Its primary purpose: "To establish a national blood program in order to assure an adequate supply of blood and blood derivatives to the civilian and military population at all times of peace or emergency and to take all appropriate action in connection therewith."

News Notes

Continued

Speakers Bureau Announced

The Insurance Institute of Indiana has announced the formation of a speaker's bureau to furnish without cost a speaker for club or other organizational meetings. Four talks are offered, each about 20 minutes in length.

"There Ought to be a Law" deals with the problem of the uninsured motorist. "The Facts of Life" is a discussion of auto accidents and their toll. "Adult Delinquency" deals with the teen-age driver and his parents. "The Chain-Letter Gag" investigates the "something for nothing" fallacy.

Programs are informational only, with absolutely no commercialization. Interested parties may write Mr. Allen Dale, 241 N. Pennsylvania St., Indianapolis 4.

A confirmed bachelor is one who believes that what God has put asunder, no man should join together.—Cy N Peace.

Hospital Housekeeping Scholarships Awarded

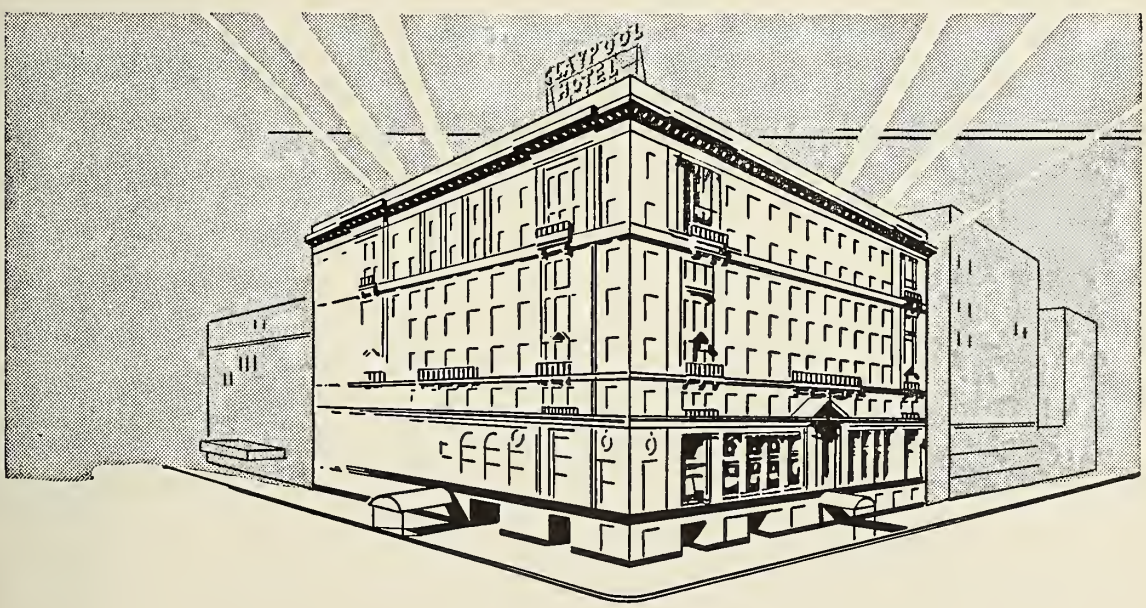
Winners of scholarships for training in hospital housekeeping were recently announced by the American Hospital Association. Ten scholarships of $350.00 each were provided by Huntington Laboratories of Huntington, Ind., to enable executive housekeepers of 10 hospitals from various parts of the country to attend a unique course in hospital housekeeping given at Michigan State University.

Frank Hood, Jr., Pitman-Moore Company chemist, has been named assistant director of pharmaceutical control, it was announced recently by the Indianapolis pharmaceutical firm.

Mr. Hood joined Pitman-Moore in 1945 as an analytical chemist.

A native of Marion, Indiana, Mr. Hood received his B.S. degree in pharmacy from the Butler University School of Pharmacy.

Continued on page 879



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ANTACID TABLETS

Each Creamalin Antacid Tablet contains 320 mg. specially processed, highly reactive, short polymer dried aluminum hydroxide gel, stabilized with hexitol, with 75 mg. magnesium hydroxide.

1. *Neutralizes acid faster (quicker relief)*
2. *Neutralizes more acid (greater relief)*
3. *Neutralizes acid longer (more lasting relief)*
4. *No constipation · No acid rebound*
5. *More pleasant to take*

News Notes

Continued from page 875

Eye Care Pamphlet Out

The National Medical Foundation for Eye Care now has available a new pamphlet entitled "Why Drops?" It is intended for distribution to patients by physicians. Its text explains the several uses of eye drops.

The foundation previously published and has distributed over a million copies of a pamphlet entitled "What is an Ophthalmologist?" This pamphlet defines the terms ophthalmologist, oculist, optician and optometrist. Either or both of these pamphlets may be obtained from the foundation at 250 W. 57th St., New York 19.

Dr. Russell Sage of Indianapolis was a guest speaker at the 32nd Annual Spring Congress of the Gill Memorial Eye, Ear and Throat Hospital of Roanoke, Virginia. The postgraduate course was conducted at the Patrick Henry Hotel from April 6 to 11. Dr. Sage spoke on "Diseases of the Mouth and Tongue," on 2 occasions.

Radiation Protection Movie Planned

A motion picture illustrating the medical aspects of radiation, including protective measures in diagnostic radiologic examinations, will be distributed soon by the American College of Radiology to the nation's physicians.

The film will be 16 mm., in color, running time ½ hour. Premier showing will be at the AMA meeting at Atlantic City. Following the premier, prints will be released immediately for distribution among the medical profession for showings at scientific programs, medical conventions, medical society meetings, hospital medical staff meetings and hospital association conventions.

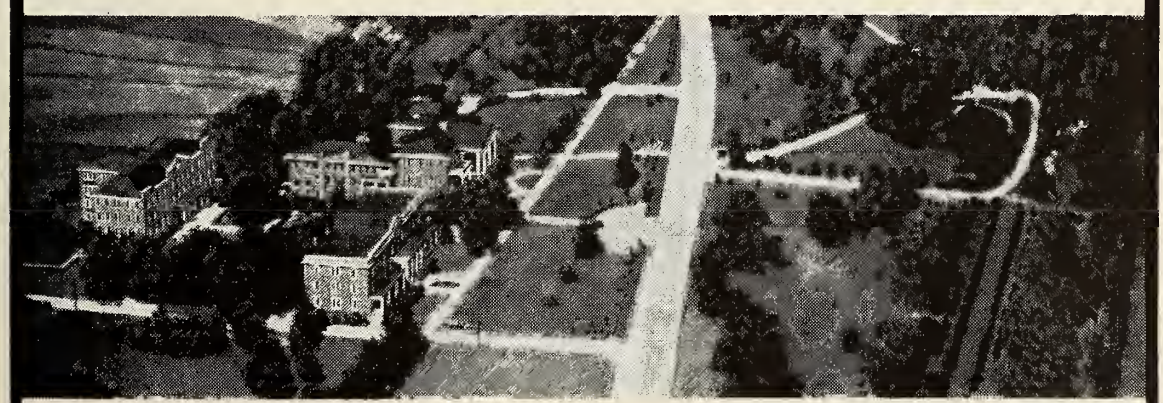
Inquiries may be addressed to the College at 20 N. Wacker Drive, Chicago 6.

The leader uses his intelligence to determine the best course of action. The "also ran" waits, watches his competitor's successful actions, and tries to copy them. —Lawrence A. Appley, *Personnel Journal.*

In order to become perfectly content, it is necessary to have a poor memory and no imagination.—*Grit.*

Nursing Care for Elders In The Deep South

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MILLEDGEVILLE, GA.



Owned by Doctors and operated by a registered nurse in a beautifully landscaped 20 acre estate in the mild climate of Middle Georgia. All buildings housing guests sprinkled. *Rates do not include medical care, medication, personal laundry or other extras.

Mrs. Sue H. Baldwin, R. N.
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*Monthly Rates } Camellia Court from $150
Magnolia Hall from $210

The South's Finest Health Resort for Elders

News Notes

Continued

TB Course in June

The Trudeau School of Tuberculosis and Other Pulmonary Diseases, which will hold its Forty-fourth Session in Saranac Lake, N. Y. from June 8-26, 1959, continues to provide a unique opportunity for training in the field of chest diseases.

This annual postgraduate course, conducted under the auspices of the Trudeau Foundation and supported by the Hyde Foundation, is able to provide outstanding instruction at a minimal tuition of $100.00 for a three weeks session. Attendance at the Trudeau School carries with it a thorough review for specialization in pulmonary disease or for work in public health involving tuberculosis.

In addition to the local medical faculty consisting of some 40 doctors from Saranac Lake, Ray Brook State Tuberculosis Hospital and the Sunmount V. A. Hospital, about 30 of the leading teachers and investigators in the Eastern United States and Canada are brought to Saranac Lake each year to lecture or to conduct seminars in their special fields.

Approximately half of the time is devoted to tuberculosis and the other half divided between such subjects as silicosis, pulmonary fibrosis, emphysema, fungus infection, sarcoidosis, pneumonias and intrathoracic tumors.

The enrollment is necessarily limited and therefore application should be made early. A few scholarships are available for those who qualify.

Inquiries should be addressed to the Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 500, Saranac Lake, N. Y.

S.A.M.A. Convention Held

The annual convention of the Student American Medical Association was held at the Sheraton Hotel, Chicago, from April 30 to May 3. In addition to scientific presentations by nationally known authorities, many scientific papers and exhibits were presented by students, interns and residents. Milton Schulman, Indiana University School of Medicine, read a paper on "Lupus Erythematosus: Review and Possible Investigative Pathways."

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News Notes

Continued

New GG Rapid Slide Test Announced By L. A. Labs

GG-Test, a new rapid slide test for estimating gamma globulin levels, is now being introduced by Hyland Laboratories, Los Angeles, a subsidiary of Baxter Laboratories, Morton Grove, Ill.

The new test, based on a latex fixation reaction, is performed rapidly on a glass slide. It requires only one drop of a patient's serum. Test reactions, clearly visible in 2 minutes, indicate a normal level, a clinically significant low level, or an abnormally high level of serum gamma globulin in the patient's blood.

Since 1952, when agammaglobulinemia was first described by Colonel Ogden C. Bruton, of the U. S. Army Medical Corps, increasing attention has focused on a group of related conditions characterized by low levels of serum gamma globulin, inadequate circulating antibodies, and unusual susceptibility to recurrent, severe bacterial infections.

A variety of screening procedures have been employed to detect these deficiencies. Some of the presumptive tests have been difficult to apply or interpret, while more definitive tests have been too expensive or time-consuming for routine use.

Hyland's GG-Test eliminates these problems by enabling a laboratory technician to estimate the gamma globulin level with a simple test performed with one drop of the patient's blood serum on a divided glass slide.

From one drop of serum, 3 dilutions in a glycine-saline buffer are prepared. A drop of each dilution is placed in a separate section of the slide, and a drop of the latex-anti-human gamma globulin reagent is added to each.

Agammaglobulinemic serum produces no reaction at all. All 3 suspensions remain smooth.

Hypogammaglobulinemia produces clumping in the first dilution while the second and third sections of the slide remain smooth.

Serum with a normal gamma globulin level produces clumping in the first and second dilutions but not in the third.

Hypergammaglobulinemia, usually found in the myeloma group of malignant blood disorders, and which often accompanies hepatic disease, sarcoidosis and the collagen diseases, is indicated by clumping in all three dilutions.

Pathologists Present Seminar

The Indiana Association of Pathologists is presenting its 1959 Eleventh Annual Seminar in co-sponsorship with the U. S. Veterans Administration Hospital, the Indiana Cancer Society and the Indiana University School of Medicine.

Subject will be "Diseases of the Male Genital Tract," presented by Fathollah K. Mostofi, M.D., Armed Forces Institute of Pathology. It will be held May 24, 1959, 10:00 a.m. (C.D.T.), at Veterans Administration Hospital, 1481 West 10th Street, Indianapolis.

A number of slide sets and protocols are available for pathologists who are not members of the Indiana Association of Pathologists, and wish to attend. The available sets will be issued to those who apply in the order of receipt of their applications. A check for $10.00 should be sent, together with the request for the set to: Dr.

Continued

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V. C. HELM

News Notes

Continued

Lester H. Hoyt, Secretary, Indiana Association of Pathologists, Methodist Hospital, Indianapolis 7, Indiana.

All members of the medical profession are cordially invited to attend, whether or not they obtain the study sets. Presentation will be by lantern slide projection, illustrating all cases.

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Three Prizes of $1000 each
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of
especially meritorious unpublished monographs
one each in the fields of the

1. Humanities
2. Social Sciences
3. Physical and Biological Sciences

A Monograph is defined for the purposes of these awards as a "scholarly contribution to knowledge, too long for an article in a learned journal and too specialized or too short for a general book."

Recipients of these prizes will be expected to make their own arrangements for publication.

The final date in 1959 for receipt of manuscripts by the committee on awards is October 1. Announcement of the awards will be made in December.

Full details concerning these prizes may be secured on request from the Committee on Monograph Prizes, American Academy of Arts and Sciences, 280 Newton Street, Brookline Station, Boston 46, Massachusetts.

Goiter Conference Planned for London

The Fourth International Goiter Conference will be held July 5-9, 1960, in London, England, under the auspices of the London Thyroid Club and the American Goiter Association. The American Goiter Association plans to make available to worthy candidates a limited number of travel grants for participants of this meeting.

Application blanks are available from John C. McClintock, M.D., 149½ Washington Avenue, Albany 10, New York, U.S.A.

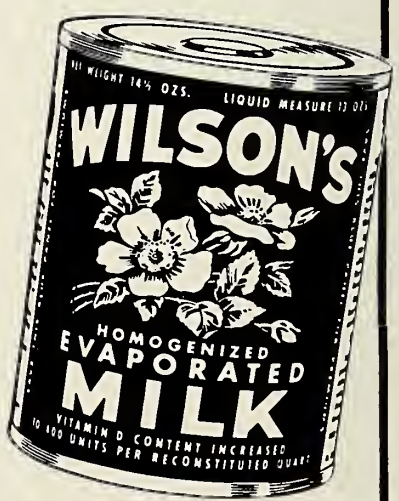
Applications will be received until January 1, 1960.

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Camp For Diabetic Children To Open at Camp Riley

The Indianapolis Diabetes Association will sponsor the James Whitcomb Riley camp for diabetic children for the fifth consecutive year. The camp session will extend from June 14th through July 3rd inclusive. The highly developed facilities in Bradford Woods under the direction of Indiana University and Riley Memorial Association will be used. The camp is located 6 miles north of Martinsville off highway 67.

Mr. Cliff Weisheit of New Castle, aided by a competent staff of counselors, will again direct camping activities of the children. A well rounded and instructive program has been arranged.

Diabetic children from 8 through 16 years old are eligible. The program will be conducted on a non-sectarian basis without restrictions as to race or creed.

The campers are under constant medical and nursing care; qualified dietitians supervise dietary needs; and a well equipped laboratory is operated for all necessary tests incident to the control of the child's diabetes.

The children will have the opportunity to enjoy the experience of summer camping, lose the feeling of being "alone" as they associate with other diabetic children, and will be taught greater self-reliance in the handling of their diabetes.

Applications will be accepted only for the full session. It is believed that the child will not obtain maximum benefit from a shorter period. The fee for the three weeks is $150.00 and this includes all diabetic supplies and the necessary laboratory procedures to maintain good diabetic control. Funds are available for financial assistance to children whose families are unable to pay the full amount.

Applications may be obtained and inquiries should be addressed to: Indianapolis Diabetes Assn., Inc., 821 Hume Mansur Building, Indianapolis 4.

Blindness Prevention Leaflets Revised

The Philadelphia Association for the Blind has announced the revision and re-publication of 3 of its most popular leaflets: "Why Glasses," "Danger Ahead—Glaucoma," and "Check Your Child's Eyes." The association has a series of 14 leaflets on various subjects of eye care and prevention of blindness. For free samples write the association at 100 E. Price St.



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Add 1

by corki

Word Vignette. Elderly man waiting for bus drops coin which rolls down the street. Another man, younger but with gray in his hair, rushes after the coin, jumps on it to stop the rolling, picks it up and hands it to first man with a big, friendly smile. Recipient smiles. I smile. Everyone smiles.

Life has become a little rosier because of a simple courteous act and a warm smile . . . which the participants will pass on to the next persons they meet who'll pass it on and on.

Who knows how many people will be blanketed in the warmth of an unpremeditated act of kindness of a few seconds duration?

On the other hand! Cars stacked bumper to bumper during commute hours. Driver pulls partially out of alley, waits patiently for a break in traffic. Another driver hangs back as if to let the first into the lane of traffic. Then, just as the first driver guns his car to slip in line, second driver zooms ahead, almost causing number one to clip his fender . . . would have, in fact, except for some fast maneuvering!

How many ill tempers were wrought before day's end by that one throughtlessly rude act?

Just a Symbol? Happened by a local school the other morning just as the flag was being raised. Busy motorists zoomed by, unconcernedly; youngsters stood and chatted as they watched; folks walked by. Not one person, including myself, with enough nerve or what-have-you to give proper respect to the flag —which is to stand at attention during the ceremony of raising the Stars and Stripes!

Is it that we are too busy for patriotisim, for the simple act of stopping a few seconds to show respect for our flag? Have we become too cynical to show patriotism or do we even care anymore? And, even if adults fail, aren't our schools teaching patriotism to our youngsters?

Standing at attention before our flag IS just a symbol, granted, and doesn't necessarily mean we lack burning patriotism for our country.

But when we lose the respect for Old Glory as she is raised over our heads, isn't there possibly a dangerous weakening of our strength of belief in what she stands for?

Some might answer: But, you can't stop busy metropolitan traffic to salute the flag. Can't you? I answer. It's done everyday on every military reservation in the country. If all traffic stops, no new snags develop. And even if they do, I still feel that when we get too busy to pay homage to our country's flag perhaps we are too busy to work and fight for her.

Then what happens to us as a nation and as individuals?

Yes, it's just a symbol!



"Pleose hurry right over, doctor! I'm sicker thon I think!"

Cartoons in a Cave. Our cartoonist, Bob Rieker of Boulder, Colo., in answering a letter wherein we mentioned the job cartoonists are doing in giving relief to the seriousness of today's life, says, "You can't tell. I'll probably be still drawing gags in some underground cave up here in the mountains when the first hydrogen bomb hits."

All of which was quoted to introduce and call your attention to the cartoons the *Journal* began running in the March issue. We have several on hand and will use as many as possible to give a little relief, we hope, to your busy and serious days. So watch for them.

Add 1

Continued

What about Spring Fever? Why is it we always look forward so much to spring when it means that peculiar malady called "Spring Fever" hitting just about the time spring housecleaning hits?

There's painting and washing the walls and drapes and floors and garages and attics and rugs and . . . you just don't run out! Then there's the yard and planting grass and flowers and bushes and . . .

And all the time that first faint warmth of sun has put us into a mood for anything but work!

Instead of being able to sit and stare off into a warmed space, we are groaning over the aches and pains brought on by the unusual strain on winter-softened muscles (I do, too, have muscles —I can feel every one!).

What's the latest prescription for sore muscles? (More work, don't tell me!)

And then there are May flowers. A silver cloud to every black lining!

Wee World Spring Planting. Oh, to believe as youngsters believe! The young daughter of an ISMA staff member was approached by her parents recently with the idea of having her very own garden. She decided against the idea. Her father suggested that perhaps she didn't want it because she was afraid she couldn't care for it properly. After a bit of serious concentration, she agreed this was right.

But she evidently gave it more serious concentration, for while getting ready for bed that night, she said, "Mother, I *will* plant a garden if you can get me some seeds for a lollipop tree!"

Anyone know where to get seeds for a money tree?

A laugh cures many ills Dept.:

Just after placing a "hold" on a customer's account, Bookkeeper (Bank of America) Bess Weidman absent-mindedly answered her phone as follows: "Bookkeeper. May I hold you?" *Bankamerican.*

Said a harassed customer to Bookkeeper Marcia Ann Gericke (B of A): "Just tell me how many checks I've written *haven't* come in for payment yet." Also *Bankamerican.*

Some wag has opined: The only thing worse than being a bachelor is being a bachelor's son.

The Fifth Wheel.

Things men like to hear girls say:

1. "No, I've never seen the golf course at night."
2. "Why bother—there's no one home here."
3. "You don't think this bathing suit is too tight, do you?"
4. "Let's go dutch!"
5. "Chaperone? What chaperone?"
6. "No, it really doesn't make any difference whether I get back at all tonight."
7. "My, but I'm cold."
8. "Yes."

The Fifth Wheel.

There must be a comment for this but I can't think of it! So until next month, Adios.

'Please, Mr. Driver, be careful . . .'

Yes, the dollie on Our Cover has a mama she needs real bad . . . to press her lovely dress, to put on a missing shoe, to give her tea . . . and her mama gets out of school soon. "Pretty unpredictable!" is a thought to keep all summer when driving where children can hop into a busy street or dart from between parked cars, hidden until in front of YOUR bumper!

This picture of the doll has traveled. It originally appeared in Southwestern Telephone News, *published by Southwestern Bell Telephone Company, St. Louis. This company not only gave the* Journal *permission to reprint, but also graciously supplied us with the black and white glossy print (with which our engraver did such nice things!). We saw it in* The Standard Oiler, *published by Standard Oil of California, San Francisco.*

So our cover doll has moved around the country, each time with different words, but each time with the same message . . .

Watch for children when school lets out—Drive Carefully!

(Corki)



Abstracts:

REHABILITATION MEDICINE. By Howard A. Rusk, M.D.

Pp. 552. Price $12.00. C. V. Mosby Co., St. Louis.

An excellent text on an often neglected field by the Dean of Science of Physical Rehabilitation, assisted by 36 collaborators.

It covers rehabilitation in all of it's aspects and while perhaps not the final word in each phase, it's contents would help any physician make his patient eliminate, reduce or enable him to live and work within the limits of that disability.

The excellent photographs portray practical ways of overcoming various disabilities. Even a cursory reading of its contents will bring knowledge to the physician and much needed help to the patient.

Physicians have too often failed to follow up on the mental and physical rehabilitation of their patients. Dr. Rusk has provided a means to a good start in that direction.

W. L. Portteus, M.D.
Franklin

PHYSICAL DIAGNOSIS by John A. Prior, M.D., and Jack S. Silberstein, M.D.

Published by C. V. Mosby Co. 363 pages with 193 illustrations.

A basic text for every physician regardless of specialty, age, duration of practice or locality.

Physical Diagnosis is the keystone of medical practice and here is a text that uses "only those terms which convey some meaning." Ample consideration is given to the art of history taking. A breakdown of the various body systems, discussed by authorities in each field, completes the test.

A complete knowledge of the 15th chapter would make any G.P. or even a pediatrician capable of handling the diagnostic problems of children's diseases. References at the end of each chapter encourage further study in your chosen field.

Certainly a text welcome in any library.

W. L. Portteus, M.D.
Franklin



"Have you any past history of being unable to tolerate bat's wings, lizard eyes or zebra intestines?"

Book Review

Reversicon: A Medical Word Finder. By J. E. Schmidt, Ph.B.S., M.D., Litt.D.

First edition, cloth, 440 pp., Springfield: Charles C. Thomas, 1958. Price $7.50.

The Reversicon is a "reversed dictionary," a medical word finder, a scientific word finder. By its use, one may find the scientific word that is needed, by expressing the meaning of the word in simple ordinary terms and then looking it up in any of several arrangements. Meanings, concepts, idea, and thoughts are arranged alphabetically followed by the scientific word.

While written primarily for the medical profession, it also includes words in the fields of dentistry, pharmacy, nursing, chemistry, botany, zoology, pharmacology, forensic medicine and veterinary medicine.

It contains more than 25,000 entries and has added features of choice of synonyms and choice of words close to or related in meaning.



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Sturdy uppers of kitten-soft elk—red, tan, white.

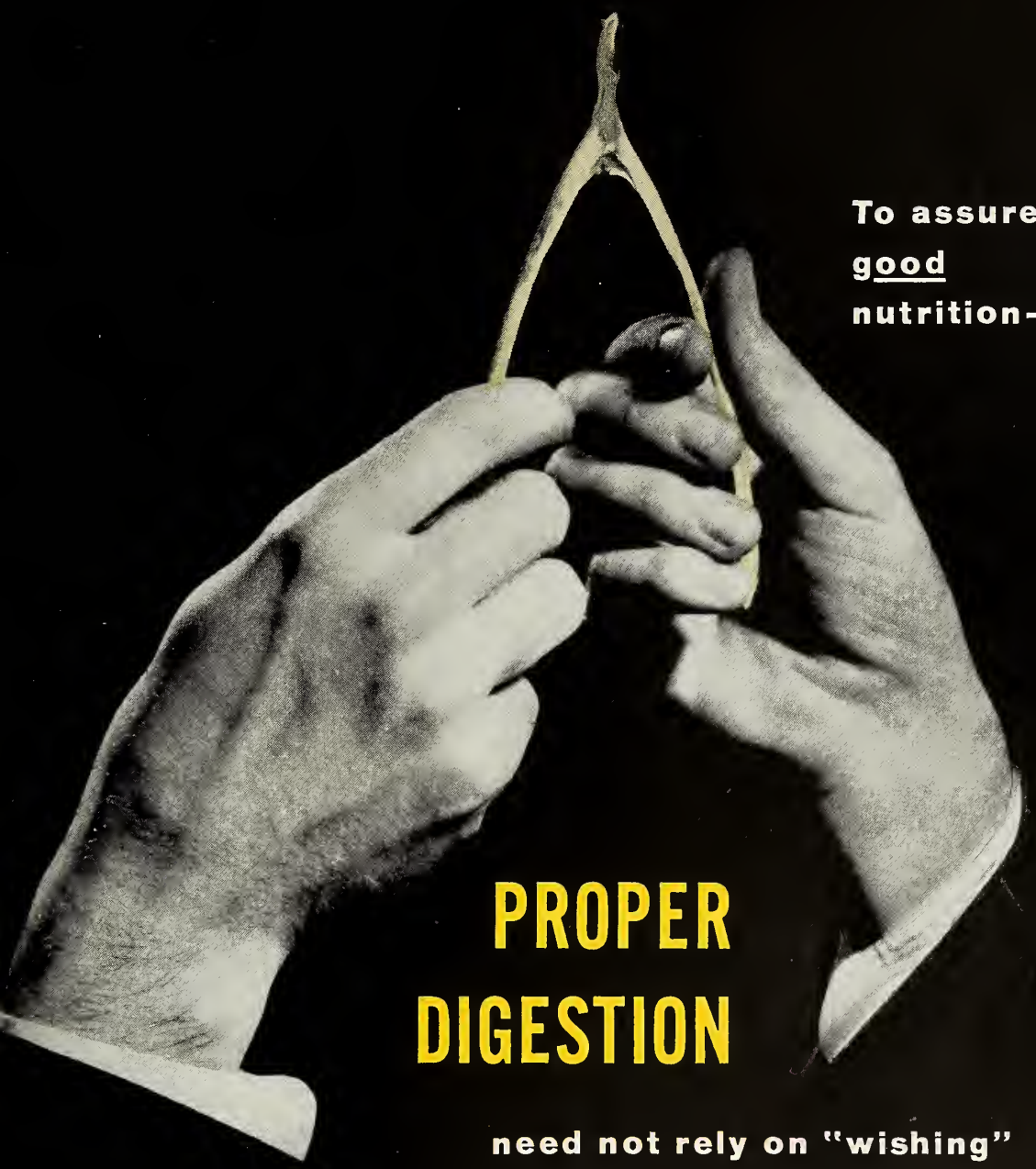
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MONTHLY REPORT – MARCH, 1959

Disease	Mar. 1959	Feb. 1959	Jan. 1959	Mar. 1958	Mar. 1957
Animal Bites	378	189	331	163	307
Chickenpox	915	752	622	485	1354
Conjunctivitis	110	53	71	47	86
Diphtheria	0	0	0	6	5
Dysentery, Unspecified	13	19	31	12	41
Impetigo	65	65	38	14	31
Infectious Hepatitis	34	49	32	22	72
Infectious Mononucleosis	18	21	22	5	69
Influenza	10,674	1011	730	1547	296
Measles (Rubeola-Rubella)	843	755	643	3704	2066
Meningitis, meningococcal	5	2	2	1	9
Meningitis, Other	9	7	6	14	6
Mumps	362	227	246	840	666
Pertussis	108	137	186	42	41
Pneumonia	196	257	275	130	134
Poliomyelitis	0	0	0	1	6
Streptococcal Infections	1536	1048	547	663	1274
Tinea Capitis	20	45	13	18	31

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ROBERT L. CRAIG, M.D.
Associate Medical Director

JOHN D. PATTON, M.D.
Clinical Director

Deaths . . .

Joseph R. Bloomer, M.D.

Joseph R. Bloomer, M.D., 77 years old, Parke County physician since 1912, died March 21 at his Rockville residence following a 4-month illness.

Born in Wabash County, he practiced medicine in Terre Haute 5 years before going to Rockville, where he stayed until his health interrupted his practice.

Dr. Bloomer served in WWI, seeing duty in France. He was a member of Fellenzer American Legion Post, Rockville Methodist Church, Parke Lodge No. 8, F.&A.M., Scotish Rite of Indianapolis and Zora Shrine of Terre Haute.

Professionally, he was a member of the Parke-Vermillion County Medical Society, a 50-year member of ISMA, AMA and a member of the American Association of General Practice. He also belonged to the Aesculapeman Society.

Clarence E. Boyd, M.D.

Clarence E. Boyd, M.D., 79, a retired Orange County physician, died January 27 at a hospital in Lakeland, Fla.

He had practiced medicine in West Baden and served as house physician for the French Lick Hotel until ill health caused him to retire 10 years ago.

A native of Paoli, he was a graduate of I.U. Medical School.

Herschel P. Bowser, M.D.

Herschel P. Bowser, M.D., 63, retired from active practice since 1943 due to a stroke, died March 28 at his Goshen home.

Born at Syracuse, Ind., Dr. Bowser attended I.U. School of Medicine, graduating in 1921. He interned at Indianapolis General.

He had studied abroad twice, studying under well-known specialists, including Prof. J. Finiser and Prof. Alfred Presser, Vienna.

Dr. Bowser was a member of the American College of Surgeons, local, state and national medical societies, New York Central Railroad Surgeons' Association, Goshen Elks Lodge, Goshen American Legion Post and was a 32nd Degree Mason.

Doster Buckner, M.D.

Doster Buckner, M.D., 66, Fort Wayne physician, died February 2 at his residence.

He obtained his medical education at I.U. School of Medicine, graduating in 1919 and then interned at St. Vincent's. He took a residency at June Byran Sanitarium. He was a captain in the Army Medical Corps Reserves.

Dr. Buckner was a member of the local, state and national medical societies, American Academy of General Practitioners and a charter member of the Academy of Medicine and Surgery. He was a member of the SAE Fraternity, Nu Sigma Nu Medical Fraternity and "I" Men's Club. He was on the Lutheran and Parkview Memorial Hospital staffs.

Norman R. Byers, M.D.

Norman R. Byers, M.D., a Bedford physician 27 years prior to his retirement in 1948, died March 9 at his home.

A graduate of I.U. School of Medicine in 1919, he began his practice of medicine in 1921.

He was a member of American Legion Gillen Post No. 33, First Presbyterian Church where he was a past deacon, the county and state medical societies and was a past president of the Bedford Kiwanis Club.

Fred O. Clark, M.D.

Fred O. Clark, M.D., 53, Syracuse physician for 26 years, died February 27 of an automobile accident which occurred in Syracuse.

Born in Palestine, Ill., he graduated from I.U. School of Medicine in 1931 and interned in the I.U. hospitals. He moved from Terre Haute to begin his practice in Syracuse.

Dr. Clark was a member of the local, state and national medical societies, Methodist Church, Syracuse Masonic Lodge 454, Rotary Club, American Legion and was president of the Syracuse Plan Commission.

Porter Jasper Coultas, M.D.

Porter Jasper Coultas, M.D., age 76, a Tell City physician for 39 years, died March 20 in the Veterans Administration Hospital, Louisville. He had been ill since November 28, 1958.

A native of Perry County, Dr. Coultas was graduated from the University of Louisville School of Medicine 50 years ago. He practiced 9 years in Bristow before moving to Tell City.

He was a veteran of World War I and continued his membership in the Reserve Officers Corp.

He was a member of local, state and American medical societies, Masonic Lodge, Hadi

Deaths

Continued

Shrine, Scottish Rite, Knights of Pythias, Moose Lodge, Order of Eastern Star, Kiwanis Club and American Legion.

Calder D. Ehrman, M.D.

Calder D. Ehrman, M.D., 80, who practiced medicine in Spencer County 56 years, died March 21 in Webster Grove, Mo.

He attended Chicago Homeopathic Medical School and, in 1900, interned at the hospital there, and served in WWI as a captain in the Medical Corps.

He was a 50-Year Club member of ISMA and a member of AMA.

George E. Ellerbrook, M.D.

George E. Ellerbrook, M.D., 50, Vevay physician and Switzerland County coroner, died March 6 at his home.

A graduate of the University of Louisville in 1932, he began his practice in Vevay in 1932. He was county coroner for 20 years.

He was a member of the Vevay Lions Club, Vevay Boat Club, local and state medical societies and Dillsboro Methodist Church.

Don G. Hilldrup, M.D.

Don G. Hilldrup, M.D., 71, retired U.S. Army Medical Corps colonel, died January 28 in Indianapolis Memorial Clinic.

Born at Windfall, he received an A.B. degree at I.U. and his M.D. at I.U. School of Medicine in 1915. He interned at Indianapolis General.

A career Army doctor, he served all over the world from 1917, when he was with the American Expeditionary Forces and the Army of Occupation in Germany, until his retirement in 1950. During WWII he established military hospitals in Central Africa as surgeon of the 4th and 5th Army Commands. He later served as medical director of the American Red Cross Blood Bank in Indianapolis.

He was a member of the local, state and American medical societies.

R. W. Kretsch, M.D.

R. W. Kretsch, M.D., 61, prominent Hammond physican since 1926, died at his Hammond home February 23.

He received his A.B. from I.U. and, in 1925, received his M.D. from I.U. School of Medicine. He became ill in 1957. Dr. Kretsch was in general medicine and surgery.

He was a member of the local, state and American medical societies.

Homer E. Line, M.D.

Homer E. Line, M.D., 76, a Chili physician since 1905, died February 12 at his home.

Dr. Line was for many years Miami County health officer at intervals, and had also been a director of the Wabash Valley Trust Co.

He graduated from the Fort Wayne College of Medicine in 1905 and moved to Chili, where he had practiced since. He served in WWI as an Army Medical Corps captain. He was a member of the Chili Methodist Church, Peru Masonic and Elks Lodges, Fort Wayne Shrine and American Legion.

Dr. Line, a native of Arlington, Ohio, also was a member of county, state and American medical societies. He was a 50-Year Club member of ISMA.

Clarence G. Macer, M.D.

Clarence G. Macer, M.D., 73, a practicing physician and surgeon in Evansville for more than 45 years, died March 24 at his home.

A graduate of Depaul University and Northwestern University Medical School in 1912, he took his surgery residency at St. Mary's Hospital, Evansville. He was a surgeon on the staffs of Deaconess and St. Mary's Baptist Hospitals.

In addition to the county, state and American medical societies, he was a member of Phi Chi Medical Fraternity and St. Paul's Episcopal Church.

Noel D. Moran, M.D.

Noel D. Moran, M.D., 56, who had practiced medicine at Versailles since 1941, died March 15 while visiting the game preserve in Trimble County.

He graduated from I.U. School of Medicine in 1935 and interned at Indianapolis General. He was from Fleming, Ky.

Dr. Moran was a first lieutenant in the Reserves from 1936 to 1942 when he became physically disqualified.

Henry L. Muncie, M.D.

Henry L. Muncie, M.D., 79, a Clay County physician for more than 50 years, died February 14 at Clay County Hospital, where he had been a patient for a week. He had been in ill health three years.

Born in Jackson Township, Clay County, Dr. Muncie graduated from Indiana Medical College in 1905. He opened his first office in Hoosierville, moving to Cloverland in 1918.

He was a member of the county and state medical societies and a 50-Year Club member of ISMA.

Vernon C. Patten, M.D.

Vernon C. Patten, M.D., 88, a physician of Shelby County for over 58 years, died March 29 in his home following a 4-month illness.

A Shelby County native, he graduated from Indiana Medical College in 1897. During WWI he was in the Army Medical Corps.

Dr. Patten was a 50-Year Club member of ISMA, senior member, and member of his county medical society and AMA. He was a Republican member of the Morristown Town Board and of the Methodist Church.

Harold C. Rininger, M.D.

Harold C. Rininger, M.D., 52, who had lived in Evansville since 1945, died February 28 in Barnes Hospital, St. Louis.

He was on the Baptist Memorial and St. Mary's Hospitals staffs of Evansville.

Dr. Rininger graduated from I.U. School of Medicine in 1930 and interned at Epworth Hospital, South Bend. He practiced in New Harmony and Chrisney and served in the Medical Corps 5 years during WWII. After the war, he resumed his practice in Evansville.

He was a member of the Center Turners in Evansville as well as the county, state and American medical societies.

John M. Stalker, M.D.

John M. Stalker, M.D., 76, physician and civic leader of Borden, died January 10 at his home.

He had practiced in Borden more than 50 years. Dr. Stalker graduated from the Hospital College of Medicine, Louisville, in 1906. He had given scholarships to the top 5 graduates at Borden for several years and aided in other civic projects.

Benjamin J. Teaford, M.D.

Benjamin J. Teaford, M.D., 81, of Corydon, died February 23 at Harrison County Hospital after a 5-month illness.

He had practiced in Louisville, Georgetown, Lanesville, Jonesville and Fairhope, Ala. He received a certificate of merit for 50 years of service as a practitioner when he retired in 1950.

He was a member of the Corydon Methodist Church, Corydon Barracks of WWI Veterans, Harrison Post 123 of the American Legion and the Corydon Masonic Lodge.

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Association Reports

Executive Committee

March 11, 1959

Roll call showed the following present: Wendell E. Covalt, M.D.; Kenneth L. Olson, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; O. W. Sicks, M.D.

Robert Hollowell, attorney, and James A. Waggener, executive secretary.

Guest: Robert Bixbey, Wolf Management Engineering Company.

Membership Report

Number of members March 11, 1959	3,713*
Number of members February 28, 1958	3,433
Gain over last year	280
Number of members December 31, 1958	4,201

*Includes 42 in military service (gratis)
165—$10 members (residents and interns)
360—senior members
30—members, dues remitted by Council
1—honorary member

Number who have paid AMA dues:

March, 1959	3,593**
March, 1958	3,383
Gain	210

** Includes 667 exempt members (gratis) —430 prior to 1/1/59; 237 so far this year.

The secretary presented a proposed letter to be sent to delinquent members of the Indiana State Medical Association. The letter was approved and ordered distributed on motion of Drs. Owsley and Covalt.

Treasurer's Office

The treasurer reported upon the financial condition of the Association and his report was approved on motion of Drs. Mericle and Sicks.

Headquarters Office

The secretary reported on the number of Medicare cases handled by the office during the previous month.

Three contracts from the government, one covering the renewal of the Medicare administration for the period April 1, 1959, through March 31, 1960; the second, the final audit by the government and determination of the per claim rate for the period of 1 July 1957 through 31 March 1958, and the third, a contract modification which reduced the funds advanced by the government for payment of physicians' services from $82,000 to a $75,000 advance, were presented.

Contracts 1 and 3 were reviewed by the attorney and adjudged in his opinion to be satisfactory, and the president was authorized to sign on behalf of the Association.

The second contract was ordered delayed pending verification by the Association auditors, and if verified, the president is to sign this contract.

The above action was taken on motion of Drs. Owsley and Covalt.

Legislative Matters

In the absence of the chairman of the Commission on Legislation, the secretary reported on the Keogh bill in Congress and the action which had been taken in the state office informing the other organizations and the component societies, and gave a report on all bills in which the Association had an interest in the last session of the State legislature.

Organization Matters

The question of the headquarters office space was discussed, and the members of the committee who had viewed other possible rental sites discussed the increased cost of any move which might be made, and on motion of Drs. Mericle and Owsley the committee voted that the Association should not move its headquarters office into other rental space at this time.

The recommendation of the Wolf Management Company that rather than increasing the rent by moving to a more expensive location and the expense of moving, that the Association should endeavor to obtain more space in the Hume Mansur Building and remodel it, inasmuch as the Association has not definitely decided on its future as far as the new building is concerned, was discussed. It was therefore agreed that the Association should enlarge its present space by making an effort to obtain the suite of rooms occupied by Dr. Alan Sparks and to remodel the space as recommended by the Wolf Management Engineering firm.

Upon motion of Drs. Owsley and Sicks the proposed plans for remodeling were approved and it was recommended that remodeling be begun as soon as possible. It was also recommended that the plan for remodeling be sent to the Building Committee of the House of Delegates and to the councilors.

The recommendation of the Wolf Management Company that money be spent at this time for fixed assets was discussed, and upon motion of Drs. Owsley and Mericle a fireproof cabinet is to be purchased and a new membership and biographical and service record is to be consolidated into this one piece of equipment.

Also, microfilming of the minutes of the Executive Committee, the Council and the House of Delegates, and old membership receipts, was authorized.

Letter from Blont Ellis & Simmons was held in abeyance.

Letter from the Chicago Medical Society requesting the support of the Indiana delegation for the election of Dr. Percy E. Hopkins of Chicago as a trustee of the American Medical Association to fill the unexpired term of Dr. Warren W. Furey was

read and the letter is to be circulated to the delegates from the State of Indiana.

Minutes of the North Central District Blood Bank Clearing House were reviewed before the committee, and Dr. Olson is to talk with Dr. Jene Bennett, the Indiana representative, concerning the possibility of the bank repaying in part the $1,000 which the Association advanced two or three years ago, and report back to the next meeting.

Letter received from the French Lick-Sheraton Hotel, stating that the dates they can give us for the 1960 meeting would be the last week in September, was read. The secretary is to check to see if this conflicts with any other state meeting and if not, the dates will be satisfactory. Otherwise, it will be left to his judgment to attempt to procure dates which will not be in conflict.

Statements of Receipts and Expenditures for the last six months of 1958 and for February, 1959, were reviewed.

New Business

The request of the Savings Bond Department for permission to distribute a flyer in the News Flash concerning the purchase of bonds was approved on motion of Drs. Mericle and Covalt.

A letter from the Indiana Chapter of the Student AMA requesting $75.00 for assistance in financing a regional meeting of the various chapters of the Student AMA was read, and on motion of Drs. Owsley and Covalt the request was granted, and the editor of *The Journal* is to be requested to publish a letter from the Indiana Chapter of the Student AMA in a forthcoming issue of *The Journal.*

Upon motion of Dr. Owsley, taken by consent, the president is to write a letter to Dr. P. T. Lamey, secretary of the State Board of Medical Registration and Examination, expressing the views of the committee concerning the interpretation of the attorney general's opinion on the licensing of chiropractors.

The secretary was instructed to write a letter to the State Board of Medical Registration for a definite ruling regarding the necessity of a license by an intern or resident taking his training in this state.

The Journal

Financial statements of *The Journal* for February were approved by consent.

There being no further business the committee adjourned, to meet again at 6:30 p.m., Central Daylight Saving Time, Saturday, April 4, 1959, at the I.U. Student Union Building, Indianapolis.

Lighter Vein—

Looking for the perfect girl may not make sense—but it's an awful lot of fun.—Russell Newbold, from *Quote.*

Anybody who's calm these days probably isn't well.—Franklin P. Jones, from *Quote.*

The only trouble with resisting temptation is that a man may not get another chance.—Dan Bennett, from *Quote.*

Most of us insist on the best, and then complain about the price.—*Wm Feather Mag.*

By the time a family acquires a nest egg these days, inflation has turned it into chicken feed.—*American Mercury.*

Impossible is a word to be found only in the dictionary of fools.—Gem Box, *Quote.*

"If you had to choose between marrying for love or money, Jane, which would you choose?" asked her friend.

"Love, I expect," replied Jane. "I always seem to do the wrong thing."—*Capper's Weekly.*

Public relations, like charity, begins at home.—Edward J. Hermann, *Music Educators Journal,* 1-'59.

One recipe for a longer life—never exceed the feed limit.—Burton Hillis, *Better Homes & Gardens.*

The way to a man's heart may be through his stomach, but a pretty girl can always find a detour.—Adrian Anderson.

Today's Health

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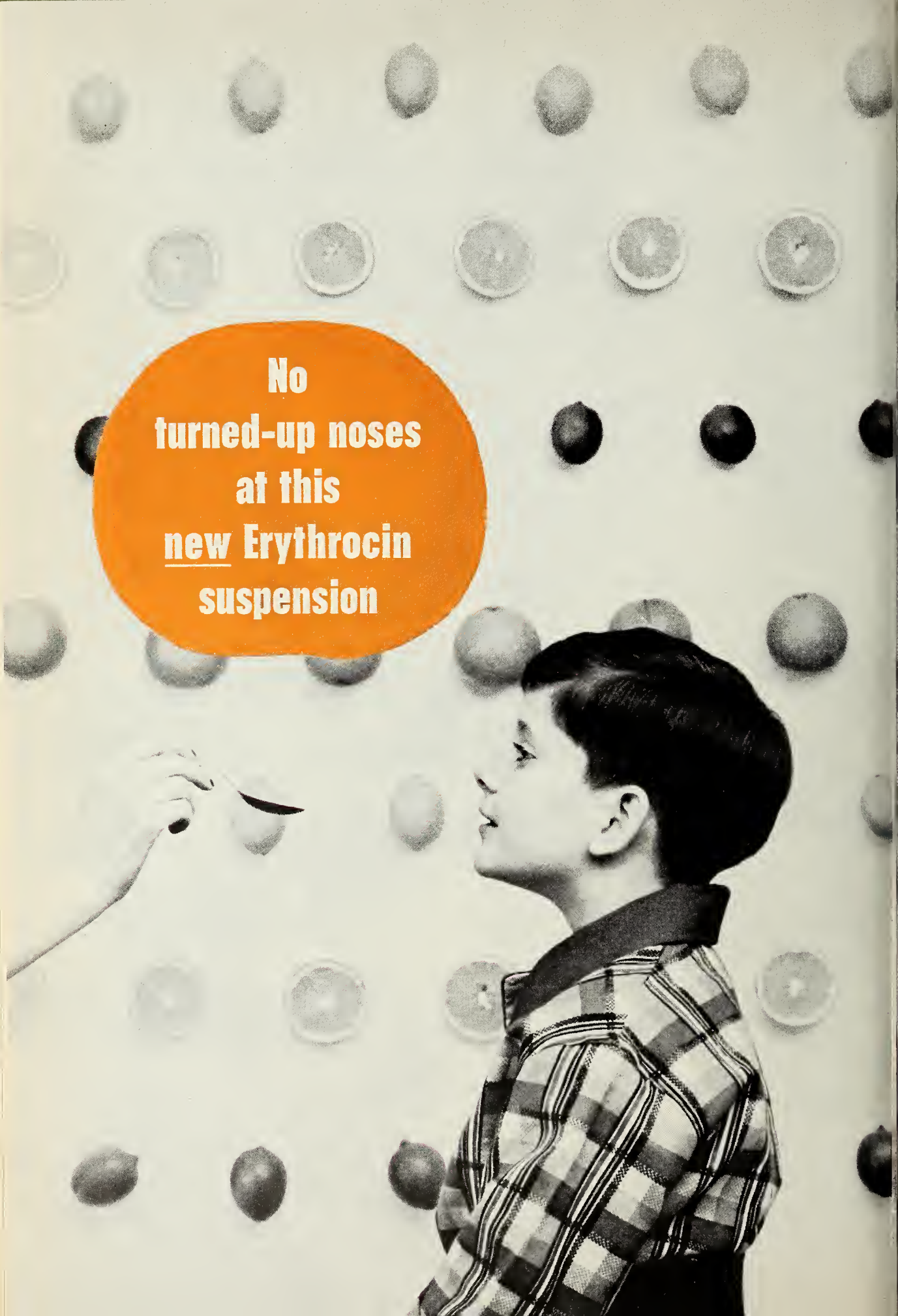
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June 1959

The Journal
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All articles must be typewritten, double-spaced with margins of one inch.

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Articles are accepted for publication only with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

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4	Joseph E. Dudding, Hope	Oct. 1959
5	Robert K. Webster, Brazil	Oct. 1960
6	Harry P. Ross, Richmond	Oct. 1961
7	Ralph V. Everly, Indianapolis	Oct. 1959
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9	K. O. Neumann, Lafayette	Oct. 1961
10	J. P. Vye, Gary	Oct. 1959
11	Max R. Adams, Flora	Oct. 1960
12	Maurice E. Glock, Fort Wayne	Oct. 1961
13	G. O. Larson, LaPorte	Oct. 1959

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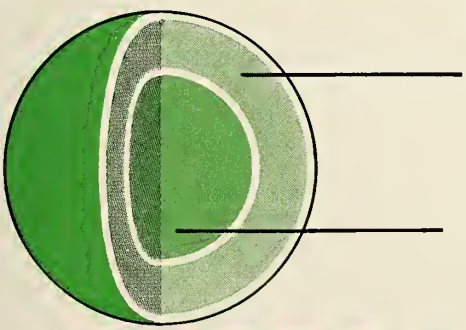
1959-60 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	W. Lawrence Daves, Evansville	J. D. McDonald, 517 Sycamore, Evansville	May 21, 1959
2.	Fred M. Dukes, M.D., Dugger	J. S. Brown, M.D., Carlisle	May 7, 1959
3.	Robert LaFollette, M.D., New Albany	Daniel H. Cannon, M.D., New Albany	New Albany, May 6, 1959
4.	Robert O. Zink, M.D., Madison	Frank W. Hare, M.D., Madison	Madison, May 20, 1959
5.	James Richart, M.D., Terre Haute	Roy Pearce, M.D., Terre Haute	Terre Haute, May 20, 1959
6.	Frank Lewis, M.D., Liberty	John H. Smith, M.D., Greenfield	New Castle, May 7, 1959
7.	Leon Gray, M.D., Martinsville	Herbert L. Egbert, M.D.	Indianapolis, May 12, 1959
8.	Forrest Keeling, Portland	Ara Badders, Portland	Portland, June 3, 1959
9.	S. E. McClure, M.D., Monon	David C. Beck, M.D., Monticello	Monticello, May 21, 1959
10.	Martin O'Neil, M.D. Valparaiso	J. R. Frank, M.D., Valparaiso	1960
11.	Eugene Cook, M.D., North Manchester	C. L. Wise, M.D., Camden	Logansport, May 20, 1959
12.	F. B. Kantzer, M.D., Garrett	Max M. Gitlin, M.D., Bluffton	Fort Wayne, May 20, 1959
13.	Richard W. Holdeman, M.D., South Bend	James M. Wilson, M.D., South Bend	South Bend, Nov. 18, 1959



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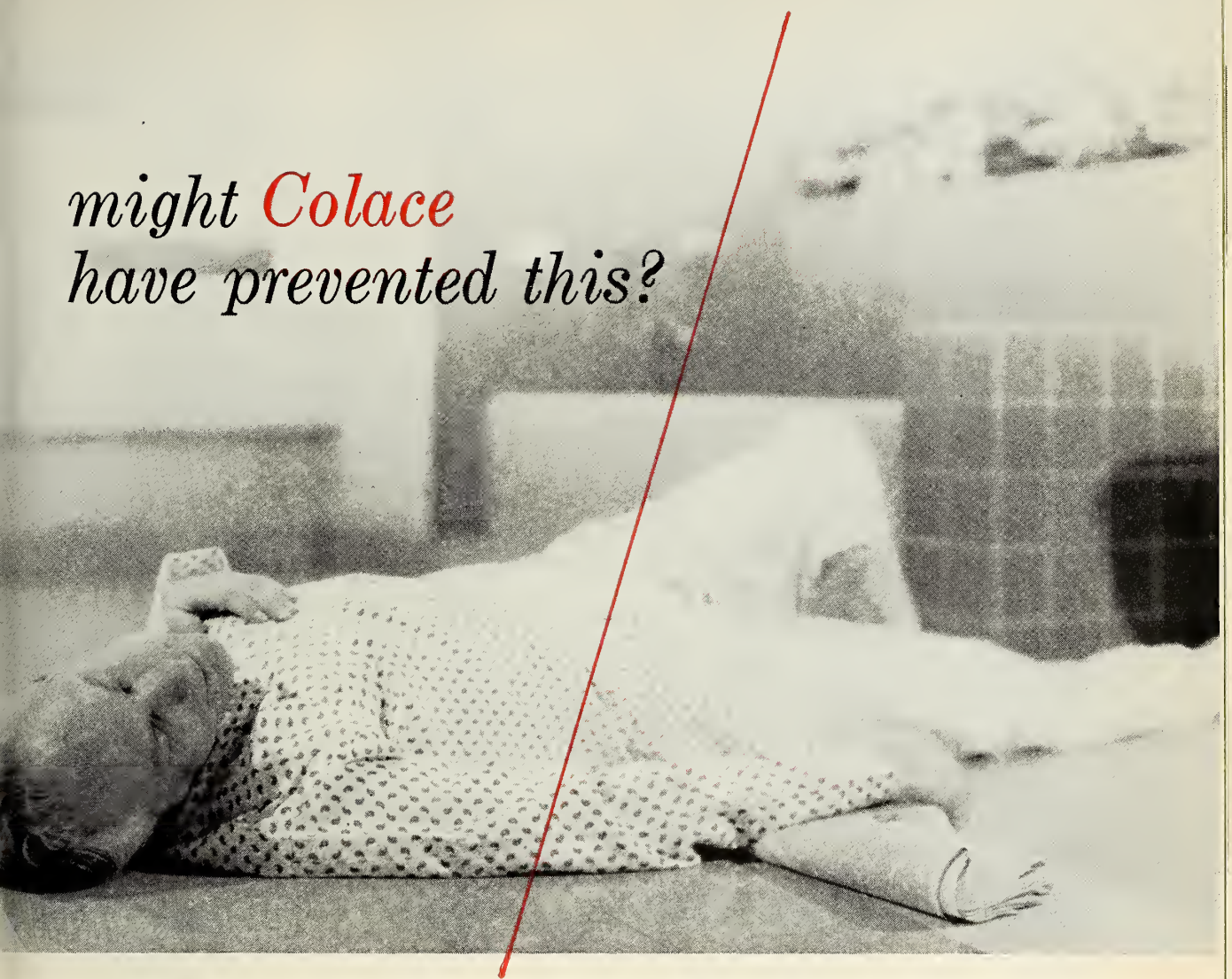
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Dennison, A.D., Jr.: Am. J. Cardiol. 400-403 (March) 1958.

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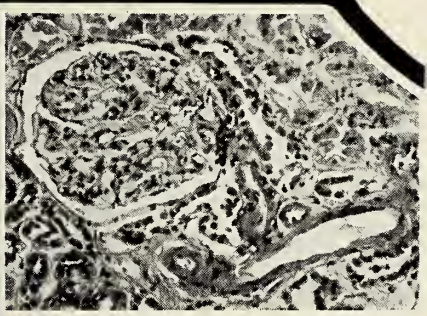
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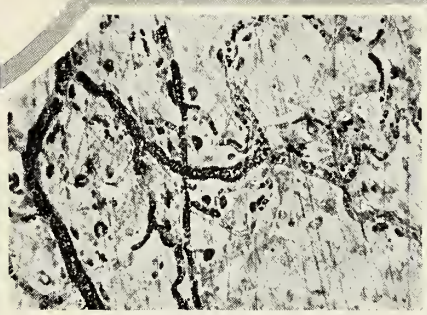
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Dosage: 2 to 6 tablets daily in divided doses initially; may be adjusted within range of 1 to 6 tablets daily in divided doses. **Note:** In hypertensive patients already on ganglionic blocking agents, veratrum and/or hydralazine, the addition of Rautrax necessitates an immediate dosage reduction of these agents by at least 50%. A similar reduction is necessary when these agents are added to the Rautrax regimen.

Supply: Capsule-shaped tablets supplying 50 mg. of Raudixin, 400 mg. of flumethiazide, and 400 mg. of potassium chloride, bottles of 100.

References: 1. Moyer, J. H., and others: Am. J. Cardiol., 3:113 (Jan.) 1959. • 2. Bodi, T., and others: To be published, Am. J. Cardiol., (April) 1959. • 3. Fuchs, M., and others: Monographs on Therapy, 4:43 (April) 1959. • 4. Montero, A. C.; Rochelle, J. B., III, and Ford, R. V.: To be published. • 5. Rochelle, J. B., III; Montero, A. C., and Ford, R. V.: To be published.

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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month preceding month of issue.

THE MONTH IN WASHINGTON

Washington, D. C. -- Congress won the first round in a battle over medical research funds, but the Eisenhower Administration is in a strategic position for the final outcome.

The House voted $344,279,000 for the National Institutes of Health, $50 million more than the Administration asked for in the fiscal 1960 budget. The move to increase medical research funds also had strong support in the Senate.

However, the Health, Education and Welfare Department and the Budget Bureau will have the final say on how much of the appropriated funds are spent during the 1960 fiscal year when the Administration is striving to balance the budget.

Arthur S. Flemming, Secretary of Health, Education and Welfare, vigorously denied a charge of the Democratic-controlled House Appropriations Committee that the Administration had "gone so far as to set back the medical research program...in a desperate attempt to present, on paper, a balanced budget." Flemming said the committee was trying to give a clearly misleading" impression. He also said it was hard to see how the Administration's $294 million program could be regarded as a backward step.

Flemming pointed out that the Administration request was for the same amount voted by Congress last year. And, he added, some of last year's appropriation will not be spent this fiscal year.

At the same time, U. S. Surgeon General Leroy E. Burney testified before a Senate Appropriations Subcommittee that there was a shortage of trained personnel in all fields related to human health, including medical research.

NOTES:

Rep. Francis E. Dorn (R., N.Y.) again has introduced a bill that would provide for a special commission making a study of the supply of physicians. In a letter put in the Congressional Record, Dr. F. J. L. Blasingame, executive vice president of the American Medical Association, envisaged an adequate supply on a long-range basis. He said: "Over the long haul, the increase in medical students is much greater proportionately than is the increase in the population...The future, I believe, looks bright."

* * * * * *

A government sponsored, 6-year study of the causes of cerebral palsy, mental retardation and kindred defects in children has gotten underway in 16 private hospitals and universities.

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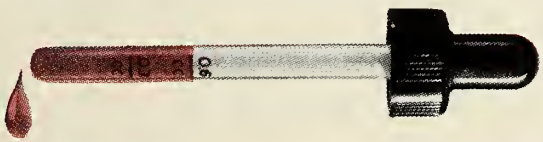
ANNOUNCING TWO OUTSTANDING ADVANCES IN PEDIATRIC THERAPY FROM PURDUE FREDERICK RESEARCH

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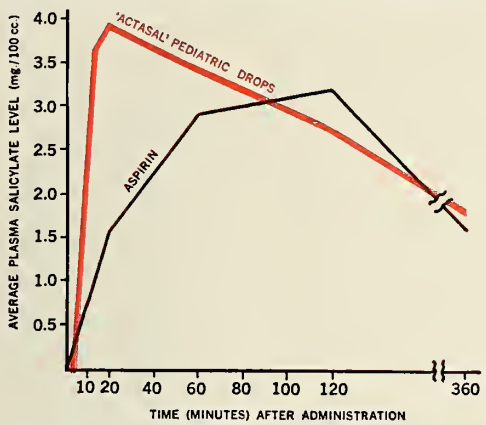
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DOSAGE: Each dropperful (0.6 ml.) contains 105 mg. Choline Salicylate, equivalent to approximately 1¼ grains aspirin.

Children 6-12 years: 2 to 4 dropperfuls every 3 to 4 hours, or as required. Children 3-6 years: 1 to 2 dropperfuls every 3 to 4 hours, or as required. Children under 3 years: 1 dropperful every 3 to 4 hours, or as required.

SUPPLY: 60 cc. bottle packaged with cellophane-wrapped calibrated dropper.

CITED REFERENCES: 1. Smith, P. K.: Personal Communication. 2. Wolf, J., Aboody, R.: Federation Proc. 18:605, 1959. 3. Broh-Kahn, R. H.: Federation Proc. 18:17, 1959. 4. Complete data available on request to the Medical Director.

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Bialkin, G.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959.

CASE HISTORY: J. D., a 5 month old white male developed a dry seborrhea capitis at approximately 6 weeks after birth which covered the whole scalp. By the time of examination, the child had been treated with various detergent ointment and lotion preparations without apparent effect. 'Soropon' Pediatric Solution was applied as a shampoo, directly to the scalp to remove the encrustations. A lanolin ointment was applied to scalp because of inherent dryness. A series of 5 treatments was required for complete removal and after this treatment period the seborrheic eczema had virtually disappeared. The patient has been symptom free since then.

Bialkin, G.: A New Anti-Seborrheic Agent in Pediatric Practice. Arch. of Ped. (to be published).

SUPPLY: 'Soropon' Pediatric Solution is available in bottles of 4 oz.

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Month in Washington

Continued

The study involves no experimentation, only observation. About 40,000 women will be kept under close check from the second or third month of pregnancy through childbirth. Observation of their children will be maintained through 6 years of age.

* * * * * *

U. S. scientists have blamed Russia for most of the radioactive fall-out thrust into the atmosphere in the last two years. But testimony before a Joint Congressional Committee on Atomic Energy estimated that overall the United States and Great Britain had created nearly 3 times as much radioactive debris by testing nuclear weapons as the Soviet Union had.

Russian tests were described as "extremely dirty" as to radioactive debris. However, the Russians have not exploded as many test weapons and devices as the Western Powers have.

The scientists differed on the degree of danger to humans posed by the radioactive fall-out. John A. McCone, Chairman of the Atomic Energy Commission, said that up to now the fall-out hazard has been "very small" and not serious when compared with common hazards, including natural radiation. But he warned against a "very serious hazard" in the future if nuclear tests are not restricted by international agreement.

* * * * * *

The Walter Reed U. S. Army Hospital in Northwest Washington quietly marked its 50th anniversary recently. Its 448,000 patients since it was founded in 1909 have included presidents, congressmen, cabinet members and other notables. President Eisenhower underwent an ileitis operation there in 1956. Gen. John J. Pershing died there in 1948 after being a patient for 7 years. The two most distinguished patients recently: former Secretaries of State John Foster Dulles and George C. Marshall.

* * * * * *

A Food and Drug Administration official has urged that physicians use care and judgment in writing PRN and similar prescriptions for sleeping pills and amphetamines. Nevis Cook of the agency's enforcement bureau said some pharmacists have been selling the drugs too freely on such prescriptions. The FDA planned to take court action when a glaring abuse presented a strong case. The issue is whether a pharmacist improperly practices medicine by indiscriminately refilling such prescriptions.

* * * * * *

Navy and Public Health Service scientists reported that a commercially prepared vaccine proved 83% effective in preventing Asian flu in a study among naval recruits at the Great Lakes Naval Training Station. U. S. Surgeon General Leroy E. Burney said the controlled survey confirmed previous observations that "good protection results" from inoculation with the epidemic Asian-strain vaccine.

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Meclizine (12.5 mg.)—most effective antihistaminic to control vestibular dysfunction.[1]

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Advantage of "dual therapy" confirmed:

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Indications: Meniere's syndrome, arteriosclerotic vertigo, labyrinthitis, and streptomycin toxicity. Also effective in recurrent headache, including migraine.

Dosage: one tablet before each meal.

Supplied: bottles of 100 blue-and-white scored tablets. Prescription only.

References: 1. Charles, C. M.: Geriatrics *2*:110 (March) 1956. 2. Menger, H. C.: Clin. Med. *4*:313 (March) 1957. 3. Shuster, B. H.: M. Clin. North America *40*:1787 (Nov.) 1956.

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The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Traffic 'Disease'

Death on the highways seems to continue its violent pace with little regard for present efforts at stopping the carnage. It may be that this relatively new horror should be attacked as fatal diseases are.

Some such approach is being made by the United States Public Health Service which has granted Harvard University $800,000 for a 5-year study of the causes of fatal traffic accidents. The award apparently is based on recognition that this problem lies in the domain of public health.

While it is not likely that researchers will come up with an inoculation to prevent auto accidents, the Harvard study is an important one. The U.S.P.H.S. grant may lead to more effective ways of combating a human affliction as deadly as many a disease.

—*Kokomo Tribune*
Jan. 19, 1959

Food Additives

A new law which quietly took effect on March 5 will benefit virtually every person in the United States. This is an amendment to the Food, Drug and Cosmetic Act of 1938, requiring that food additives must be tested and found safe for human consumption before foods containing them may be sold.

In general, manufacturers and processors have been pre-testing additives for some years past. This has been done on a voluntary basis, however, and there's the rub. Because testing before sale was voluntary, some questionable products came on the market. Before such a product could be removed from grocery shelves, the Food and Drug Administration had to prove in court that it was harmful.

The principal effect of the new law is to shift the burden of proof from the FDA to the manufacturer or processor. This is as it should be. From now on, a test report on all proposed additives—substances used to improve flavor, appearance, keeping qualities, and so forth—must be submitted to the government. Only when the FDA approves will a new product be placed on sale. Appeal procedures, including public hearings and recourse to the U. S. Court of Appeals, protect the industry.

The amendment does a couple of other important things. It removes needless restrictions on some chemicals. It also provides industry with detailed guidance to help it make the most of new developments in food technology. All in all, this law serves the best interests of both industry and the public.

—*Kokomo Tribune*
March 3, 1959

Belts That Save Lives

Arthur S. Flemming, secretary of Health, Education and Welfare, dramatized one facet of the traffic safety problem when he ordered seat belts installed in his department's staff automobiles. His action was prompted by a Cornell University report which concludes that perhaps 5,500 lives could be saved annually if seat belts were generally used.

The report from Cornell, which has pioneered in traffic safety research, also suggests that if seat belts were standard equipment, major injuries could be reduced by about one-third. Whether or not this and the estimate on possible saving of life err on the side of optimism, there is little doubt that universal use of seat belts would substantially reduce the toll of death and injury.

Seat belts are no guarantee against disaster. Some research even suggests that in certain accident situations a belt can do more harm than good. But the heavy weight of evidence indicates that properly designed crash belts are effective. Perhaps the manufacturers should start installing such belts as standard equipment.

—*Kokomo Tribune*
April 5, 1959

The Best of Ethics

At a recent meeting of the Wayne County Medical Society, which includes the city of Detroit, a doctor paid high tribute to one of this country's leading pharmaceutical companies. The company in question is Eli Lilly—but, as the doctor pointed out, what he said applies equally well to any of the leading drug concerns. All of them maintain research departments staffed with highly trained specialists.

The reason for the tribute is a new anti-rabies vaccine developed after 7 years of work and research, conducted at great expense. The old Pasteur treatment, valuable as it was, would on occasion produce terrible side effects. Sometimes these resulted in death. Even though the patient survived, he might be a mental and physical wreck all his life.

The new vaccine is safe, and eliminates hazards to the brain and central nervous system. It thus is a milestone in medical progress. Yet, as the doctor observed, the company probably never will recover the expense of producing it, because of the rarity of rabies.

To quote him directly, "This is pharmaceutical ethics, business ethics, medical ethics at its highest."

— *Anderson Bulletin*
April 6, 1959

Taking Its Own Advice

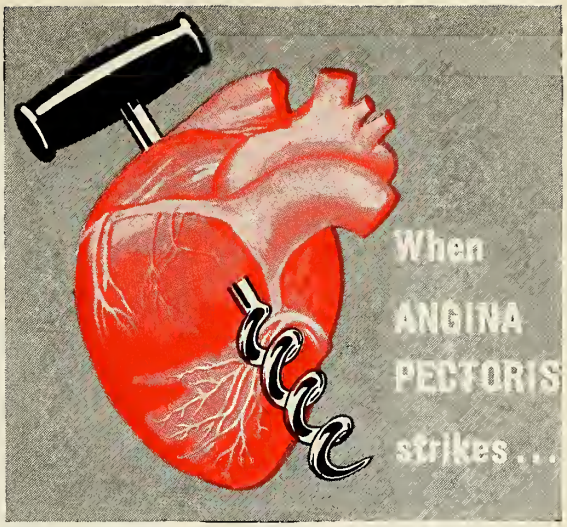
The Federal Department of Health, Education, and Welfare has decided to take its own advice. It has just ordered that its 500 automobiles be equipped with safety belts, as the public health service recommends to all car owners.

Dr. Leroy E. Burney, chief of the public health service, has underscored the finding of an accident study showing that universal use of safety belts could cut the annual auto death toll by 5,500. That is more than recent census figures for such Chicago suburbs as Tinley Park or West Chicago.

We congratulate the Health Education, and Welfare Department on taking seriously its own excellent counsel to car owners. Now our national government, which advises individual citizens so to live as to be able to pay their income taxes, should follow its own exhortations and live within its income.

— *Chicago Tribune*
April 1, 1959

Continued on page 928



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the unique specific

This exclusive development is a ***definite chemical,*** neutral in action, and ***specific in prophylaxis and treatment of angina pectoris.*** It is effective orally in about thirty minutes, for periods of 7 to 8 hours . . . and, even when given routinely, does not cause nausea or gastric upset. Niphylline is an efficient vasodilator and diuretic combining the effectiveness of Neothylline (soluble, neutral, stable derivative of theophylline) and pentaerythritol tetranitrate, substantially more effective than mannitol hexanitrate. Thus, the patient receives the benefits of both drugs without any annoying side effects.

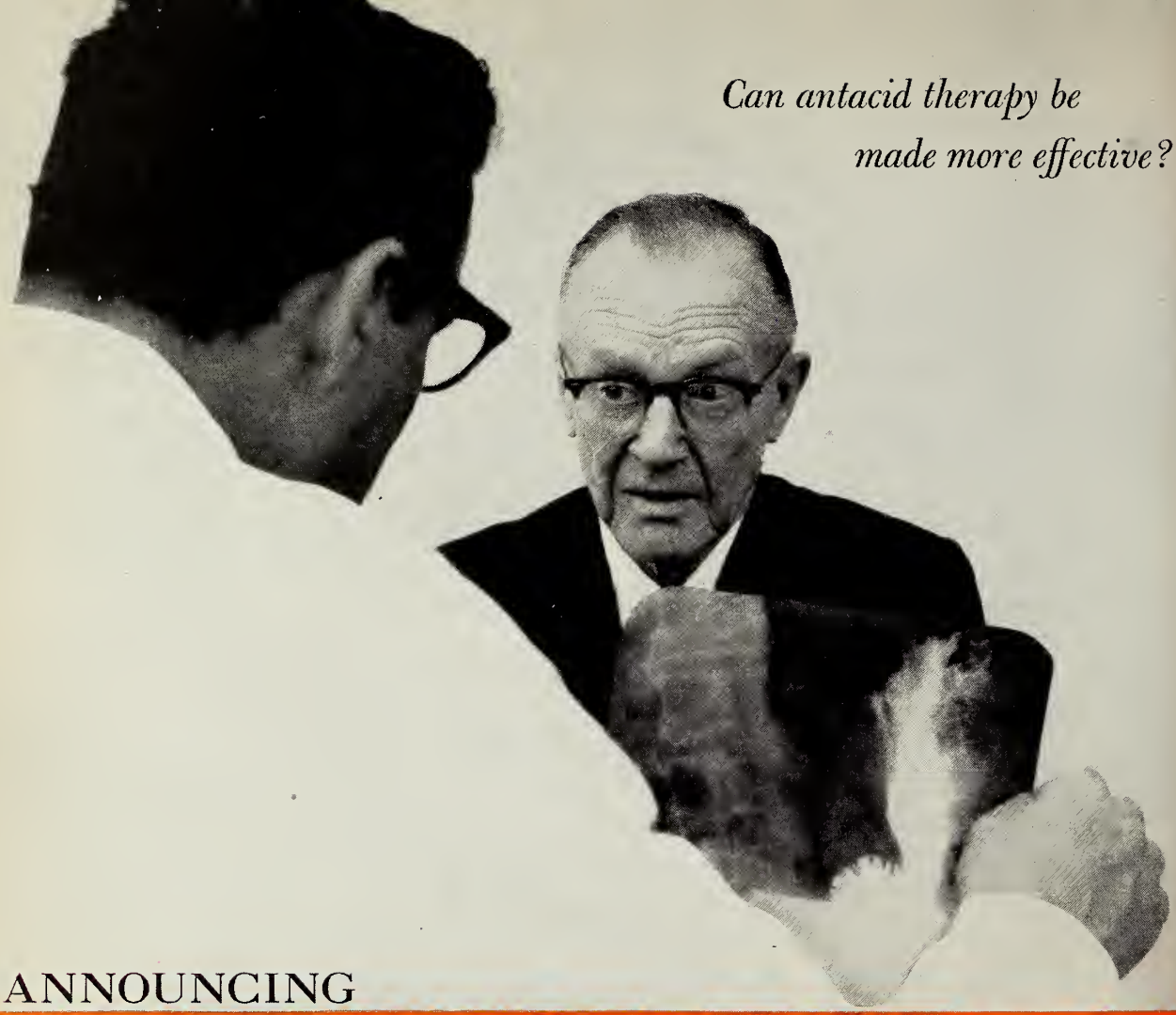
Niphylline is safe, and well tolerated . . . exerts strengthening effect on heart muscles, and acts synergistically, remarkably reducing severity and frequency of cardiac attacks.

Indications: Relief and control of angina pectoris, cardiovascular symptoms, asthenia, coronary spasm with myocardial pain, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Dosage: One or two tablets, 3 or 4 times daily, or as directed by physician.

Supplied: Bottles of 100 and 1000 tablets.

PM **PAUL MANEY**
LABORATORIES, INC.
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Can antacid therapy be made more effective?

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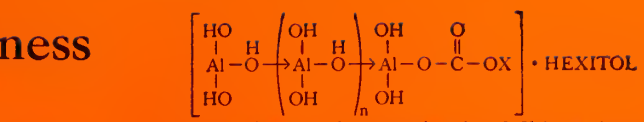
THE MOST SIGNIFICANT IMPROVEMENT IN ANTACID THERAPY SINCE THE INTRODUCTION OF ALUMINUM HYDROXIDE IN 1929

NEW Creamalin® ANTACID TABLETS

Each Creamalin Antacid Tablet contains 320 mg. specially processed, highly reactive, short polymer dried aluminum hydroxide gel, stabilized with hexitol, with 75 mg. magnesium hydroxide.

1. *Neutralizes acid faster (quicker relief)*
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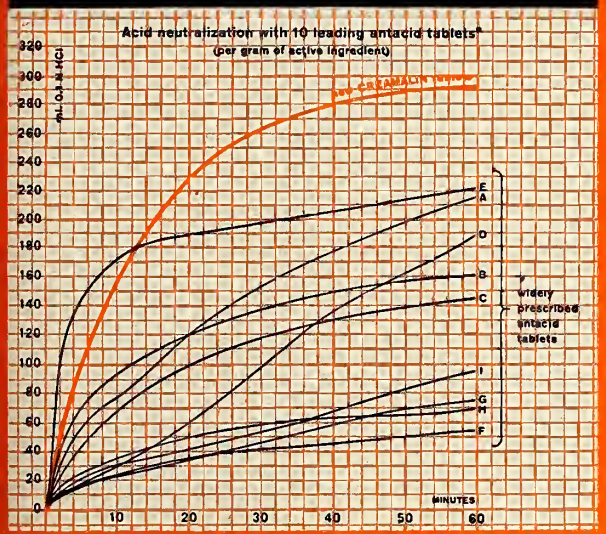
a new high in effectiveness and palatability



n is at least 1 and averages less than 6. X is a cation.

CREAMALIN neutralizes *more* acid *faster*

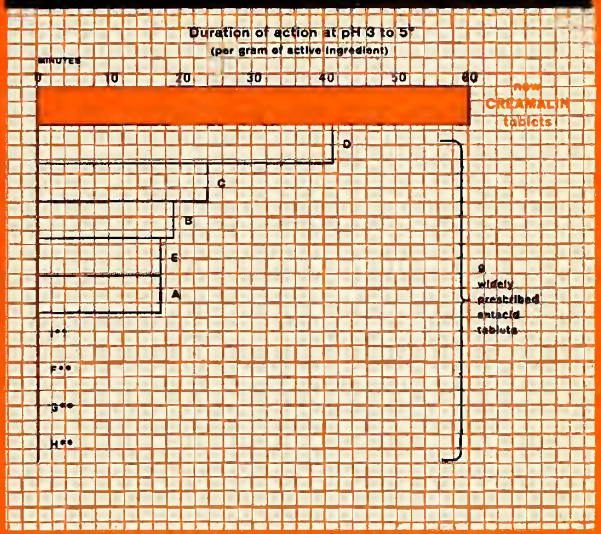
Quicker Relief • Greater Relief



Tablets were powdered and suspended in distilled water in a constant temperature container (37° C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour.

CREAMALIN neutralizes *more* acid *longer*

More Lasting Relief



*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**ph stayed below 3.





No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

• NO ACID REBOUND • NO CONSTIPATION
• NO SYSTEMIC EFFECT

Adult Dosage: Gastric hyperacidity: 2 to 4 tablets as necessary. Peptic ulcer or gastritis: 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

Supplied: Bottles of 50, 100, 200 and 1000.

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Fourth Estate

Continued from page 925

The Hospital Fund Drive

Volunteer workers are preparing to canvass Kokomo and Howard County in an effort to raise $350,000, and more if possible, as a supplementary fund for the new county hospital.

The hospital movement stems from recommendations by several groups, including the county medical society and the Indiana State Board of Health. These groups have recommended increased hospital facilities for the Kokomo area, and a plan to supplement the facilities provided by St. Joseph Hospital with an additional hospital was approved by the public in a referendum.

The trustees of the new hospital hope to have enough money available to build an institution of 100 beds, with central or ancillary facilities designed to accommodate 150 beds. This plan is looking in to the future, the trustees say, and contemplates further growth of the community.

According to the trustees, State Health Board studies indicate a need for 99 additional medical and surgical beds now. They say that if the county raises sufficient money to build an institution that could be expanded to 150 beds sometime in the next decade, the county could effect large savings by doing so.

So, as it is outlined by the trustees, the objective now is to raise funds enough to construct a 100-bed hospital. In order to assure a hospital of that size, they say, the public subscription drive that is being planned must raise $491,605. If that much is raised, the county can qualify for a $150,000 federal grant from funds appropriated under the Hill-Burton Act.

If the campaign raises $350,000, the county can still qualify for the $150,000 in Hill-Burton funds, but can build only an 84-bed hospital.

Whatever is raised in the upcoming drive would be added to the $150,000 Hill-Burton grant and the $1,800,000 which has been obtained through sale of county bonds. Total estimated cost of a 100-bed hospital is $2,475,413. The money raised by the bond issue has been invested and is earning interest, and in addition the hospital foundation has received a number of gifts.

The trustees say that the current bond issues are so near the bonded debt limit of the county that any further bond issue now could provide only a fraction of the funds needed. They believe the county should be able to raise enough for a 100-bed institution and point out that citizens of Logansport subscribed more than $800,000 in the past two years for expansion and improvements to that city's two hospitals, that Grant County people recently subscribed $1,200,000 for hospital expansion and that Anderson citizens raised $3,152,626 for a new hospital and improvement of other facilities there.

One of the important needs in any progressive community is a strong system of hospital facilities. Citizens here should be interested in the facilities the area already has at St. Joseph Hospital and should loyally support that institution. They should also be interested in the campaign now being started by the new hospital and give it their loyal support.

—*Kokomo Tribune*
March 27, 1959

Polio Hits the Uninoculated

The polio story in America is beginning to shape up as one of the most baffling in our modern history.

Thus far in 1959 the total of paralytic polio cases in this country is 55% ahead of the comparable 1958 period.

The number of killed and crippled from this disease in 1958 was, at the same time, 24% over the low 1957 level.

The tragic, stunning thing about these figures is that they are unnecessary. In the Salk vaccine we have the weapon that could win—was winning—the war against polio.

From 1954 to 1957, the toll of dead or crippled from this ailment dropped from 18,300 to 2,500. But this remarkable progress has now been arrested, and reversed.

Why?

Not because a preventive does not exist, but because millions of people, including many parents with children at the vulnerable ages, have not taken advantage of the Salk vaccine.

More than 14 million persons under the age of 20 have had no Salk shots at all. Another nearly 11 million have had less than the 3 shots considered adequate protection.

According to Surgeon General Leroy Burney, interviewed recently by Scripps-Howard reporter John Troan, it is this uninoculated group that



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WHENEVER SULFAS ARE INDICATED

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Sulfamethoxypyridazine Lederle

provides therapeutic sulfa levels for 24 hours... Highly soluble... rapidly absorbed... produces fast, sustained plasma-tissue concentrations. Simple, easy-to-remember, single 0.5 Gm. daily dose. No crystalluria. [1]

with low incidence of sensitivity reactions... Extremely low in toxic potential. [2, 3] No cutaneous or other objective reactions seen in a wide scale study of clinical toxicity. [2] Even minor subjective reactions are not expected to occur [2] or are reported absent [3] when recommended schedule is used.

TABLETS, 0.5 Gm., bottles of 24 and 100. New ACETYL PEDIATRIC SUSPENSION, cherry flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.), bottles of 4 and 16 fl. oz.

1. Editorial: New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med. & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

*Reg. U.S. Pat. Off.

Lederle

Continued

now is being hit hard by the resurgence of polio.

On top of this, there are some 32.5 million adults in the still-susceptible 20-to-40 age bracket who are unprotected against the ravages of this disease.

Since the vaccine is 85 to 90% effective, the great majority of persons who contract polio have no one but themselves or their parents to blame.

Is it for this result that the "mothers marched on polio," that Dr. Jonas Salk and others toiled endless hours in the laboratory, that millions were amassed for research?

Rising polio figures are a strange way to celebrate medicine's brilliant advance against this disease.

—*Kokomo Tribune*
March 3, 1959

They're Still With Us

Did you ever hear of the "merchants of menace"?

A pamphlet recently issued by the *American Medical Association* tells who they are. They're the lineal descendants of "the frontier medicine man whose potent snake oil and wolf milk elixirs were always 'smuggled out of the sacred tombs of ancient Egypt.'"

Nowadays, the pamphlet goes on, "The top hat and torchlights are gone—but the medicine man is still with us, and how he's beating the drums for his potions and remedies at your doorstep, on lecture platforms and through the mail. He's the sophisticated salesman who bleats warnings against 'that tired feeling', 'subclinical deficiencies', 'devitalized food', and 'aging before your time'!"

This modern medicine man offers—at handsome prices—pills, capsules, powders and other preparations which, he swears, will compensate for deficiencies in your diet that are causing your ills. Usually his products are harmless in themselves, but they won't cure anything. So tragedy may befall an ill person who is duped into believing in the efficacy of the concoctions —and doesn't seek qualified medical advice until it's too late.

The AMA pamphlet points out that a well-balanced daily diet should include milk and dairy products, vegetables and fruits, meat, fowl, fish or eggs, and bread and cereals. If we use these standard foods in reasonable balance and quantity, there's no need for supplements unless, of course, your doctor recommends them and tells you what kind to get.

Don't patronize the medicine men.

—*Shelbyville News*
March 17, 1959

Immunizing the Public

The official organ of the American Academy of General Practice, an organization comprised of "family doctors," recently reported that Americans are being practically dunned by charity groups who are crusading against various diseases.

Said the publication: "An expanding variety of ailments and afflictions" are being used for "nickel-dime-and-dollar fund solicitations." The article pointed out that if a particular disease is arrested the organization that had been associated with it usually goes out and adopts another illness as its own. Very often there are overlapping and competing agencies in the same field, and the report went on, there are now "68 solicitations revolving around the human body" and its ailments.

The fight against most of them is undoubtedly worthy of public attention and support. But fund-raising agencies already report they are having a difficult time finding volunteers to canvass neighborhoods because the average housewife has become resistant to giving now that so many organizations have their coin-cans extended.

The Government, also has entered the picture, assigning millions of tax dollars to areas normally the concern of private groups. States and counties, too, are deeply involved in activities related to health.

The eventual result, unfortunately, of so many zealous tax collectors and so many zealous private organizations laying siege to the citizen's pocketbook is not difficult to forsee. We may be moving toward the day when people will stop showing they care, when the public will be largely immunized against any and all appeals for help.

Wall Street Journal
March 30, 1959

Continued

the means *(second to none)*

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INJECTION • SUPPOSITORIES • REPETABS • TABLETS

- *leads* all phenothiazines in effective antinauseant action
- *frees* patients from daytime drowsiness
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FOR RAPID CONTROL OF SEVERE VOMITING

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5 mg. ampul of 1 cc.

Relief usually in 10 minutes[1]...nausea and vomiting controlled in up to 97% of patients[2]... virtually no injection pain.

ALSO NEW TRILAFON SUPPOSITORIES

4 mg. and 8 mg.

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8 mg.—4 mg. in outer layer for *prompt effect*, 4 mg. in inner core for *prolonged action*

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2 mg. and 4 mg.

(1) Ernst, E. M., and Snyder, A. M.: Pennsylvania M. J. *61*:355, 1958.

(2) Preisig, R., and Landman, M. E.: Am. Pract. & Digest Treat. *9*:740, 1958.

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TRJ-429

Fourth Estate

Continued

Good News for the Elderly

Big and good news for millions of our elderly citizens comes from the American Medical Association. The AMA's House of Delegates, by unanimous vote, has approved a proposal which calls for physicians to provide medical services at adjusted rates to persons over 65 years of age with reduced incomes and modest resources.

Specifically, the proposal asks insurance companies and medical prepayment plans to develop new policies at special low premium rates for people in this category. It further provides that if the income and resources of the insured falls below a specified sum, doctors would agree to adjust their rates accordingly. Doctors throughout the country are urged to "accept a level of compensation for medical services rendered . . . that will permit the development of such insurance and prepayment plans."

In the words of the *Minneapolis Tribune,* this ". . . is evidence that the nation's medical leaders are ready to give serious consideration to new ways—which may prove to be better ways—of giving people the good medical service they want and need." In case of the elderly the problem is especially important. People are living longer than they used to, and the proportion of the aged to the whole population is steadily increasing.

The AMA, working with other interested organizations, has a number on target—to solve medical and socioeconomic problems arising from a rapidly expanding aging population. The new plan is a big step in that direction.

—*Milford (Ind.) Mail*
February 12, 1959

Unused Protection

"The Salk vaccine has succeeded in winning the war against this disease, but by failing to get their shots, Americans are in danger of losing a just and lasting peace on the polio front."

That statement comes from Dr. Leroy E. Burney, a former Hoosier who is now Surgeon General of the U.S. Public Health Service. Dr. Burney points out that cases of paralytic polio so far this year are 55% above last year's level. And during 1958 the number killed and crippled by this disease was 24% above the low mark set in 1957.

Progress against polio has been little short of amazing. In 1954, the year before the *Salk vaccine* was licensed, 18,308 persons in the United States were killed or crippled by polio. In 1957, the toll was down to 2,499. But last year polio staged a comeback, with more than 3,100 persons either killed or crippled by it.

Although the increase so far this year gives pause for serious concern, no one can tell what the year as a whole will bring, for polio is a highly unpredictable disease. But one thing is certain, the public in general is not taking anything near full advantage of the proved protection provided by the Salk vaccine. As Dr. Burney says: "All the evidence we have gathered shows the Salk vaccine is remarkably effective in preventing paralytic polio. It is one of the best vaccines on the market."

It is estimated that more than 57 million Americans under the age of 40—those most susceptible to the disease—have yet to get all the polio shots they should. The normally prescribed series of shots is 3, although in many cases a fourth shot is recommended for maximum protection.

Continued

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of serving physicians of the Middle West with high quality and rigidly controlled pharmaceutical products.

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Pharmaceutical Specialties
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PENTAFORT

Provides BOTH fast and prolonged vasodilation for practical prophylaxis in angina pectoris.

Combines TWO (Nitroglycerin and Pentaerythritol Tetranitrate) time tested coronary vasodilators in a stable and economical dosage form.

Glyceryl Trinitrate (Nitroglycerin) 1/150 gr.
Pentaerythritol Tetranitrate.15 mg.
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around the clock ulcer control with **B.I.D.** *dosage*



Just one 10 mg. Daricon tablet in the morning, and one at night before retiring, keeps your patient free from the pain and discomfort caused by gastrointestinal spasm, hypermotility, and hypersecretion.

Daricon is a remarkably potent and well tolerated antisecretory/antimotility agent. Its *naturally* prolonged action provides day and night relief of pain and symptoms associated with peptic ulcer, functional bowel syndrome, biliary tract dysfunctions, ulcerative colitis, and other gastrointestinal disorders characterized by spasm, hypermotility, and hypersecretion.

Dosage: 10 mg. b.i.d. (morning and evening).

EVEN REFRACTORY CASES RESPOND

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Pfizer *Science for the world's well-being*

Pfizer Laboratories
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

References: 1. Finkelstein, M., et al.: J. Pharmacol. & Exper. Therap. 125:330 (April) 1959. 2. McHardy, G., et al.: Postgrad. Med., in press. 3. Winkelstein, A.: Amer. J. Gastroenterol., in press. 4. Finkelstein, M., et al.: Presented at Fall Meeting, Amer. Soc. Pharmacol. & Exper. Therap., 1958. 5. Leming, B.: Clin. Med. 6:423 (March) 1959.

*Trademark

Fourth Estate

Continued

The Salk vaccine is one of the most noteworthy medical developments of modern times. It seems almost unbelievable that so many millions of us who should have the protection it affords, have failed to get it. And it is as close as our family doctor!

— *Shelbyville News*
March 16, 1959

Now Up to Bus, Truck Drivers

Indiana's new legislation raising the speed limits for trucks and buses on the open highway is reasonable.

The speed limits are raised to 55 and 65 miles an hour, respectively, on the divided highways.

Trucks and buses provide vital transportation. Daily in Indiana they carry thousands of passengers and thousands of tons of a wide variety of goods essential to the economy of the state and the nation. To hamper the movement of these vehicles unnecessarily is neither fair nor desirable from the point of view of public convenience and necessity.

The higher speed limits for the commercial carriers, however, increase the responsibilities of drivers and operators. The higher limits don't suggest a proportionate increase in frequency of accidents involving commercial vehicles, but there shouldn't be any complacency.

Indiana state police would do well to watch the situation carefully and prepare to make a report to the 92d General Assembly in 1961.

As matters stand, the trucks and bus drivers and operators are, in a sense, on unofficial probation. They can make the most of the opportunity by proving that the limits should have been raised. Or they can so deport themselves that a clamor is sure to arise for reducing the speed limits to the former levels or lower.

It is accepted! that truck and bus drivers and operators are as conscious as anyone, and possibly more so than many other drivers of the hazards of excessive speed. If anything, the higher limits should sharpen this consciousness.

At this point the elevation of the speed limits appear reasonable, desirable and realistic. The responsibility is squarely on the drivers and operators to prove that the state legislature didn't make a mistake.

Reprinted in *Kokomo Tribune*
March 24, 1959



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For every topical indication, a Burroughs Wellcome 'SPORIN'...



Ointment: Tubes of ⅛ oz. and ½ oz. (with applicator tip) for ophthalmic or dermatologic application.

Otic Drops: Bottles of 5 cc. with sterile dropper.



Ointment: Tubes of ½ and 1 oz. and tubes of ⅛ oz. with ophthalmic tip.

Ophthalmic Solution: Bottles of 10 cc. with sterile dropper.

NEW { **Lotion:** Plastic squeeze bottles of 20 cc.
Powder: Shaker-top bottles of 10 Gm.



Ointment: Tubes of ½ oz., 1 oz. and ⅛ oz. (ophthalmic tip).

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Community Service Approach to Health Care Financing

This article is the fourth in a series prepared by Blue Cross—Blue Shield dealing with trends in the financing of health care.

Blue Cross—Blue Shield believes that health care financing organized on a community service, not-for-profit basis is in the best interests of members, doctors, hospitals and the general public.

Any real solution to the problem must be based on these two principles: (1) adequate protection should be made available to all persons, and (2) money paid in for health care should be paid out for health care.

"All persons" includes those of high, medium and low income. Protection should be available to them when working, after termination of employment, after retirement and when they are sick. The protection should be continuous, and it should not be canceled or waivered because of utilization, condition of health or change in employment status.

Blue Cross—Blue Shield accepts the community responsibility of attempting to enroll all segments of the population on such a basis. Varied programs have been devised to meet the needs of employed workers, pensioners, self-employed, college students, over-age and retired individuals. During 2 state-wide open enrollment campaigns everyone in Indiana has been given the opportunity to obtain Blue Cross—Blue Shield protection.

Today nearly one-third of all Hoosiers are enrolled in Blue Cross—Blue Shield, including more than 26% of the special problem group of persons 65 and over.

The Plans were organized to solve social as well as economic problems. The goal is service rather than profit; the concern is protection rather than price. In pursuit of such objectives, Blue Cross—Blue Shield has successfully bypassed experience rating and other underwriting principles insurance companies feel are necessary to successful operation, and has never canceled membership because of use, health or change in job status.

What does this type of not-for-profit operation mean to members, providers of service and the general public? In 1958 Blue Cross—Blue Shield paid out 92.2% of all income for members' benefits, held operating costs to a low 6.6% of income, and kept the balance of income in reserve against future contingencies of high utilization and increasing costs. Not-for-profit administration and economical operation on a volume basis make it possible for Blue Cross—Blue Shield to provide the greatest benefits at the lowest cost.

The growth of health care financing proves that the budgeting of the cost of health expense in advance makes good sense to most Americans. The dependence upon some "third party" agency is now an indispensable factor.

Today's question is: what kind of an agency will it be? A community service organization like Blue Cross—Blue Shield? A commercial insurance company? The government?

The choice should be the organization that does the best job at the lowest cost to the community as a whole—including taxpayers.

Here are a few questions to use in evaluating such a health care program. Does it provide protection after retirement? When members change jobs? When they are ill? Is a maximum proportion of the money paid in used to pay health care bills?

The Blue Cross—Blue Shield answer to each of these questions is: Yes. Unless health care financing organizations can answer all these questions in the same fashion, they are not meeting the needs of the community.

Blue Cross—Blue Shield has grown by refusing to be bound by traditional insurance practices. For example, Blue Cross—Blue Shield has never offered "loss leaders," or shifted the cost of health care to the patient by means of deductibles and co-insurance, and believes that the public's reliance upon voluntary prepayment can-

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control

virtually all runaway diarrheas.. promptly, effectively with



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Prompt and more dependable control of virtually all diarrheas can be achieved with the comprehensive DONNAGEL formula, which provides adsorbent, demulcent, antispasmodic and sedative effects—with or without an antibiotic. Early re-establishment of normal bowel function is assured—for all ages, in all seasons.

DONNAGEL: In each 30 cc. (1 fl. oz.):

Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

DONNAGEL WITH NEOMYCIN

Same formula, plus

Neomycin sulfate	300 mg.

(Equal to neomycin base, 210 mg.)

A. H. ROBINS CO., INC., Richmond 20, Virginia · *Ethical Pharmaceuticals of Merit since 1878*

Wanted: PHYSICIANS LOCATIONS

Following are the latest requests received by the Physicians Placement Service of ISMA:

HANCOCK COUNTY—Fortville, population 2,000. Located 20 miles from Indianapolis. Nearest hospital 11 miles away located at Greenfield. Office space available for rent and a home for sale. Contact Harold M. Manifold, M.D., Fortville, Ind., for further details. Also Mrs. Otis V. Morris, 205 E. Ohio St., Fortville, Sec'y, Citizens' Committee.

SCOTT COUNTY — Scottsburg, population 3,000. County seat town. New hospital in town. Two physicians in Scottsburg. There is a need for additional physicians in the county. For further information contact Dr. Marvin McClain, Scottsburg or Mr. Hancock, Hancock Drug Store, Scottsburg, Ind.

RIPLEY COUNTY—Friendship. Large rural area in need of a physician. Located close to Lawrenceburg, Ind. and Cincinnati. For further information contact Mrs. Henry D. Fisse, Friendship, Ind.

MILAN—population 1,500 with large surrounding territory. Nearest hospital is located at Batesville, 20 miles away. Good roads. Only one physician in the town. There is an opening for a general practitioner either as an associate or solo practice. Contact William J. Warn, M.D., or Mr. Paul Stepleton, Chamber of Commerce, Milan, Ind.

HENRY COUNTY—Middletown, population 2,500, centrally located between the industrial areas of Anderson, Muncie and New Castle. Also farming community. One active physician in the town. Contact Robert F. Wisehart, Chamber of Commerce, Middletown, Ind.

SULPHUR SPRINGS—population 400. Rural community. Located 8 miles from New Castle, Ind. Contact Alfred C. Ayres, Cashier, Union State Bank, for further information.

SWITZERLAND COUNTY — Vevay. Office and medical equipment of the late Dr. George Ellerbrook available. Located close to Madison, Ind. on the Ohio River. There is need for a general practitioner in this community. Contact Mrs. Anna K. Ellerbrook, 205 West Main Street, Vevay, Ind., for further details.

Physicians Seeking Locations

John H. Calvert, Jr., M.D., 8 Hatcher, Sheppard AFB, Texas.

Harold R. Dowell, M.D., Wherry Apt. 53-D, Fort Campbell, Ky.

Howard S. Brown, M.D., Ancker Hospital, St. Paul 1, Minn.

James Black, M.D., 525B Carpenter St., Akron 10, Ohio.

Dwight W. Anderson, M.D., Box 134, Mokena, Ill.

Specialists

Gerald P. Fitzgerald, M.D., 709 N. Ringold St., Janesville, Wisc., **Ophthalmology.**

Burton J. Shapiro, M.D., 23404 Cedar Rd., Cleveland 21, Ohio, **Ophthalmology.**

Keith R. Rabinov, M.D., 11915 Mayfield, Los Angeles, **Radiology.**

Samuel L. Karr, M.D., 7310 Brookhaven Rd., Philadelphia 31, Pa., **Internal Medicine.**

F. G. Cummins, M.D., 3466 E. Redlands, Fresno 3, Calif., **Ob-Gyn.**

Fitzablert M. Marius, M.D., 4649 Tulare St., Fresno, Calif., **Surgery.**

James D. McAlindon, M.D., 3538 "S" St., N.W., Washington, D. C., **General Surgery.**

Josef Meir, M.D., c/o Mt. Sinai Hospital, 1800 East 105th St., Cleveland, Ohio, **Preceptorship, General Surgery.**



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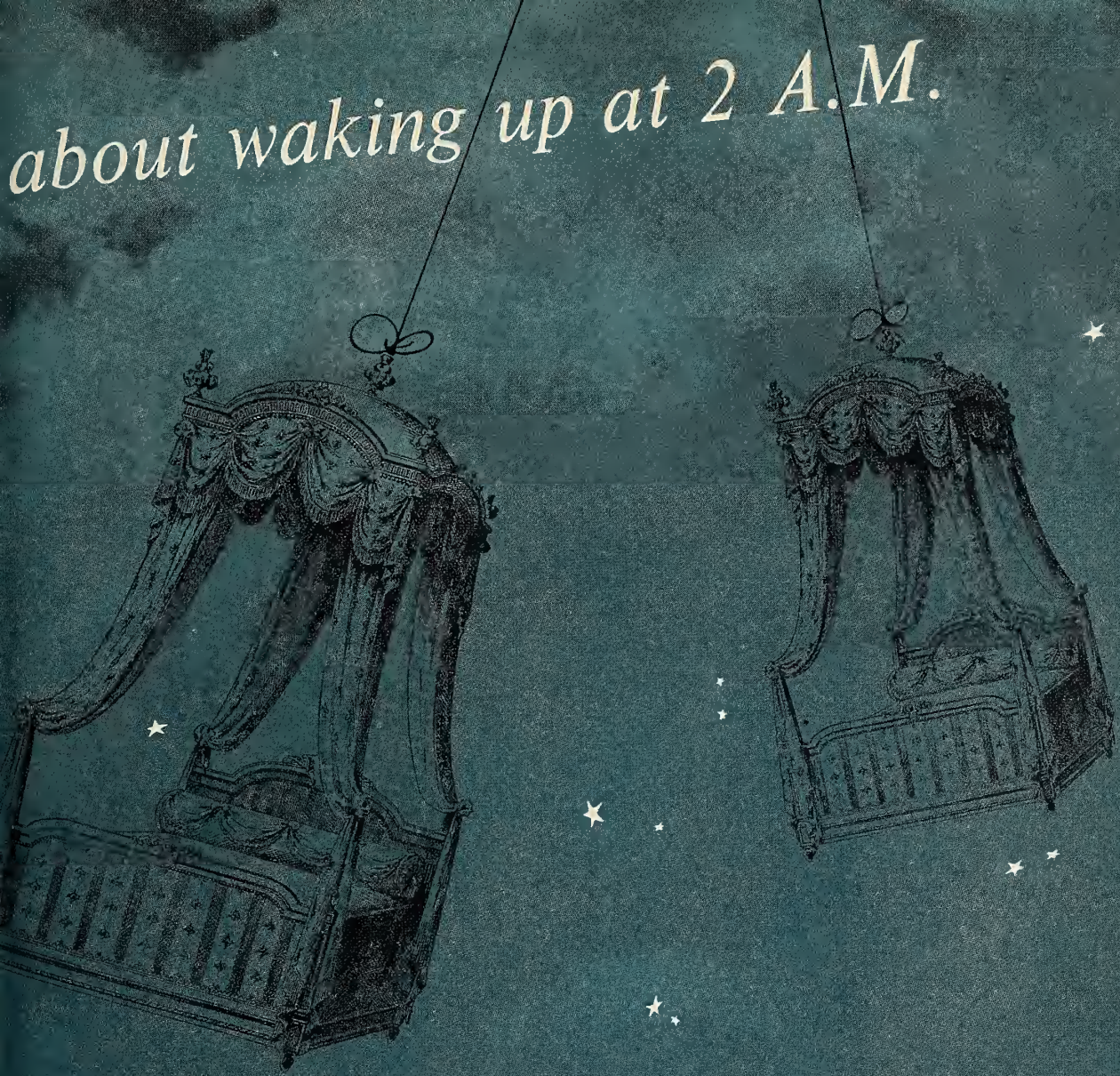
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Indiana Driver Licensing Law

Medical Profession Aid Needed in Making Highways Safer from Physically and Mentally Handicapped Drivers.

ROBERT L. McMAHAN*

Indianapolis

THE SUBJECT assigned to me today is the Indiana Driver Licensing Law and suggested improvements therein. I cannot criticize our law and I do not have many recommendations for improvement. True, there are minor changes I can recommend, none of which are too serious. The Indiana law grants to the Commissioner of Motor Vehicles ample authority to do the things desired under a good driver license law. Let me quote to you the Indiana law and I think you will agree the authority is ample:

> "The Department shall not license any person when the Commissioner has good cause to believe that the operation of a motor vehicle on a public highway of this State by such person would be inimical to public safety or welfare."

The past legislatures of Indiana have been very much aware of their responsibility in presenting good legislation. The 1957 legislature took one of the most forward steps when it enacted a mandatory re-examination program. Indiana is the second state in the entire country to adopt such a policy. Only North Carolina also requires a re-examination of every driver. True, some states have discretionary programs which they enforce when they are not too busy and which they by-pass when their workload gets too heavy.

Here in Indiana we have no such choice. Every driver on the highways of Indiana must now be examined every 4 years. You would be interested, I know, in how we determine what drivers should or should not be permitted on our highways. In reality, there are two grades of standards, and I know we will all agree the first is what is known as the desirable standard. That standard which every driver should meet, such as perfect vision, perfect health, perfect coordination and things like that. However, we must recognize the frailties of the human being and adopt a minimum standard by which we can determine which drivers should not be permitted on the highways. On many of the border-line individuals we use restrictions such as driving only when wearing corrected lenses, with outside rear-view mirrors, only in daylight or with automatic shift equipment, etc. Individuals who barely meet our minimum standards become better drivers upon learning of their deficiencies and, thereby, compensate by being more careful.

Let me tell you who the individuals are that are causing our traffic safety problem. It is not those as a rule who meet our minimum standards, even though some of those individuals may be accident prone. Who are the individuals violating our traffic laws? They are individuals like you and me and our neighbors. They are the individuals whose driving attitudes are at fault. They are the very same individuals who will step aside to let a lady enter the doorway first but 10 minutes later will step on the accelerator in order to beat her across the intersection.

I want to discuss the problem of the driving attitude of our citizens a little more in detail, but

Address before the Traffic Safety meeting Feb. 15, 1959.

* Commissioner, Bureau of Motor Vehicles, State of Indiana.



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Indiana Driver

Continued

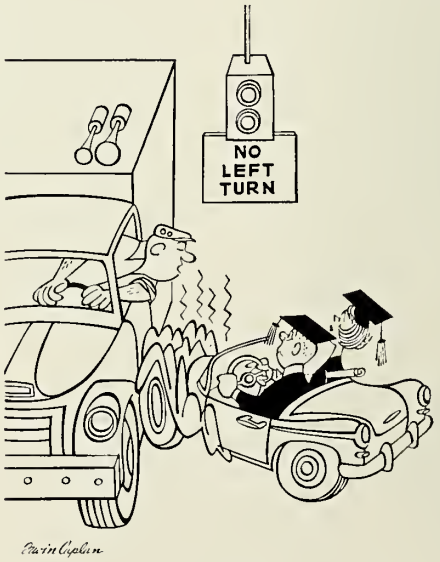
before going into that subject would like to call your attention to additional admonitions in our driving license law. We are directed by the law to not issue licenses to habitual drunkards, drug addicts or persons suffering from such physical disability or mental diseases as will serve to prevent such persons from exercising reasonable and ordinary control over a motor vehicle while operating such vehicle upon the public highways of Indiana. How are we in the Department to determine who the habitual drunkard is, who is a drug addict and who is suffering from such physical or mental disabilities as to prevent their being safe drivers? Here the Bureau of Motor Vehicles and the Commissioner need the help of your profession. We need your cooperation, advice and assistance.

About 2 years ago it was necessary for me to develop and put in operation our new reexamination program. I needed professional assistance at that time especially in administering vision test to all of the nearly two and one-half million drivers of Indiana. The American Association of Motor Vehicle Administrators had considerable material collected, but I felt I wanted the advice of Indiana professional people, so I approached the School of Medicine and the Optometry School of Indiana University for the benefit of their knowledge. I am sorry to relate to a meeting of this profession that the School of Optometry of our great State University immediately volunteered and gave to me the utmost cooperation and assistance, but my reception from the Ophthalmology Department of the School of Medicine left much to be desired. I was subjected to a 45-minute dissertation of what was wrong with the entire program and received no further assistance. I am glad to say the active practitioner in that field has assisted greatly but the academic people I feel let me down. We must all agree that the psychiatric specialists in the profession will have to guide us in answering the problem of the poor driver who is a poor driver because of a poor attitude.

How have we tried to reach this individual from a layman's viewpoint? Strict enforcement to hail the traffic law violator into court is of course one method of pinpointing the chronic law violator. The point system was developed in Indiana some 6 years ago to call to the attention of the Department those drivers whose attitudes must be changed. However, strict enforcement can only be obtained so long as the public demands it, and I am sorry to report that the public is strangely apathetic. Too many citizens of Indiana, like those of every other state, take the attitude that they are good drivers, accidents cannot happen to them, so why worry about the problem. They fail to realize that their high insurance costs are caused entirely by the increasing number of severity of traffic accidents.

Under the point system we have been able to remove many drivers from the highway and make many other drivers become more cautious. We have a saying in the traffic safety field that drivers will not slow down to save their lives but they will slow down to save their licenses. Traffic accidents can happen to you and to me and the statistics across my desk every day scare me. I have become the most cautious driver you have ever seen, for I now drive as if an accident is going to happen to me at every intersection.

What are you doing to help solve this problem? We in state government can only lead and suggest. We need and implore you people and people in your positions of influence in your various communities to organize your communities for better traffic safety.



"READING NOT REQUIRED FOR A DIPLOMA THESE DAYS?"

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Polycystic Disease of the Kidneys in Adults

SHERMAN B. LINDSEY, M.D.

Temple, Texas

AN EXTENSIVE cystic invasion of the renal parenchyma has been recognized for many years as *polycystic disease of the kidneys*. This condition is uncommon, but it occurs frequently enough to be of clinical significance. The diagnosis may not be made early in the disease unless the physician considers polycystic disease in the differential diagnosis and uses roentgen studies to investigate vague genitourinary symptoms and minimal abnormalities of the urine.

A survey of the clinical records from 1938 to 1958 at the Scott and White Memorial Hospital and the Gulf, Colorado and Santa Fe Railway Hospital revealed 40 cases of polycystic disease of the kidneys in adults. The diagnosis was made by demonstration of abnormalities typical of polycystic disease on intravenous pyelograms, by surgical exploration, or by necropsy findings. Because an early diagnosis and proper treatment of the complications of the disease may prolong a patient's life, these 40 verified cases were studied as to symptoms and physical and laboratory findings at the time the polycystic disease was discovered (Table 1).

From the Department of Internal Medicine of the Scott and White Clinic and Consultant in Medicine at the Gulf, Colorado and Santa Fe Railway Hospital, Temple, Texas.

POLYCYSTIC DISEASE OF THE KIDNEYS

Data at Time of Discovery in 40 Adults

Symptoms	Cases	Percentage
Blood Pressure		
Over 140 systolic	24	60.0
Loin Pain	16	40.0
Dysuria	15	37.5
Urinary Calculi,		
Present or in past	9	22.5
Urinary Findings:		
Grade I WBC	16	40.0
Grade II-IV	5	12.5
Grade I RBC	4	10.0
Grade I-IV	4	10.0
Albuminuria I-IV	10	25.0
Elevation of Blood Urea	11	27.5
Average Age at time of Diagnosis		48.8 Years

Etiology

Polycystic disease of the kidneys is considered to be a congenital developmental defect, but the exact etiology is unknown. The most accepted

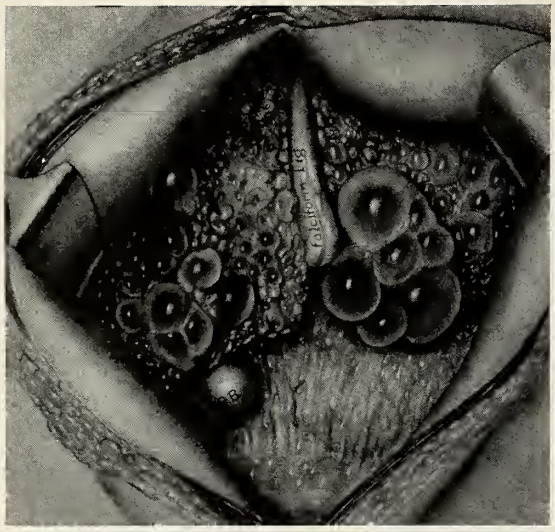


Fig. 1. Multiple cysts of the liver associated with polycystic disease of the kidneys. (Artist's drawing at the time of operation).

theories involve the failure of the uriniferous tubules to unite with the collecting tubules, failure of the early uriniferous tubules to atrophy, or a localized failure of the tubules to develop normally. The cysts involve both the cortex and the medulla, and usually they are lined with cubical epithelium.

The disease is found in all age groups, the diagnosis being made most frequently in infants and in adults during the fourth and fifth decades. In our series of 40 adults, the average age at the time of discovery of the disease was 48.8 years. There is no predilection for sex. A familial tendency has been demonstrated so frequently that the hereditary aspect of polycystic disease of the kidneys deserves careful investigation in the patient with vague urinary complaints or hypertension.

The mortality rate is high in the infantile type of polycystic disease of the kidneys. If the kidneys are extensively involved by polycystic changes, the majority of infants die at birth or a few weeks later. Grossly, the cysts are more uniform in size, but the microscopic changes are similar to those demonstrated in the adult form.

Congenital abnormalities in other organs may be associated with polycystic kidneys. Cysts of the liver have been found in 19 to 28% of the patients with polycystic disease of the kidneys.[4] In one case included in our series, almost all of the surface of the liver was replaced by cysts (Fig. 1). In another instance, the renal condition was associated with a cerebral aneurysm.

Arteriosclerosis of renal vessels may play a part in the rapid progression of the disease later in life.

Discussion

Although attention usually is directed to the genitourinary tract, the early symptoms of polycystic disease of the kidneys are not specific. Burning on urination, hematuria, loin pain and fever frequently bring the patient to the doctor. A history of passing a renal stone is common. The initial diagnostic impression may be that of urethritis, prostatitis, cystitis, ureteral calculus, pyelonephritis, renal arteriosclerosis or glomerulonephritis. Simple multiple cysts, echinococcal renal cysts, multilocular cysts, congenital medullary cysts, and unilateral multicystic disease of the kidney should be considered in the differential diagnosis. Polycystic disease of the kidneys has been reported as simulating herniated nucleus pulposus.[3]

Hypertension may be the first clinical sign. In our series, it was the most frequent finding; 60% of our patients having a systolic blood pressure of more than 140 mm. of mercury. Before being diagnostically classified as having "essential hypertension," patients with hypertension should have adequate genitourinary studies.

Symptoms of renal insufficiency may be present when the diagnosis is first made; however, this is not an early sign. In our series, only 27% of the patients had an elevation of blood urea at the time the disease was discovered.

A routine urinalysis usually shows a slight increase in pus and red cells in the urine along with mild albuminuria early in the disease. Complications such as acute urinary tract infection and calculi increase the frequency of abnormal findings. Unless there is marked hematuria, infection, or renal insufficiency, the blood count is normal early in the disease.

To avoid confusing the early symptoms of polycystic disease with other conditions of the kidneys, an intravenous pyelogram should be made. When demonstrated on the pyelogram, this disease causes the calices to appear elongated, blunted and irregular in outline. (Fig. 2). Before intravenous pyelograms were employed rather routinely, 2 cases in our series were not discovered for several years because plain survey roentgenograms were used to exclude polycystic disease of the kidneys. Retrograde pyelograms may be necessary in some cases. Because roent-

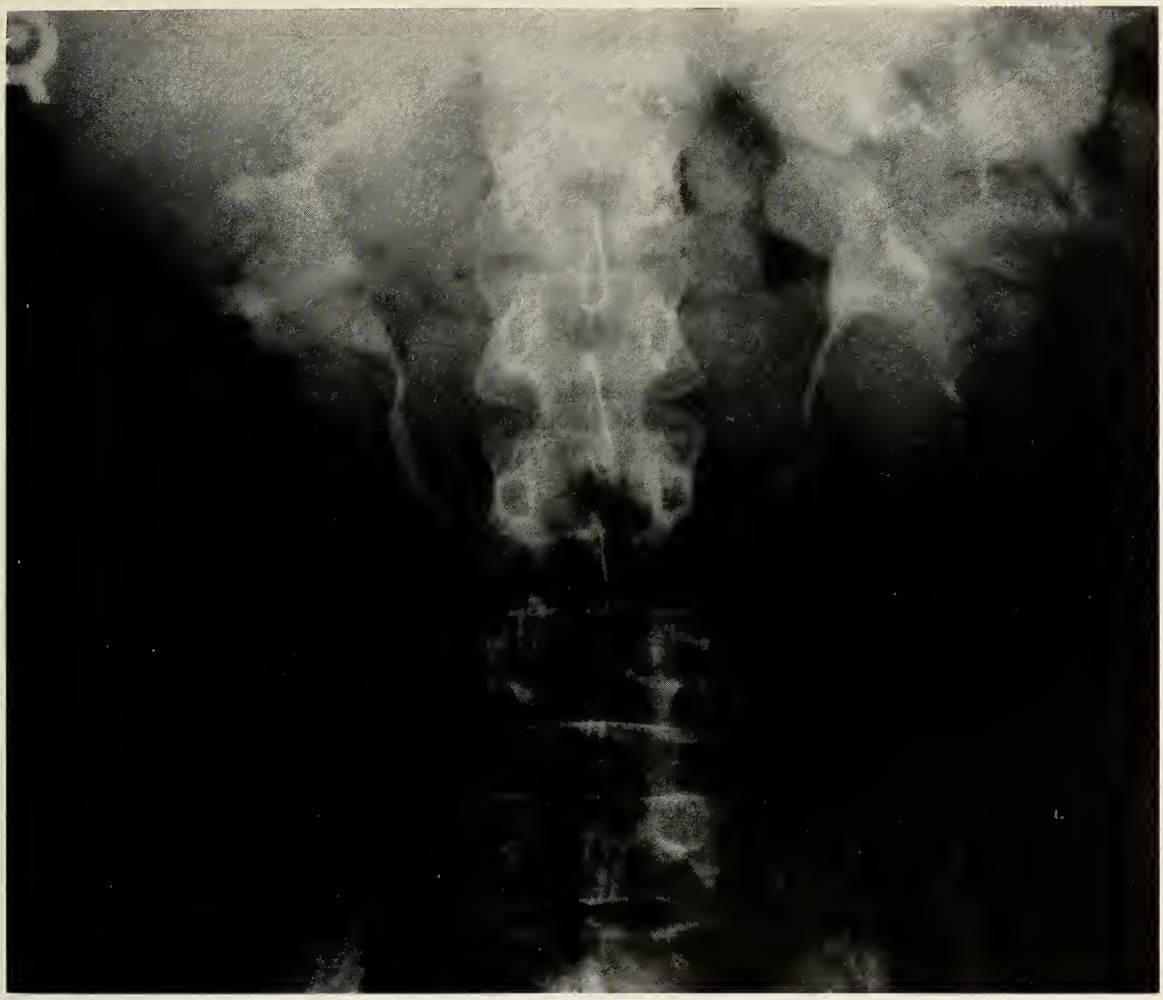


Fig. 2. An intravenous pyelogram showing polycystic kidneys.

gen demonstration of the abnormality was not typical of polycystic disease, several of our patients were considered to have solitary cysts, abscesses or tumors prior to surgical exploration.

Usually both kidneys are involved.[2] Prior to exploration of the renal areas or autopsy (Fig. 3), it is difficult to exclude bilateral disease by roentgen studies or palpation of the abdomen. A condition termed congenital unilateral multicystic disease of the kidney has been reported.[5] It is described as differing from polycystic disease in that the disease involves all structures of the kidney and is unilateral.

The finding of a mass in the loin may be helpful in making the diagnosis. Obesity and tense abdominal muscles may prevent detection of a large cystic kidney.



Fig. 3. Bilateral polycystic kidneys. An autopsy specimen.

Prognosis

Congenital polycystic disease of the kidneys is progressive in nature, but destruction of renal

tissues, unless hastened by infection, usually is slow. Although the prognosis is poor, careful medical management will prolong and add comfort to the lives of these patients.

Rall and Odel[4] found the average duration of life of 85 patients with polycystic disease of the kidneys to be 49.3 years and the duration of life after onset of symptoms was 9.3 years. (Infants, younger than 6 months, were excluded.)

In this disease, the most frequent terminal events include renal insufficiency, cardiac failure, cardiac infarction and cerebral hemorrhage. Malignant changes are rare in polycystic kidneys.

Treatment

As no cure or preventative is known for congenital polycystic disease of the kidneys, treatment usually is medical and attention is directed to general nutrition and to treatment of complications. Hypertension and uremia are treated as they are in pyelonephritis and glomerulonephritis. Anemia is improved temporarily by blood transfusions. Urinary infection should be treated promptly by employing the proper antibiotic agents, and adequate drainage of the lower urinary tract should be maintained.

Except for draining an infected or painful cyst, surgical treatment usually is contraindicated because of the bilateral and progressive nature of the disease.

Summary and Conclusions

Early symptoms of polycystic disease of the kidneys may simulate the clinical picture of less serious genitourinary diseases; however, the early signs and symptoms usually do direct attention to the urinary tract and adequate roentgen studies will help to establish the correct diagnosis.

Patients with hypertension should have adequate studies of the urinary tract before a diagnosis of essential hypertension is made.

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'dad-burn hook-and-line'

Pity the poor city lad who knows not the meaning of Riley's poem on our cover this month. What is more wonderful than the memory of stealing off on some quiet riverbank with that "saplin'-pole," "dad-burn hook-and-line" and a faithful friend whose name just might have been Rover?



Hoosier boys, as a whole, probably are luckier than those in the big Eastern cities for, except for some of the more unfortunate Nap Towners, most of them at least get to see such river banks. A recent letter to the editor printed in a Hartford, Conn., daily implored the fact that boys don't even play sandlot ball in Hartford anymore. There's lots of sandlot or grassy field ball diamonds in Indianapolis, so maybe that means there's still youngsters like our cover boy. We hope so!

This photograph was taken by Henry S. Wood of New Palestine, who has supplied us with our scenic shots used thus far. Our engraver, Rheitone, Inc., came up with the line screening which gives the picture that "old" appearance. The photo actually wasn't taken on Riley's "old Brandywine," but on Big Sugar Creek in Hancock County. Mr. Wood tells us this is known as one of Indiana's best bass fishing streams; "a rather poor fishing spot for the amateur, but many fine catches have been made by the more skilled anglers." Maybe the lad in his picture isn't a "skilled angler," but don't you feel that he really doesn't care?

corki



The Impact of the Family and Home Environment on the Performance of the School Child

JAMES E. SIMMONS, M.D.*

Indianapolis

THE PERFORMANCE of the school child is not a reflection of his family environment alone or his intelligence and personality make-up or the capabilities of his teacher. In any given child, elements from all of these areas and many more will determine his success or failure in school.

Historically, schools developed as institutions of learning designed primarily for the transmission of knowledge to the young and uninformed. Formerly, mere transmission of knowledge to a receptive few was sufficient. With pressure for more education for a larger and larger percentage of the population, we have become concerned with all factors which enhance or disrupt the educational process.

Actually, one of the earliest references regarding the effect the physical and mental state of a child has on his capacity to learn was written by a pediatrician in Constantinople in 400 A.D.[1] Concern over the physical and emotional health of the school child is not a new concept but it has taken a long time for these "new" ideas to be incorporated into common practice.

In order to succeed in its primary goal of imparting knowledge to the majority of the population, schools have had to assume some of the responsibility for the health of the children. By tradition this obligation has largely belonged to the family. The struggle between the home and school over the exact dividing line for this responsibility cannot be settled here. For example, recently in the newspaper a woman was reported to have petitioned the school to ban cigarette smoking, tight clothing and public petting to and from school because she could not curb these activities in her own children without some external forces. All of you here would have some idea about who should assume the responsibility for settling such issues but I doubt if all of us would agree completely on it.

The situation becomes extremely complicated and difficult when we are trying to deal with emotional health. It is known that the personality and emotional health of any child are influenced very much by the emotional climate of his home during the early pre-school years. His general adjustment and capacity to learn at any time is also affected very greatly by the current environment in which he lives. For example, separation of the father from the home by death, divorce or military service may seem to produce a marked decrease in a child's school performance. However, we know that all children whose fathers were in service did not fail. Therefore, we must assume that more than one factor would be causing a given difficulty at any given moment.

Emotional upsets are usually conflicts of one's own feelings and these conflicts are mostly experienced and expressed in our relationships with other people. The primary factor in the home

Presented at the Indiana State Medical Association Convention Oct. 14, 1958, Indianapolis.

* Associate Professor of Psychiatry and Coordinator of Child Psychiatry Services, Indiana University Medical Center, Indianapolis 7.

environment, then, is the interpersonal relationships of the family members. The complexity of this becomes apparent when you consider mathematically that in a family of 3, 4 separate although overlapping human interrelationships are possible and in a family of 6, 57 such relationships are possible.[2]

In discussing "The Impact of the Home on School Performance," I hope to do more than merely point out the high percentage of cads, beasts and shrews we have among parents today. All of us who work with children tend to overidentify with the younger generation. We see our charges as little innocents who are the victims of grossly ignorant, rejecting and hostile parents. Actually, such attitudes on the part of professional persons working with children are apt to more clearly reflect the degree to which we have failed to resolve our own childhood conflicts than to shed light on the problems of today's school children.

Such slogans as "there is no such thing as a bad boy, just bad parents" may, at first glance, appear to indicate great understanding. Closer examination shows that such statements are merely moral judgments made against parents in order to find a scapegoat. Society went through a period of rather frequently removing "helpless" children from these bad or incompetent parents. The terms "bad" and "incompetent" were a little difficult to define but if you become angry enough with the parents, such minor definitions would not stand in the way.

I believe there has been general disappointment in this heroic approach to saving our youth. The orphanages and children's institutions became overcrowded and were not able to supply much more stability, personal security or freedom from abuse than the children's own homes. The extensive use of foster homes has been an effort to correct this difficulty. However, many times placement in a foster home is from the child's viewpoint a jump from the frying pan into the fire.

Currently, many modern social agencies are spending much time, money, and energy to keep families intact as functioning units and to deal with the family problems in such a way that the family life is happier and more effective. Literature is being published such as "the Rights of Parents" and "Parents are Human, Too." I don't think we have to take sides and be for or against parents or for or against children. If we really want to understand and help any child we must look at him within his total family situation. In what I hope will be a non-judgmental way, let us look at some of the family influences which may affect the school adjustment of the children.

The home environment is mostly determined by the personalities of the parents. In turn the parental personalities are determined by a complex interaction of cultural, economic and emotional factors. Unfortunately today, with the emphasis on psychological phenomenon, we are apt to overlook some very obvious economic or cultural situations. This was pointed out to me recently when I gave a talk on special education and counseling programs within the schools. Afterward, a teacher came to me and said all the ideas I had were just wonderful but in her school the problems were a little different. Her district was in a low economic area and before they could consider spending money for counselors and other special teachers they had to convince their board of the value of free milk for the youngsters who didn't get it at home. In cases of extreme economic privation with inadequate diet and overcrowded housing, the struggle for mere existence may be so great that little energy is left for educational pursuits.

We must also keep in mind that by the standards of some subcultures within our own state, higher education is deemed unnecessary or even viewed with suspicion. Some in-groups are hostile to the authority or the society with which the school is identified. If their children are psychologically "normal," they will identify with their own parents and accept family standards and ideas rather than the ideas of any out-group. Hence, these children appreciate that the teacher is interested in education because it is his means of earning a living, but for them education has no value and they have no particular motivation to learn.

Even methods of discipline are more closely a reflection of the family culture than the emotional state of the parents or the children. Much energy is expended in meetings and in the press on whether children should or should not have corporal punishment. A study[3] of behavior problem children of a large city school system in 1952 revealed, among other things, that parents of lower educational level and lower socio-economic status used physical forms of punish-

ment much more frequently than the more educated parents.

However, punitiveness of some sort was a constant finding in both groups of parents with problem children. The exact methods of punishment did not seem directly related to either the presence or absence of behavior problems in the children. The *method* of punishment used merely reflected cultural attitudes of the families. In considering any school child's performance we must keep in mind his cultural heritage and his family's social and economic position if we are to understand him.

It is even more difficult at this stage of our knowledge to state which psychological factors in the parents have a positive effect and which have a negative effect upon the performance of the school-age child. From our clinical experience some rather general conclusions about psychological factors which adversely affect the child's adjustment can be made. The practitioner is always confronted with adverse situations and I wish I knew of some scientific studies which accentuated the positive psychological elements in the home. Until such studies are made we must content ourselves with the observations we make in our work with the sick and maladjusted.

Parents who have severe problems with their own dependency strivings seem to have a larger percentage of children who are emotionally upset. These parents are apt to be younger than average in age but not necessarily so. By "dependency problems" we mean some conflicts exist over the parents' need to lean on others emotionally or financially and socially in an immature way while at the same time wanting to be independent, self-sufficient and mature. This dependency-independency struggle is usual in adolescents. The conflict is not always resolved by age 21 or by parenthood.

Commonly, in these situations there is a grandparent in the house or close by. There is constant conflict between the parents and grandparents, usually over how to handle the children. Typically, these parents complain bitterly of grandparental interference but they will have many reasons or excuses why they continue to live with the grandparents or why they must discuss all of their own family problems in front of the grandparents. In short, they cannot give up their dependency on the older generation but they find being treated as a child by their parents quite offensive. The dependency-independency struggle may be a conflict between the parents themselves or with in-laws and other people.

The children who are exposed to such situations are often greatly affected because their parents are unsure themselves and leave many issues unclarified and unsettled or the parents contradict themselves. Many times these children are described as always "testing the limits." That is, the child is never certain what is expected of him. Therefore, each day he goes as far as he can until some reaction is produced in the adults around him. His internalized concepts of right and wrong are as vague and uncertain as his parents' standards. Hence, the child is dependent upon external authority to control him.

Another problem known as "school phobia," a morbid fear of leaving home, occurs in families where the parents are frankly confused in their roles as parents and in what to expect of the child. The child and his mother may want very much for him to be able to act independently of the family. Yet, independent action is a very fearful thing and both are overwhelmed with anxiety when they are out of each other's sight.

The chronically angry, aggressive child is thought to result from maternal and/or paternal rejection. This may be true but to be helpful, the basis of the rejecting attitudes must be discovered. Sometimes parents are subtly rejecting without realizing it because of deep unresolved neurotic conflicts over their task of parenthood or the unconscious identification of a child with some feared or hated person in their own past.

Bobby Z., an 8-year-old patient of ours, was so aggressive that it was impossible to keep him in the regular classroom. There were many facets to Bobby's problem. However, one thing that puzzled us was the father's preoccupation and fear that Bobby would become a criminal. The father's fear compelled him to lecture the boy daily on the evils of wrong-doing. Mr. Z. insisted Bobby watch crime programs on TV, following which the child was told that this is another example proving "crime does not pay."

Finally, Mr. Z. told us his own younger brother was in prison. After expressing considerable anger at his brother and at the same time revealing much guilt for not having helped the brother more, Mr. Z. was able to give up the morbid practice of daily crime lectures to his own son.

The "overprotective" mother has long been thought to be struggling with an unconscious desire to harm or reject her child. It is relatively

simple to discover evidence that a child is overtly or covertly rejected by his parents. To comprehend and correct the basis of the rejection is extremely difficult because the neighbors and the school can see it long before the parents can.

Children are affected also by the behavior of their siblings. An example is 14-year-old Alice who suddenly began eating poorly and paying little attention in school following the elopement of her favorite sister into a "forced" marriage. Everyone is familiar with problems that have arisen after the birth of a new sibling. However, here, the child is concerned with the sibling only to the extent he believes it affects his own relationship with the parents.

Marital problems of all kinds plus frank neurosis or psychosis in the parents or siblings affect a child's school adjustment in two possible ways. (1.) He may be so preoccupied with what is going on at home that he can't keep his mind on school, becoming restless and overactive; or (2.) the emotional turmoil in the home may be actually producing neurosis or severe personality upsets in the child.

Parent-child conflicts in various forms will naturally influence the child's school adjustment. The causes and exact nature of these hopeless tug-of-wars that occur between members of the same family are multiple and varied. It is not surprising that parent-child conflicts affect school performance. School is the main job or occupation of the child. Along the same line, industry recognizes that the home-life of its employees has a profound effect upon productivity on the job. In the close association of family life no one member can have emotional problems without the other members being affected to a greater or lesser extent.

In considering the impact of the home environment on the performance of the school child, my main thesis is that examination of the home must be more than fixing the blame or pointing the finger. The family must be looked upon as a complex interacting system of human relationships. The members feed upon each other's happiness and react to each other's sadnesses, hurts and angers. They learn to maintain some type of equilibrium or homeostasis in this interacting system. When the interaction is efficient and mutually satisfying while still in harmony with the community at large, the members usually can be productive and contented. When there is disharmony or inefficiency it is useless to try to find the "one" who is causing it all. In such a balance system all members are contributing something to the inefficiency. It becomes a vicious circle involving all. The problem is how to break the vicious circle.

In no situation will we find a single cause of family disharmony. There will be socio-economic, cultural and emotional components. One bright 10-year-old whom we had been treating for many months said, "I want to talk about my mother's problems, not mine." When asked "Why?" he replied, "Her problems are financial but mine are all up here," and he pointed to his head.

We as objective observers, can often help families focus upon which problem areas are primary or most urgent. When the performance of the school child is affected by the home or family environment, we must try to determine whether the family situation is due primarily to economic, cultural or emotional problems. Stated very simply, then, helping such families becomes a matter of feeding the hungry, educating the ignorant or treating the emotionally sick.

In "feeding the hungry" I refer to all reality deprivations. Little 9-year-old Harry was truanting, failing and otherwise misbehaving in school. A well-meaning professional person saw Harry for many weeks in individual "play therapy" sessions to help him but he failed to improve. A home study revealed that Harry's father was in a tuberculosis hospital, one brother was confined to bed with rheumatic fever and there were 3 younger children at home. Some specific and concrete help to Harry's overburdened mother brought about a change in Harry's attitude toward school in a comparatively short space of time.

In our modern society it seems it should not be necessary to educate families about the value of education. However, such is the case often. To change a child's set of values without changing the family's attitudes is like trying to make him disloyal to his own family. Most all of us would resist such manipulation.

Treatment of the emotionally sick family is also a major undertaking. It is very difficult to refer people for marital counseling or psychiatric treatment. Sympathy, tact and patience are needed to be able to make such referrals. The very conflicts causing the problem may also make it impossible for the parents to see their need

for professional help or accept such help. For example, a mother who is struggling to overcome severe dependency problems is cast into an inferior or child-like role to accept counseling. Her very neurosis will make her resist any advice.

The performance of the school child is a reflection of the youngster's intelligence and personality make-up, his home environment (parents) and his school environment (teacher). In consideration of my topic, the home environment, it is useless and unprofessional to just fix blame on the parents. The child's adjustment may be affected by problems in the family's economic status or cultural level or by disequilibrium in the emotional interaction of the family members. Usually, there is a combination of 2 or more elements rather than a single causative factor. Hence, there is no simple panacea for correcting a family milieu that is adversely affecting a child's performance. However, I hope my review has given you some frame of reference in which to look at the children and their families who are of concern to you daily in your practice or in your teaching.

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Parents of children should be warned against allowing children to play with the thin plastic bags such as those used to enclose dry cleaning garments. The material builds up an electrostatic charge and clings to the youngsters' faces and in several instances has produced death by suffocation.

Report Shows Senior Citizen Health Insurance Growth

A 1958 study by the U.S. Department of Health, Education and Welfare has revealed progress in providing persons 65 year of age and older with health insurance, according to the Health Insurance Institute.

The study showed that the number of older age persons with health insurance was growing at a much faster rate than the senior citizen population itself. The government report disclosed that the number of Americans 65 and over increased by 13% from March 1952 to September 1956, while the number of senior citizens covered by health insurance went up 56%.

The Institute estimated that 40% of persons in this age category now have health insurance.

Tonography in Clinical Practice

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TONOGRAPHY is used to evaluate aqueous outflow by the changes in ocular tension during the application of a tonometer to the cornea for a given length of time. It is of value in the diagnosis and treatment of glaucoma in addition to the usual methods of provocation, gonioscopy, tonometry and perimetry.

The purpose of this paper is to review the clinical uses of tonography.

Theory

The facility of aqueous outflow is expressed in terms of cubic millimeters per minute per millimeter of mercury pressure. The formula for calculating this was derived by Grant, [1,2]

$$C = \frac{\triangle V}{T \text{ (average Pt - Po)}}$$

where C is the coefficient of outflow, $\triangle V$ is the change in ocular volume for the initial and final readings, Po is the intraocular pressure immediately before tonography, T is time in minutes, and Pt is intraocular pressure during tonography.

Grant[1,2] expressed the formula for the flow rate of aqueous as

$$K = C(Po\text{-}Pv)$$

where K is the net rate of flow in cubic millimeters per minute, C is the coefficient of facility of aqueous outflow, Po is the intraocular pressure immediately before tonography, and Pv is the episcleral venous pressure. It was recognized that aqueous flow depended on a gradient between the intraocular pressure and the episcleral venous pressure, and no obstruction to aqueous outflow. In 1951 Goldman[3] determined the value for the Pv to be approximately 8-10 millimeters of mercury.

It is no longer necessary for the clinician to make laborious calculations to obtain the information he needs. Tables are available so that the Po value and C value are easily and quickly derived. These tables assume a normal scleral rigidity coefficient (E) of .0215, and although they may be somewhat inaccurate for an occasional case, they are satisfactory for most clinical purposes.[4]

Values

Facility of outflow (C). The normal ranges extend from about 0.20 to 0.35. Becker[5] pointed out that a facility below 0.20 should detect approximately 6% of all open-angle glaucoma cases. He showed that some normal eyes have a facility below 0.20, but these can be separated when tonography is combined with a water drinking test.

The average K value has been shown to be 1.45 cubic millimeters per minute.[6]

Po/c ratio. This ratio provides a convenient clinical method for evaluating the control of the glaucoma patient. It is an empirical value which takes into consideration the outflow facility for a given secretory level, thus permitting a more accurate clinical evaluation even in eyes in which hyposecretion has maintained the control of pressure in spite of an impaired outflow facility.

In the Becker and Christensen series,[5] 71% of known glaucoma cases showed a Po/c ratio of 100 or more, and one hour after a water drinking test, 97 of their cases had an index of over 100. Only one % of normal eyes fell into this category. A Po/c value greater than 100 is therefore considered abnormal.

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Method

The procedure, as it is usually done, consists of a continuous recording of the intraocular pressure during a 4-minute application of an electric tonometer to the cornea. The tonometer is connected to a recorder and a tracing is obtained. A simpler method is to apply the Schiotz tonometer to the cornea and note the scale readings every 30 seconds for 4 minutes.

It is important that care should be taken in the preparation of the patient. A relaxed patient is essential. Tonography should be done in a quiet room so that the patient's attention can be given to the procedure. He should be reclining comfortably with his head on a pillow. Tight garments around the neck should be loosened.

One drop of one-half % tetracaine is instilled in each eye. The patient is asked to fix on a target on the ceiling, since accommodation increases the facility of outflow.[7] The patient is cautioned to be as quiet as possible and to avoid any movement of the eye. The lids are retracted, usually with the forefinger and thumb of the operator. As in tonometry, care is taken not to press on the globe. At first the tonometer is held hovering over the eye to be tested for about 15 seconds so that the patient becomes used to the instrument.

The operator should be comfortably seated, resting his hand on the patient's forehead, in order to be at ease during this 4-minute procedure.

Before applying the tonometer to the fellow eye, an interval of 5 minutes should pass. This eliminates the possibility of consensual increase in facility in the fellow eye.

It is essential that meticulous care be given the tonometer. The plunger should be removed and wiped carefully with lint-free tissues. Many commonly used tissues are not lint free. If there is even the smallest amount of foreign material in the barrel of the tonometer or on the plunger itself, proper pulsation of the plunger will not take place, and the recording will not be accurate. Even tears may have a similar effect, and certainly pipe cleaners should not be used for the same reason. The plunger should be wiped and the barrel cleaned by inserting a twisted tissue after each eye is tested.[8]

When periodic tests are to be made on the same patient, they should be done at about the same hour of the day, since the coefficient of outflow may vary during the day. If this is done, tracings made before and during treatment can be used to help evaluate the effectiveness of the therapy.

The scleral rigidity factor (E) may be a source of error. The determination of E is best accomplished by doing applanation measurements first, followed by the usual tonogram with the appropriate weight. In this way, prior measurements do not interfere with the subsequent tonogram since the volume of fluid displaced by the applanation tonometer is only 0.45 cubic millimeters with a cornea of average radius of curvature.[3]

Nomograms[4] for calculation of the scleral rigidity coefficient are available.*

If average scleral rigidity is assumed, one may use the simplified tonographic tables for computation of C.[4] However, erroneous values may be obtained if the scleral rigidity is low or high.

In patients with a low scleral rigidity, the C and Po values will be elevated, suggesting hypersecretion glaucoma.

When the scleral rigidity is high, the coefficient of outflow facility appears to have a lower value when calculated with the tables mentioned; these cases erroneously resemble glaucoma of a hyposecretion type.

If tonography is performed at scale readings less than 3, falsely elevated pressure and facility values are obtained.[9] Therefore, when performing the test, if the tonometer registers less than 3 increase the weight on the tonometer.

Another source of error is the behavior of the uncomfortable or apprehensive patient. Also, the patient's head in the dependent position may induce a rise in the intraocular pressure of one to three millimeters of mercury, or even more when no pillow is provided.

Abnormal values may occur in keratoconus and other diseases of the cornea where the foot plate of the tonometer is not properly resting on the corneal surface.

Proper electrical installation of both recorder and tonometer is essential, since voltages may vary enough to produce artefacts in the tracings.

Clinical Application

The C value provides one of the best safeguards against insidious loss of control of the

* Ostertag Optical Co., 3851 Washington, St. Louis.

glaucoma patient. If, on repeated tonographic readings, there is a low C value, the control of glaucoma is inadequate. This can be true even in the presence of an apparently normal intraocular pressure. Such cases require close scrutiny and adjustment of therapy.

Normal tonogram. A normal tonographic tracing is shown in figure 1. The C value is 0.24, Po is 19, and Po/c<100. The first minute of the tracing may often show a rapid drop in the intraocular pressure, followed by a more gradual decrease for the next 3 minutes. The pulsations are steady and regular. The undulating waves correspond to Traube-Hering waves.

Abnormal tonogram. In *open-angle glaucoma,* there is increased resistance to the outflow of aqueous. Presumably, this could be due to various factors affecting the trabeculum, such as excessive uveal pigment, exfoliated lens capsule, blood, tumor, neovascularization or sclerosis of the trabeculum fibers. Endothelial proliferation in the canal of Schlemm, or obstructive changes in the episcleral or aqueous veins could also account for increased resistance to outflow.

Resistance to outflow is clearly shown in figure 2. The Po value is 34, C=0.01, and Po/c>100. The tracing is characteristically flat. The prominence of the pulsations gives assurance that the plunger was functioning properly.

In chronic simple glaucoma, outflow is enhanced by miotics (Figs. 3a and 3b). A flat tracing was first obtained prior to treatment (figure 3a); Po/c>100 and facility 0.12. After miotic therapy was instituted (Fig. 3b), the facility improved to 0.19 and Po/c was 100.

The effectiveness of filtering operations for open-angle glaucoma can be evaluated by tonography. A continuing decrease in the facility of outflow may be the first warning of failure of the drainage channel, and thus the physician is forewarned of impending danger.

Tonography is also helpful in secondary glaucoma if the patient is on acetazolamide. When there is an increase in the facility of outflow, the drug may be discontinued.

In *closed-angle glaucoma* the root of the iris is pressed against the trabeculum, obstructing outflow. When this persists, anterior synechiae form, and a permanent obstruction results. A swollen lens, air behind the iris, ciliary body tumors, dislocated lens, or edema of the ciliary body may cause this. The tonogram in these

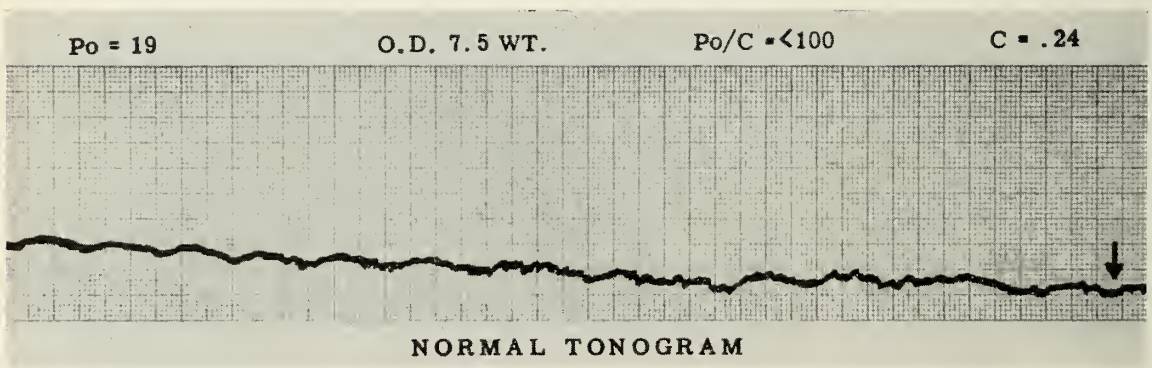


Figure 1

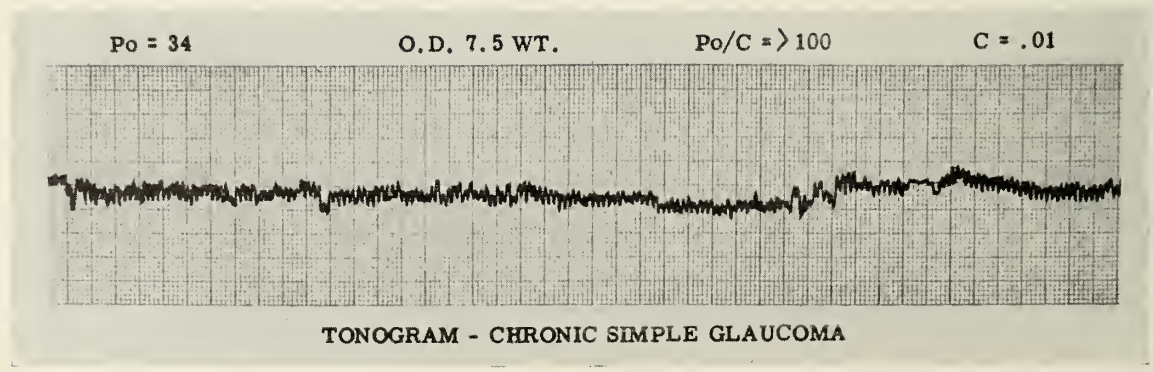


Figure 2

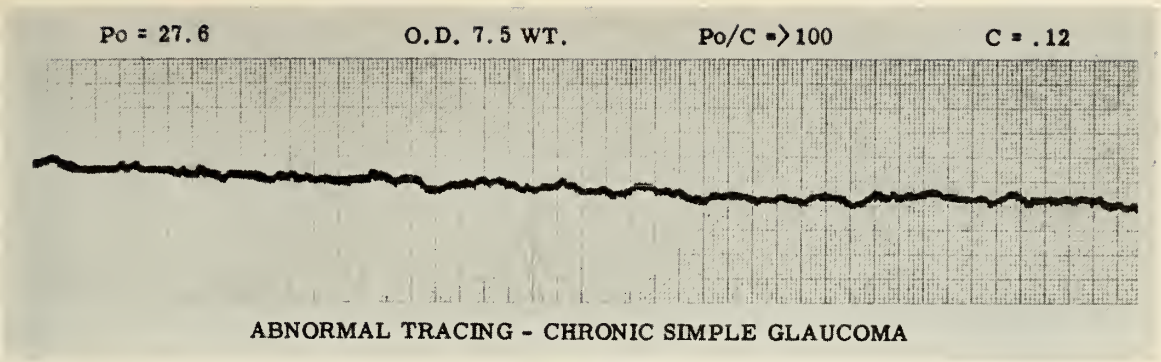


Figure 3a

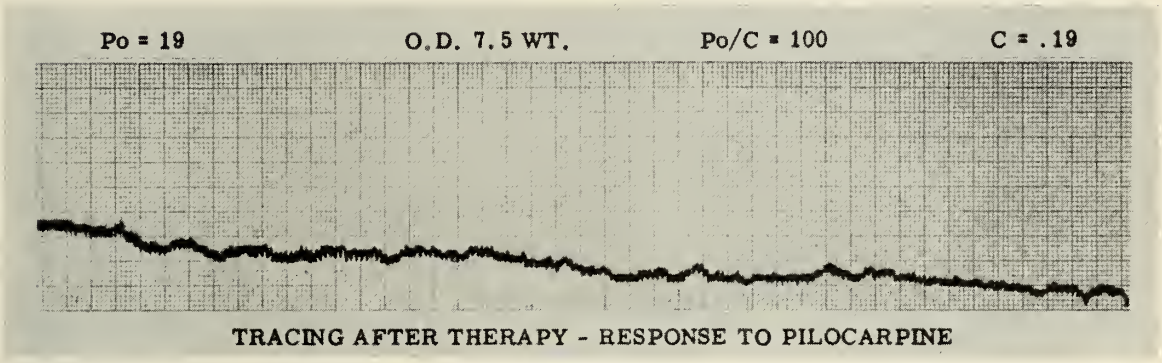


Figure 3b

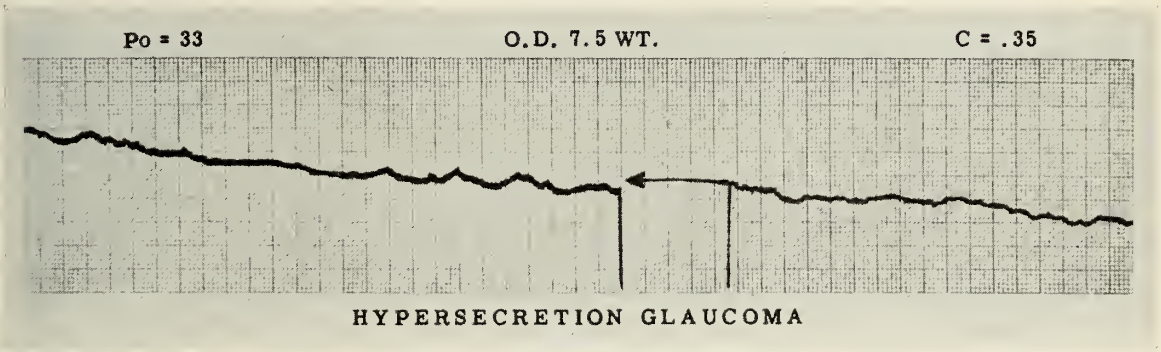


Figure 4

cases is flat, the C value reduced, and Po/c>100. Pilocarpine increased the facility of outflow in closed-angle glaucoma by reopening the area of filtration of the angle.

Tonography is of value in closed-angle glaucoma during an acute attack. Under these conditions, the outflow is markedly reduced, but if there is an increase in the C value after miotic therapy is instituted, iridectomy is the operation of choice. If anterior synechiae have already formed and the C value is reduced, iridectomy will be ineffective, and one must resort to a filtering procedure.

In some cases of acute congestive or closed-angle glaucoma, as will be mentioned later, the intraocular pressure and C value may both be reduced, paradoxically, due to hyposecretion which usually is temporary.

Hypersecretion glaucoma. Although there has been some question as to whether such an entity exists, Becker[5] has convincing evidence in several tonograms with high intraocular pressures and normal C values. In our clinic to date, we have observed one such case (Fig. 4). Typically, after this patient was given acetazolamide, the tonogram showed a decreased intraocular pressure, but the facility remained the same (Fig. 5).

Hyposecretion glaucoma and *low-tension glaucoma* are found occasionally. The intraocular pressure is within normal limits, but the out-

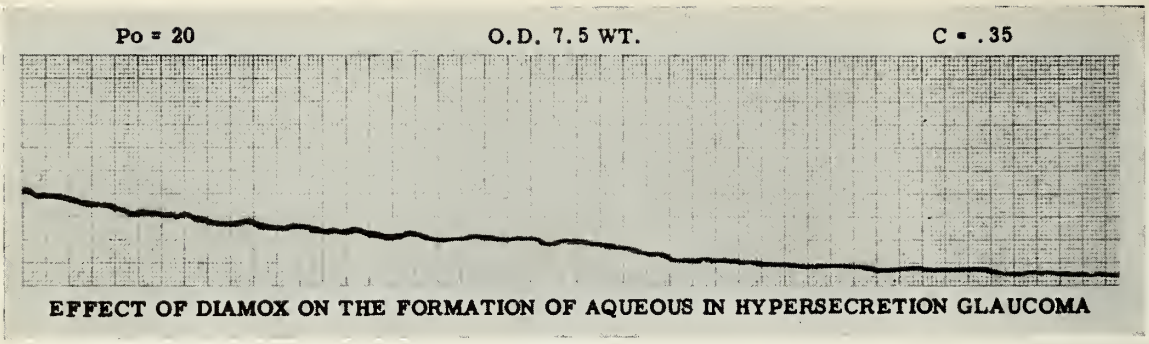


Figure 5

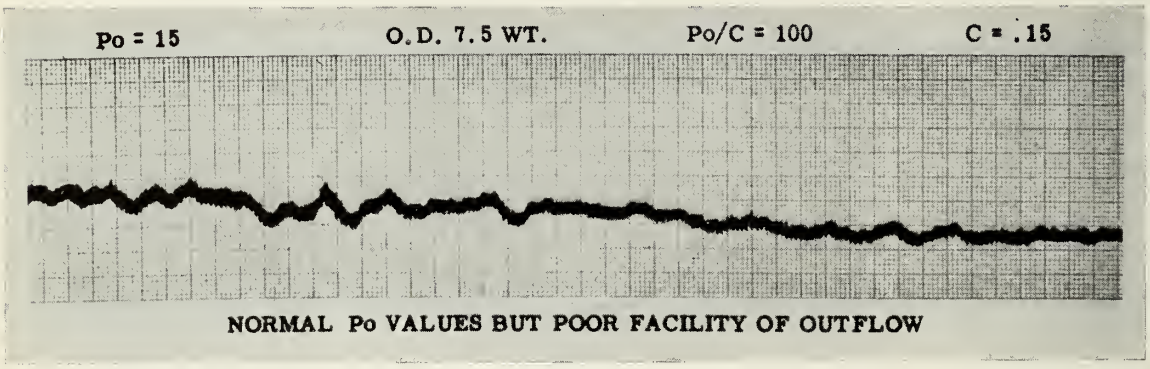


Figure 6

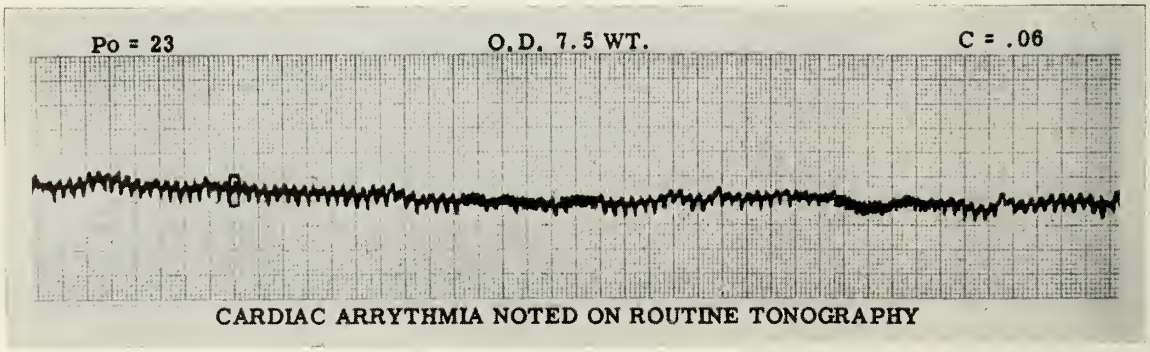


Figure 7

flow facility is reduced (Fig. 6). This may be seen during phases of chronic simple glaucoma when the ciliary body is hyposecreting. It is also found on occasions immediately after acute congestive attacks; in these cases, presumably, the ciliary body has been traumatized. The intraocular pressure is not elevated in spite of reduced facility, until the aqueous secretion resumes.

Incidental findings in tonography may occasionally be interesting. These are usually due to cardiac arrhythmias. In one such case (Fig. 7), the patient was unaware of the arrhythmia, and subsequent examination by an internist substantiated the findings.

Conclusion

In clinical practice, tonography frequently aids the evaluation and management of the glaucoma patient. It provides information which is often confirmatory and supplementary, and at times is independently significant for both diagnosis and therapy.

It is not surprising therefore that alongside the usual methods of glaucoma study, clinical tonography is taking its proper place in ophthalmology.

1100 West Michigan Street (7)

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Yogurt for Childhood Cardiacs

Yogurt is preferable to the Karell milk diet as a means of stringent sodium restriction in the childhood cardiac according to two Russian pediatricians. With added milk and low-sodium fruits, it is better for the growing child with cardiac dystrophy. The Russians also report that Yogurt may potentiate the action of organomercurial diuretics. (From DIURETIC REVIEW, specialty publication dealing with cardiorenal subjects, from Lakeside Laboratories, Inc., for the profession.)

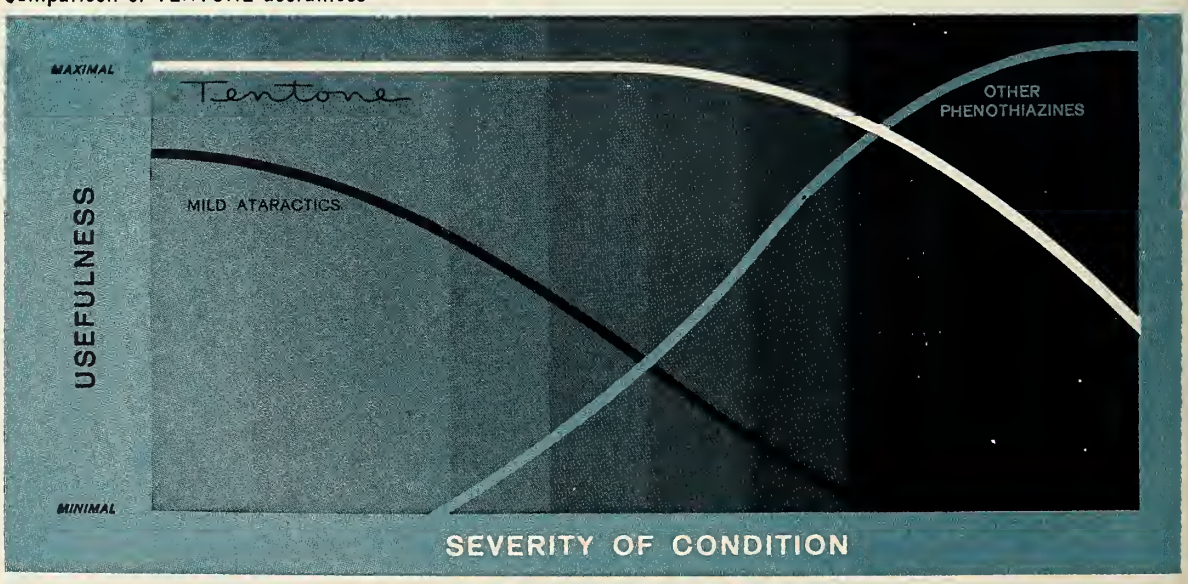
Health Insurance for the Aged Grows

"Substantial progress was made last year in providing sound programs for persons over age 65 through employer-sponsored group plans as well as individual health policies," the Health Insurance Institute has reported.

"Health insurance protection for elderly retired persons is fast becoming as prevalent as it is for the employed population, shown by the fact that the growth of coverage for the aged population has, in large measure, come about in the last five years."

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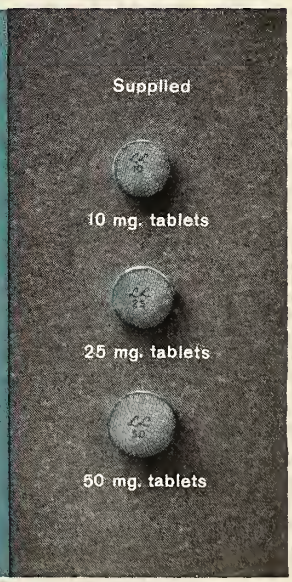
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Thrombosis of the Inferior Vena Cava and The Nephrotic Syndrome

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Elkhart

FRIEDRICH MUELLER first proposed the term "Nephrosis" to distinguish the primarily degenerative from the primarily inflammatory forms of Bright's disease, though at that time they were often indistinguishable clinically. Gradually, the pathological states produced primarily by vascular lesions were excluded and more recently, the nephrotic syndrome became identified with proteinuria, decreased serum albumin, lipemia and edema.

The morphologic changes in the nephrotic syndrome have always been most striking in the tubules, with less constant and obvious glomerular changes. The presence of sufficient proteinuria over a length of time necessary to cause decreased serum albumin, and thus, edema is thought to be the requisite of the syndrome and it is still not clear as to the genesis of the associated lipemia. There is still some disagreement as to the degree in which glomerular permeability to protein[6] or decreased tubular reabsorption of protein is mainly responsible for the proteinuria. Neither is it known whether the marked tubular changes are primarily etiologic, concomitant phenomena, or merely secondary to the proteinuria.

In any event, the glomerular tubular imbalance for protein, which causes the syndrome, has most commonly been noted in luetic nephrosis, eclampsia, the nephrotic stage of glomerulonephritis, and the questionable entity of lipoid nephrosis. It has also been noted in other diseases such as diabetic nephropathy and amyloid disease, but Fishberg[10] feels that perhaps the concomitant cachexia and dietary restrictions play a role in these situations. McManus,[11] at autopsy, has noted cases which pathologically seem to be indicative of chronic pyelonephritis in patients who had had a nephrotic syndrome. However, the medical histories suggested the possibility that the pyelitis might have been superimposed upon glomerulonephritis.

In a recent review, Feinerman[9] notes that although Rayer first described the association of thrombosis of the renal vein and the nephrotic syndrome in 1840, there has been an increasing awareness of this association in recent years and though still quite unusual, more case reports are appearing. Pollack[13] in a 1956 report felt theirs was the first case diagnosed and successfully treated in life. The present case report is one of unquestioned thrombosis of the inferior vena cava, which presumably involved or went above the level of the renal veins, and was associated with a nephrotic syndrome.

Case Report

A 12-year-old white male.

This lad had a history of frequent sore throats with occasional asthmatic bronchitis until he had a tonsillectomy in 1952. At that time, the routine urinalysis revealed microscopic hematuria which apparently went unnoticed. He had always been somewhat nervous and had gotten up twice at night to urinate as long as he could remember, but otherwise had always seemed in perfect health until the present illness. During the 1957

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Christmas vacation, he went to Mexico with his parents and at that time received a smallpox vaccination and also had a febrile illness associated with diarrhea for a few days but no other localizing signs or symptoms. In early February of 1958, he had mild upper respiratory symptoms for 3 to 4 days and at about that time the onset of marked edema was noted. On hospitalization, the edema was the most notable clinical finding and was massive. His complete blood count, blood urea and serology were normal. Chest x-ray and electrocardiogram were normal. Streptococci and staphylococci were cultured from the urine, but since none were seen on direct smear, these were considered as possible contaminants. Sedimentation rate was 39 mm. an hour, serum albumin 0.9 gm. %, globulin 2.6 gm. %, serum cholesterol 384 mgm. %. 5.12 grams of albumin was excreted in the urine in 24 hours. Urine contained a 3 plus albumin, with 2-3 white cells and 1-3 red cells per high power field. There were coarsely granular casts and hyaline casts noted in gradually decreasing amounts during his hospitalization.

The patient, on a regimen of decreased salt, bed rest and a 10-day course of penicillin to remove any latent infection, had a marked diuresis. All symptoms disappeared and he was discharged in approximately 10 days to continue his regimen at home. He did well for 2 weeks at home, but then developed some form of gastroenteritis with vomiting and gradually began to go downhill with all symptoms and signs recurring, despite the fact that he was started on prednisolone, 20 mgm. a day, which was later raised to 40 mgm. a day. On March 3, 1958, in addition to the recurrence of the edema, the patient complained of pain in his legs upon trying to extend them, and the physiotherapist made a note at that time that he seemed to have pain in his calves when he tried to straighten them. This apparently responded to physiotherapy. During this admission, the patient was continued on steroids and again seemed to gain an excellent response. The laboratory studies revealed the serum sodium and chloride to be at the lower level of normal. Potassium and CO_2 combining power were normal and the sedimentation rate was down to 31 mm. an hour. The urinary findings were essentially unchanged and as high as 9.9 gm. of protein was excreted in the 24-hour urine. Serum calcium and phosphorus and urea were again normal; serum albumin was up to 1.8 gm. % and the cholesterol was 320 mgm. %. The complete blood count remained normal. On discharge he was considered to be in a nephrotic stage of chronic glomerulonephritis and did well on conservative therapy. At this time, the possibility of thrombosis of the renal veins was mentioned, but with no supporting evidence, this diagnosis was discarded as extremely unusual. By late May of 1958, the mother had noticed that the veins in the lower abdomen seemed more prominent, and the patient developed an acute and obvious ileo-femoral thrombophlebitis of the left leg of some severity and was re-admitted to the hospital on June 12, 1958. He had remained on steroids and was receiving 24 mgm. of Aristocort a day. The mother said that he had, during the entire 4 months since the onset, an occasional low grade fever in the evening. Physical examination revealed an obese youth. The skin was dark. The obesity involved chiefly the face and trunk, with a slight buffalo hump on the back. The skin was thick, dry, scaly and almost lichenified, especially over the lower body, with striae and a Cushing's syndrome appearance. There was an acute ileo-femoral thrombophlebitis involving the left leg, with marked edema of the left leg and slight edema of the right leg. Temperature was 100, pulse 116, respiratory rate 18 and the blood pressure 104/80. There was a venous hum heard over the right neck and there was a congenital cyst with the opening just beneath the left clavicle. The nasal mucous membranes were slightly reddened and crusted. After vigorous exercise, a low pitched, systolic sound was heard over the precordium. There were extremely prominent dilated veins over the lower chest, the entire abdomen anteriorly and over the lumbar and the lower dorsal area posteriorly and also a few were noted on the legs. (Fig. I-II.)

Laboratory studies revealed white count of 15,600 and the differential count was normal. Hemoglobin was 15.6 grams %. Electrocardiogram and x-ray studies of the chest, colon, kidneys and upper GI tract were all normal. A vena cavagram gave excellent visualization of extremely large collaterals in the abdomen but non-visualization of the vena cava. (Fig. III.) This seemed to adequately substantiate the diagnosis of thrombosis of the vena cava. Serum electrolytes, BSP., gamma globulin, and a congo-red test were all normal. Serum cholesterol was 296 mgm. %. Albumin was 3.2 mgm. %.

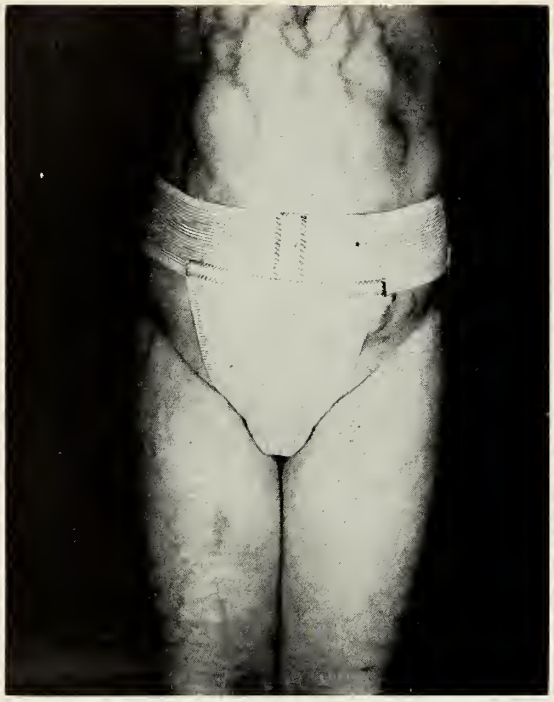


Fig. I—Infrared photograph of patient



Fig. II—Photograph of patient.

Urinalyses showed continued improvement, until at the time of discharge, there was only a trace of albumin and a rare formed element. During the patient's hospital stay, he was placed on anticoagulants and steroids were gradually withdrawn. He lost 10 pounds in weight as a result of diuresis and though he continued to run a low grade fever despite prolonged courses of specific antibiotics governed by urine cultures, clinically he obviously progressively improved. An unexplained finding was the fact that he had 150 cc of residual urine. Since discharge he has been maintained on elastic stockings and long-term anticoagulants and has been able to return to a normal life. On Dec. 1, 1958 his urine varied in concentration from 1.028 to 1.002. PSP excretion in 30 minutes was 54%; in 60 minutes 73.5%; in 2 hours 89%.

Comments

On reviewing the literature, Pollak[13] stated that "in adults renal vein thrombosis may present acute symptoms referable to the affected kidney, as the nephrotic syndrome of obscure etiology or as a combination of the two." This apparently depends upon the rapidity and completeness of occlusion of the renal veins and on the development of collateral circulation draining the renal parenchyma. It apparently makes little difference whether the thrombosis involves only the renal veins[12] or whether the occlusion goes from the common iliacs up the vena cava almost to the level of the hepatic veins and involves also the portal, the mesenterics and the renals.[8] Pathologically, the changes are not strikingly different from those found in other types of nephrotic syndromes, although the glomerular changes may be less prominent. Acute thrombosis of the renal veins in animals,[14] or in humans,[17] (usually in infants with diarrhea and dehydration) may result in infarction of the involved kidney, which rapidly enlarges for the first 5 days and then gradually atrophies over the next several months. The condition is usually fatal, especially in infants, so that pediatricians feel surgical removal of the kidney is indicated if it is unilateral.

More gradual obstruction produced experimentally in dogs,[14] or by thrombosis of the renal veins in humans[1,16,18,3] may actually produce minor symptoms though usually there is a decrease in urine formation, with microscopic hematuria and albuminuria which may be of extremely long duration. Oft quoted is the case of Shattock.[16] Dr. W. Rivers Pollock in 1884 won the 120-yard hurdle race for Cambridge against Oxford in the then record time of 16

seconds and held his breath during the entire race. Immediately after the race, he was bedridden by severe lumbar pain and shortly after, edema of the legs, abdomen and scrotum appeared with albuminuria. The veins of the abdomen became dilated and prominent, but after 6 months of bedrest, only albuminuria persisted and he carried out an active obstetrical practice for 25 years with only constant albuminuria as a residual until his death of tonsillitis and septicemia. At autopsy, the only remnant of the vena cava was a fibrous cord from below the hepatic veins, to and including the common iliac veins.

Between these extremes are other cases.[2,8,9,13,12] As Fishberg[10] states "of great interest despite its rarity, is the production of the nephrotic syndrome in all its details by thrombosis of the renal veins." The reported cases apparently resemble pathologically the description of nephrotic kidneys due to other causes[5] and the prognosis is uniformly poor. In the recent literature available to us, all except one case[13] have expired within a few months to a few years. Usually the cause of death was a nephrotic syndrome, complicating infections, renal failure or further thrombo-embolic phenomena. Pollak[13] and his co-workers report a case with periodic renal biopsies and noted first the striking interstitial edema. They believed that renal vein thrombosis and constrictive pericarditis could apparently cause the nephrotic syndrome on a purely mechanical basis with increased venous pressure, perhaps affecting mostly the peri-tubular capillaries. One kidney later became non-functioning with a persistently positive urine culture. (They quote the work of Nisio, who found intravenous E. coli became implanted in the kidneys if the renal veins were tied.) A nephrectomy was accomplished and the patient recovered, being on anticoagulants both pre- and postoperatively Though absolute proof is lacking without subjecting the patient to rather hazardous procedures, our case seems to be quite similar to the others in which thrombosis of the inferior vena cava extends above the renal veins and is associated with the nephrotic syndrome. The possibility exists that the nephrotic syndrome, perhaps due to the nephrotic state of glomerulonephritis, existed originally and that thrombophlebitis with subsequent involvement of the vena cava occurred later. This seems unlikely in view of the fact that in retrospect, the patient noted leg symptoms within a few weeks of the onset of the syndrome. Allen[3] states that thrombosis of the inferior vena cava is most commonly an extension of thrombosis or thrombophlebitis of the leg or iliac veins, with abnormalities of blood flow or chemical or physical alterations in the blood itself mentioned as possibly etiological. And, it is true that bedrest, edema and hypoproteinuria are all mentioned as predisposing to thrombophlebitis. It is also interesting that McManus[11] has noted that thromboses of renal venules are relatively frequent in all types of kidney disease, but not especially the nephrotic syndrome. Our patient was treated with steroids and there is disagreement[7-15] as to whether this predisposes to thrombosis.



Fig. III—Venogram done shortly after I.V.P.

Summary

In summary, we have presented a case in which the nephrotic syndrome was associated with thrombosis of the inferior vena cava. In all probability the latter extended above the renal veins and caused the nephrosis. A brief review of the literature is also included.

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Studies by The Travelers Insurance Companies show that driver error caused 85% of the highway accidents in 1958.

Health Care Benefits Payments Record Set

Despite the general adjustment that took place in the national economy, a new record was reached when an estimated $4.8 billion in health care benefits were paid by all insuring organizations during 1958 to help the public meet the cost of accident and sickness. This surpassed the 1957 benefit payment figure of $4.2 billion by more than 14%.

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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THE BUSINESS SIDE OF MEDICAL PRACTICE

A BOOKLET by the above title has been published by the AMA in cooperation with the Sears-Roebuck Foundation as a guide to physicians about to enter practice.

Attractively printed and well illustrated, the 52-page publication covers in concise style most of the problems which confront a young doctor in his first establishment of an office.

The various intracacies are discussed under the following headings:

1. The physician faces the practical problems of setting up practice.
2. Selecting the place to practice.
3. Clearing legal hurdles and securing professional assistance.
4. Locating the office.
5. Financing the establishment of an office.
6. What insurance should a doctor carry?
7. Mechanics of providing good medical service.
8. Running the business of a practice.
9. Billing and collecting.
10. As your practice grows.

While this booklet was prepared primarily for those planning to enter practice, it might well be of interest to doctors already in practice. A few copies are available on request to the ISMA Headquarters Office.

POLIO IMMUNIZATION

"IT'S A TRAGIC circumstance that hundreds of children and young adults will be spending the balance of their lives in wheel chairs or on crutches because of a failure to be vaccinated against polio."

There are 57.7 million people in the United States under the age of 40 who have not completed the inoculation against poliomyelitis.

Children of school age have attained the highest status of immunization, but are still incompletely protected. Children of 5 years and under and adults are even more poorly covered.

School children have been immunized in larger numbers due to the ease with which they may be organized for mass inoculations. Studies of 1958 epidemics shows that the pre-school children were afflicted with the paralytic form of the disease more often than any other age bracket.

With the reduction of polio in school ages the disease is affecting more and more adults. An immunized child may carry and pass the virus to non-immunized adults without being sick.

Surgeon General Leroy Burney, who is responsible for the above quotation, has called upon all civic minded and public health groups to organize each community in a far-reaching and vigorous campaign for immunization.

It may be that partial immunization of the population will produce an epidemic in the future that will concentrate its deadly and paralyzing effects on infants and adults. Now is the time to prevent such a happening.

It has recently been demonstrated that a fourth injection of vaccine, some 8 to 12 months after the third dose, will greatly increase the titer of antibodies. The fourth dose has been recommended for all those who have completed the standard 3-injection immunization schedule in the past.

BIRTH RATE IN THE U. S.

FOR THE PAST 5 years births in the United States have been at an unprecedented high level. Recently the *Statistical Bulletin* of the Metropolitan Life Insurance Company reported some interesting figures on births in the United States.

With over 4 million babies per year the total for the 5 years is almost 21 million. Births were at an all-time high in 1957 with approximately 4,300,000; and were but slightly lower at 4,240,000 in 1958.

During recent years nearly 1 out of every 6 married women below the age of 45 bore a child. In 1940 the ratio was nearly 1 in every 8.

It is expected that the birth rate will continue at this level for many years. The only change expected is that which is associated with the likelihood that in about 1965 the immediate post World War II boom crop of babies will be entering parenthood and will further increase the increase to well over 4 million annually.

The birth rate for first, second, third, fourth and fifth born children declined steadily from 1917 to between 1935 and 1940. Each of these rates rose between 1940 and 1945 except that for first born. After 1945 the first born rate rose precipitously for 2 years, then declined to a plateau. Since 1945 the rate for the other orders of birth has risen slowly and steadily; the rate for second born now being practically as high as that for first borns.

The trend now is toward moderate-sized families. Third and subsequent births have increased in proportion from 38% in 1940 to 46% in 1957.

At the present time almost three fifths of the babies are born to mothers in their twenties, and nine tenths to those under the age of 35. This is practically the same proportion as obtained in 1940. Thus it is evident that the trend to larger families has not increased the age of mothers at time of birth, due to a compensating increase in early marriages.

THE MENTALLY RETARDED

ONE OF THE 387 new laws passed by the recent General Assembly creates a legislative planning committee to continue the study of problems and needs of the mentally retarded and to formulate a long-range program.

The committee is appointed under the authority of the Legislative Advisory Commission. It consists of 2 representatives, 2 senators and one member of the Indiana Association for Retarded Children.

The committee is instructed by the act to employ a full-time research director, and to prepare a written report of its investigation and recommendations for presentation to the next session of the General Assembly.

Specific elements to be investigated are outlined in the law as follows:

(a) Examine the present state facilities for diagnosing the mentally retarded in the public schools, mental health clinics and institutions.

(b) Examine existing agencies and facilities concerned with the training, care and treatment of the mentally retarded whether such agencies or facilities are public or private.

(c) Examine methods or procedures designed to prevent the occurrence of mental retardation, to reduce the rate thereof, and to make more effective the training, care and treatment of the mentally retarded.

(d) Recommend the improvement, expansion, integration or coordination of public agencies and facilities concerned with the training, care and treatment of the mentally retarded.

(e) The committee shall develop, formulate and plan a long-range program best suited to the expanding needs of the mentally retarded.

The committee shall be entitled to call to its assistance and avail itself of the services of such employees of any state department, board, bureau, commission or agency as it may require, both for technical, professional and expert opinion on the matter under investigation and for such other assistance which the committee may deem necessary.

It is apparent that this is a step in the right direction. Sessions of the General Assembly are too crowded with other business to allow the careful and minute study necessary for a reasonable solution of such a technical problem. This committee is endowed with the time and money necessary to collect the information, hear the experts, coordinate all the findings and arrive at a workable solution.

Resolution passed by the Texas Medical Association at its recent annual meeting: WHEREAS, we stand firm on the principle of security through personal initiative and will not yield to the temptation of personal gain at the expense of future generations or political expedience. . . . WHEREAS, in a survey of the Texas Medical Association by secret ballot 91% of Texas physicians voted against the inclusion of physicians in Social Security. . . . RESOLVED that the Texas Medical Association in regular session unequivocally opposes the inclusion of self-employed physicians in the Social Security system. . . . BE IT FURTHER RESOLVED that we strongly urge the Texas Delegates to the American Medical Association to continue to uphold the overwhelming opinion of Texas physicians.

CERTIFIED FOREIGN MEDICAL GRADUATES

THE EDUCATION COUNCIL for Foreign Medical Graduates (ECFMG) was formed in 1957 for the purpose of examining graduates of foreign medical schools and certifying them as qualified, both in medicine and in command of the English language, for the assumption of internships and residencies in hospitals of the United States.

The sponsoring agencies were the American Hospital Association, the American Medical Association, the Association of American Medical Colleges and the Federation of State Medical Boards of the United States.

The council has its offices in Evanston, Ill. Dr. Dean F. Smiley is the executive director.

The number of foreign trained doctors who have taken the examination has increased rapidly since the first examination. Only 298 took the first examination. Since then 844 and 1772 were examined on two occasions and there are over 1,000 applications on hand now for the next examination in September, 1959.

With the increase in applicants, the facilities for the examination have been expanded. There were no foreign centers for the first test, 30 for the second and 44 for the third. For the next examination there will be 15 centers in Latin America, 14 in the Far East, 7 in the Near and Middle East, 13 in Europe and 1 in Africa. There are also several centers in the United States.

In the 3 examinations slightly less than half of the candidates have been awarded standard ECFMG certificates. It was discovered during the first examination that inadequate command of the English language was the main obstacle to most of those who failed the test. Temporary 2-year certificates have been awarded in the other 2 examinations to approximately 25% of the candidates. The temporary certificates are granted on grades between 70 and 74, the standard certificates to grades of 75 or above. Apparently most of the candidates in the 70 to 74 group fall in that category due to language difficulties.

As would be expected the foreign trained physicians who take the examination in the United States experience little trouble with the language. Of the 1,278 who have been tested in this country none failed and only 3 did poorly in this regard.

The examinations not only have become extremely popular with foreign graduates, but are serving a very important function. Hospitals of the United States have twice as many approved internships as there are graduates each year. The well trained foreign graduate, if he is able to understand and communicate in English, aids in rounding out the intern quota, and gains considerably in medical knowledge from his contact with American medicine.

A standard means of examining and certifying these doctors for intern and residency training is proving to be of immense value in the process of inducting and assimilating foreign M. D.'s in our teaching hospitals.

President's Page

REHABILITATION

I have had occasion to have presented to me in various ways the problem of rehabilitation of the ill patient. Rehabilitation centers seem to be the coming vogue. Several organizations are studying to plan centers of rehabilitation around the various cities of the state. I believe that the leaders in rehabilitation of patients should be the doctors. It may be possible that we as doctors have concerned ourselves completely with the acute illness and have not given too much thought to the return of the ill patient to a useful member of society.

It has been said that the patient with paralysis resulting from a stroke has been given excellent and prompt care for the cause of the stroke, but very little or no care to restore that patient to a useful life. I realize that in the larger hospitals in the larger cities that physical therapy departments are more readily available, but even here improvement is in order. It is to the patient in the smaller hospitals and in the homes without available physio-therapy departments, that our attention should be directed. I have asked the Commission on Special Activities to make a study of rehabilitation to present a program that will permit doctors to be the leaders in expanding our rehabilitation of the ill patient of all types. I hope that this program will succeed, for I believe we will enlarge our usefulness to mankind and bring us greater esteem. This program might also include expansion of teaching rehabilitation to our students at the medical school.

We must always be mindful, as we treat the ill, of the patient's future. Our services must include our concern for restoration of the patient to as normal a life as possible, and the use of many known skills at our command to prevent the patient from becoming an invalid.

I hope each one of us will make a greater effort to search out means of restorative methods for our patients.

Kenneth L. Olson M.D.

The Woman's Auxiliary

REPORTS TO I.S.M.A.

Dear Doctor:

The Fifteenth Annual House of Delegates met in Fort Wayne April 23-24 at the Hotel Keenan.

From the report of the registration chairman, there were 233 registered, including 28 county presidents, 21 presidents-elect, and the remainder were delegates and members. We also had 9 guests present.

We were honored in having the state auxiliary president, Mrs. Robert Reagan, and president-elect, Mrs. Harold Gay, from Michigan; also Mrs. Jesse Funk, president of the Kentucky State Medical Auxiliary.

Dr. George Buckner, president of the Allen County Medical Society, welcomed the auxiliary to Fort Wayne.

Dr. Kenneth Olson, president of the Indiana State Medical Association, gave a vote of thanks to the auxiliary for their support and urged them to continue their interest.

Dr. George Lull, retired general secretary and manager of the American Medical Association, now president of the American Medical Education Foundation, gave an informative dissertation on the need of money for medical schools. He also stated the funds are capably handled by the deans of the Medical Schools. Dr. Lull announced that 1960 is to be known as "Ethel Gastineau A.M.E.F. Year."

Mrs. Frank Gastineau, Indianapolis, president-elect of the National Auxiliary, was an honored guest and spoke at the Friday luncheon on "Highlights of the National Program." Mrs. Gastineau also installed the new officers.

Reports in printed forms of the officers and state chairmen were given to Auxiliary members. County presidents each gave a 2-minute oral report on their activities for their year.

Approximately $8,000.00 is in the A.M.E.F. fund; scholarship fund available either by outright gifts or loans totaled $11,882.00; number of nurses in training, 70; medical assistants, 4; medical technologists, 4. One 4-H nursing scholarship was given by the State Auxiliary. *Today's Health* subscriptions totaled 2400.

Mr. Converse of Blue Cross-Blue Shield talked on Medical Care Insurance. Our thanks to Mr. Converse and Blue Cross-Blue Shield for their able assistance with this House of Delegates.

Mr. James Waggener, executive secretary of I.S.M.A., was present and received our many thanks for his cooperation.

Area III, consisting of Districts 8, 11, 12 and 13—or 22 organized counties—all contributed to making this House of Delegates a success.

I am sure that everyone who attended gained in information as well as fellowship from their association with doctors' wives from the various parts of the state.

Please urge your wife to attend the next House of Delegates which will be held April, 1960 in French Lick.

Sincerely,

Mrs. Earl Bailey
Immediate Past President

Chemotherapy of Specific Infectious Diseases of the Lower Respiratory Tract

Report of Committee on Chemotherapy and Antibiotics, American College of Chest Physicians.

THE MAJORITY of pulmonary infections can be successfully treated by the judicious use of antibiotics and other chemotherapeutic agents. It is important to establish a diagnosis of the type of infection in all infectious diseases of the respiratory tract. Cultures should be made prior to therapy whenever feasible. Sensitivity tests of the organisms found in all prolonged infections are essential guides in the care of the patient. It is sometimes difficult to make an exact bacteriological diagnosis at the onset of a pulmonary infection, and treatment may have to be started at once. A simple Gram's stain of a fresh sputum specimen is important in determining the type of therapy while awaiting the cultures. If the diagnosis is still obscure and the patient has a severe infection, therapy designed against both gram-positive and gram-negative organisms should be instituted. Obviously all other clinical guides will be useful, such as the manner of onset of the disease, the characteristics of the sputum, the white count, the cold agglutinins, etc. Treatment should be vigorous and should be continued until all signs of infection have cleared. This is important to prevent development of chronic disease of the lungs and bronchi.

Classification of Pneumonias

I. *Bacterial*
- a. Pneumococci
- b. Streptococci
- c. Staphylococci
- d. Klebsiella Pneumoniae
- e. Hemophilus Infections
 1. Pertussis
 2. H. Influenzae
- f. Pasteurella Infections
 1. Pasteurella Pestis
 2. Pasteurella Tularensis
- g. Coliform, Proteus and Pseudomonas (gram-negative bacilli present in the intestinal tract)
- h. Salmonella Group
 1. Typhoid
 2. Paratyphoid A.B.C.
- i. Brucella
- j. Anthrax
- k. Glanders

II. *Viral* (Known and Probable)
- a. Psittacosis
- b. Influenza A & B
- c. Variola
- d. Varicella
- e. Rubella
- f. Lymphocytic Choriomeningitis
- g. Primary pneumonitis of infants
- h. Infectious Mononucleosis
- i. Erythema Exudativum Multiforme
- j. Primary atypical pneumonia

III. *Rickettsial*
- a. Typhus
- b. Rocky Mountain Spotted Fever
- c. Q Fever

Reprinted from *"Diseases of the Chest,"* official Journal of the American College of Chest Physicians, Vol. XXXIII, No. 4, p. 435 with special permission from the editors.

Chemotherapy

Continued

IV. *Mycoses* (Producing a pneumonia-like picture)
- a. Actinomycosis
- b. Nocardiosis
- c. Blastomycosis
- d. Coccidioidomycosis
- e. Histoplasmosis
- f. Moniliasis
- g. Cryptococcosis
- h. Aspergillosis
- i. Geotrichosis
- j. Penicilliosis
- k. Sporotrichosis

Treatment of Pneumonias

I. Bacterial Pneumonias

Pneumococcal Pneumonia. Penicillin is the drug of choice in the treatment of pneumococcal pneumonia. It is best given by the intramuscular route, using 300,000 units of aqueous penicillin every 3 to 4 hours, or 600,000 units of procaine twice daily. Oral penicillin is not advised except in mild cases. Therapy is continued until the temperature has been normal for 3 days. Larger or smaller doses may be used, depending on the severity of the disease. The sulfonamides are highly effective in the treatment of pneumococcal pneumonia. The dosage is 6 to 8 gm. daily. The broad-spectrum antibiotics, including tetracycline, chloramphenicol and erythromycin are all effective, but should still be considered second to penicillin.

Streptococcal Pneumonia. Treatment of streptococcal pneumonia is the same as that of pneumococcal pneumonia.

Staphylococcal Pneumonia. Treatment of staphylococcal pneumonia requires considerable care in view of increasing development of staphylococcal resistance to most antibiotics. Sensitivity tests should be made early. If the organism is penicillin sensitive, large doses of penicillin, 2 to 4 million units daily, should be given and no other antibiotic need be given with it except perhaps streptomycin. If the organism is penicillin resistant and susceptible to erythromycin or novobiocin then one or the other of these drugs should be used. Vancomycin, which is not yet on the market, is an excellent bactericidal agent for staphylococci and should be used if the organism is resistant to other more readily available drugs. In the seriously ill patient who is not responding to the prescribed therapy, bacitracin in doses of 25,000 units every 6 hours should be added. The nephrotoxic potentialities of bacitracin must be watched. Treatment of staphylococcal infections should be prolonged for 3 or 4 weeks.

Klebsiella Pneumonia. Test of susceptibility should be performed but usually this type of pneumonia is best treated by streptomycin 2 to 4 gm. daily plus one of the tetracyclines in 4 gm. dosage initially. After response to therapy the dosage may be lowered. Sulfadiazine has also been quite effective in conjunction with streptomycin. Treatment must be continued for several weeks because of the severity and chronicity of the disease. The potential toxicity of streptomycin when used too long must be kept in mind.

Hemophilus Infections. Chloramphenicol or tetracycline in doses of 2 to 4 gm. daily are effective in both pertussis and H. influenzae infections. Sulfadiazine or streptomycin should be used in combination in the serious case.

Pasteurella Infections. Sulfadiazine, streptomycin, chloramphenicol and tetracycline have all proved effective in the treatment of plague pneumonia. Streptomycin is the drug of choice. Streptomycin is the ideal agent in the treatment of tularemic pneumonia in dosage of 2 to 4 gm. daily. The broad-spectrum antibiotics are also effective.

Coliform, Proteus and Pseudomonas Group. This group is becoming increasingly important as a result of antibiotic therapy. Sensitivity tests must be done to find the most effective drugs. The organisms may be sensitive to the broad-spectrum antibiotics, sulfadiazine and streptomycin. A tetracycline may be sufficient for the coliform and proteus types of pneumonia if the organism shows susceptibility to these agents but combinations of antibiotics are usually necessary. If these organisms are resistant, combination of tetracycline and streptomycin in full dosage should be tried. If response does not occur penicillin, in large doses, in combination with chloramphenicol should be tried. In resistant infections polymyxin may be used with a tetracycline. Polymyxin is the drug of choice for pseudomonas pneumonia. The drug is both nephrotoxic and neurotoxic. It should be used with

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SEARLE

Chemotherapy

Continued

caution. In general, infections by this group respond poorly to all antibiotics.

Salmonella Group. The typhoid bacillus is a rare cause of pneumonia. Chloramphenicol 2 to 4 gm. daily followed in a few days by 1 gm. dose is specific. In the other Salmonella infections, chloramphenicol or one of the tretracyclines may be used.

Brucella Infections. Brucella infections are best treated by a combination of tetracycline, ¾ gm. every 6 hours in combination with streptomycin 1 gm. daily for a month.

Anthrax. Pulmonary anthrax is a rare complication of anthrax but when present is a very serious and fulminating disease. The tetracyclines are the drugs of choice, though penicillin and the sulfadiazines have also been used successfully.

Glanders. Lung lesions occur in about one-quarter of the glanders cases. Sulfadiazine and streptomycin are effective in the treatment of glanders. The broad-spectrum antibiotics have also been used successfully.

II. Viral Pneumonias.

Psittacosis. The tetracyclines are the drugs of choice using 4 gm. daily for the first 2 days, followed by a 2 gm. daily dosage. Penicillin has been used successfully.

Virus Influenzal Pneumonia. There is no known specific for influenzal pneumonia.

Variola. Pulmonary lesions often occur in smallpox. There is no specific for the primary disease but because of secondary infections by bacteria appropriate chemotherapy for these infections should be used.

Varicella. Pneumonia occurs rarely. Treatment should be directed to secondary bacterial infections.

Rubella. Bronchopneumonia is a common complication of measles. While there is no specific for the measles virus, superimposed bacterial infections are frequent and can be successfully treated by penicillin or the tetracyclines.

Lymphocytic Choriomeningitis. Pneumonia occurs in lymphocytic choriomeningitis. Treatment is symptomatic.

Primary Pneumonitis of Infants. There is a serious disease in the newborn and premature



he deserves

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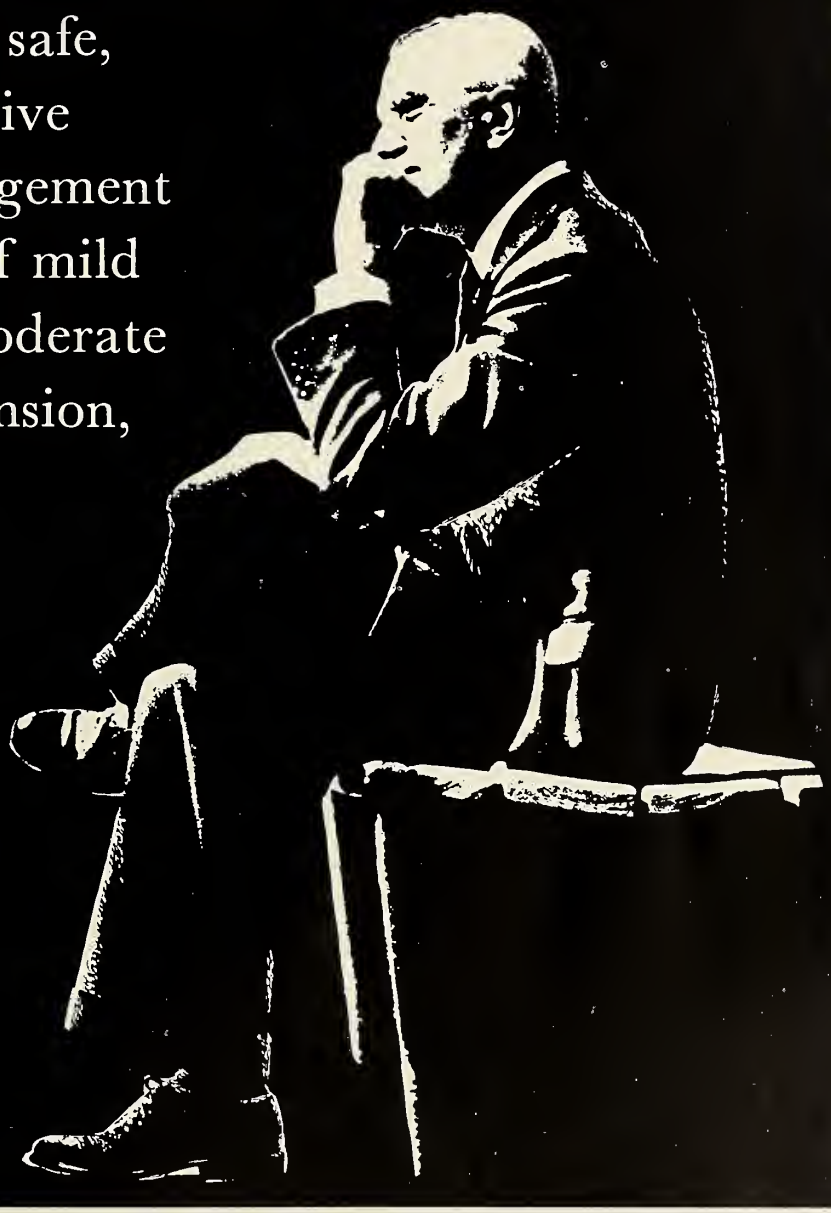
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Prescribed with confidence 8,863,769 times Veratrite continues to be the antihypertensive of choice for treating geriatric patients.

Veratrite effectively reduces blood pressure through action on the sympathetic nervous system, without detriment to the cardiac output.

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Sodium nitrite	1 gr.
Phenobarbital	¼ gr.

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Chemotherapy

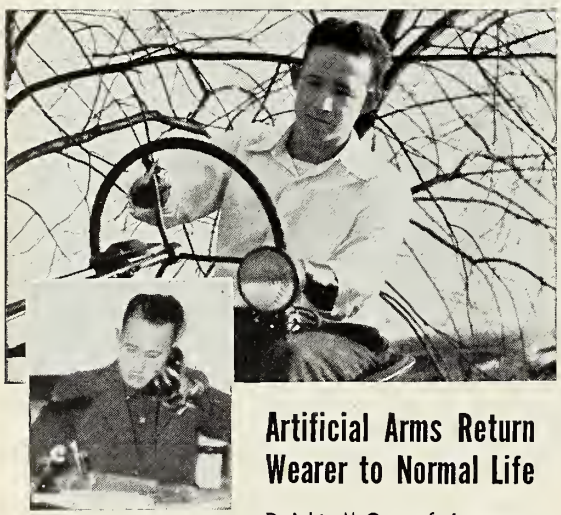
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infants probably due to a virus. There is no known specific therapy.

Infectious Mononucleosis. Bronchopneumonia is a rare complication of infectious mononucleosis. There is no known specific for this disease.

Erythema Exudativum Multiforme (Stevens-Johnson Syndrome). Pneumonia is a common accompaniment of this disease. It appears to be due to a virus which is not affected by any known antibiotic. Steroid therapy has often proven to be helpful.

Primary Atypical Pneumonia. The status of drug therapy of Primary Atypical Pneumonia is still under question. Some observers feel that a tetracycline 0.5 gm. every 6 hours should be given until temperature has been normal for at least 3 days, principally to guard against secondary bacterial invaders. Some observers prefer to use no antibiotic therapy in the average case unless there is indication of a secondary infection.



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Dwight McGee of Lancaster, Ohio, wearing two Hanger Arms, can write, shave, use a knife and fork, drive an automabile, and says he can da about anything an ordinary person can da. Hanger Arms are custom-made ta fit the wearer's stump and his particular daily needs, and are carefully fitted by experienced Hanger fitters. Arms can be furnished with casmetic ar mechanical hand and haak.

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III. Rickettsial Pneumonias.

Treatment of all of the rickettsial pneumonias may be combined together. Chloramphenicol or a tetracycline appears to be equally effective. The dosage in severe cases is 1 gm. every 6 hours for 3 doses, then 0.5 gm. every 6 hours until the temperature is normal.

IV. Mycotic Infections

Actinomycosis. Penicillin is the drug of choice, one or 2 or more million units a day usually along with surgical drainage if necessary. One of tetracyclines may be just as effective. Treatment is continued for at least 6 weeks and should be kept up long after the lesions have disappeared to prevent a recurrence.

Nocardiosis. Sulfadiazine is the drug of choice for nocardia infections. The broad-spectrum antibiotics may be helpful. The treatment must be prolonged.

Histoplasmosis. At present there is no proven therapeutic agent for this disease, but very suggestive results are being obtained with a new antibiotic, amphotericin B. The drug has been employed in a number of cases and the incidence of serious toxic manifestations has been relatively low. It has also demonstrated definite therapeutic effect. The drug is very difficult to administer and must be given intravenously in a slow drip over a period of 6 hours. Approximately 1 mgm. per kilo per day is the usual daily dose and treatment is continued from 30 to 60 days. Under special circumstances the daily dose may be increased to as much as 100 mgm. per day. An oral form of the drug is avaliable, but has not proved to be effective. Immediate febrile complications during therapy are not unusual especially if the drug is given too fast. These effects may be ameliorated by aspirin. These reactions have not interfered with the continued use of the drug.

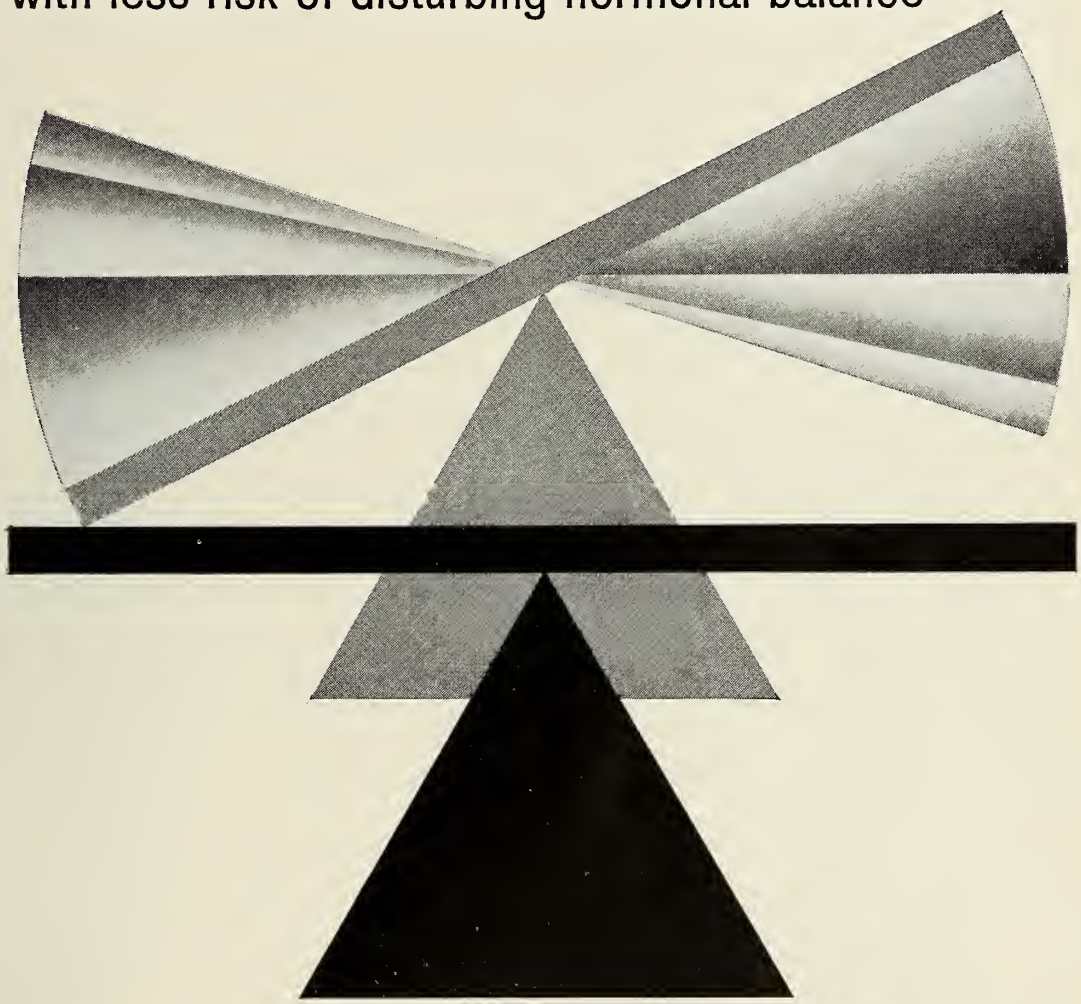
Blastomycosis. 2-hydroxystilbamidine is the most effective agent in the treatment of blastomycosis. Standard daily dose is approximately 250 mgm. dissolved in 250 to 500 cc. of 5% dextrose, and given intravenously. This is given rather slowly over a period of several hours at least. The drug should be used immediately after preparation and the solution should be protected from sunlight. Thirty to 60 days of daily dosage of 250 mg. is recommended. The drug may be repeated in case of a relapse. Facial neuropathy may occur but is much less frequent than with

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Geigy

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Sterazolidin® (prednisone-phenylbutazone Geigy). Each capsule contains prednisone 1.25 mg.; phenylbutazone 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg. and homatropine methylbromide 1.25 mg.

1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

Geigy, Ardsley, New York

03859

Chemotherapy

Continued

stilbamidine. Recently amphotericin B has appeared quite effective in treatment of Blastomycosis.

Coccidioidomycosis. Amphotericin B may be used for treatment of coccidioidal disease.

Moniliasis. Mycostatin is an effective antifungal drug for intestinal moniliasis, or it can be used locally. It has no effect on the systemic disease, as it is not absorbed from the intestinal tract. In systemic moniliasis it is suggested that one of the newer antibiotics be employed, such as amphotericin B.

Cryptococcosis. Amphotericin B may be used. Its effectiveness is still under investigation.

Aspergillosis, Geotrichosis and Penicilliosis. These diseases are refractory to all known antibiotics. Amphotericin B should be tried.

Sporotrichosis. This usually responds satisfactorily to potassium iodide. 2-hydroxystilbamidine should be tried in the refractory case.

Steroid Therapy

The role of steroids in the therapy of infectious disease is a subject of tremendous controversy. When overwhelming infections cause adrenal insufficiency steroid therapy is indicated. The beneficial anti-inflammatory and "antitoxic" effect of the steroids is opposed by the adverse influence of the steroids on tissue localization of infection. However, it is likely that one may accomplish the desirable and prevent the potential harmful effects of steroids by the simultaneous use of anti-microbial agents to which the infective agent is susceptible. On theoretical grounds, at least, it would be undesirable to use steroid therapy in infections caused by organisms resistant to anti-microbial agents. There appears to be a place for the use of steroids in overwhelming infections not responding to conventional therapy.

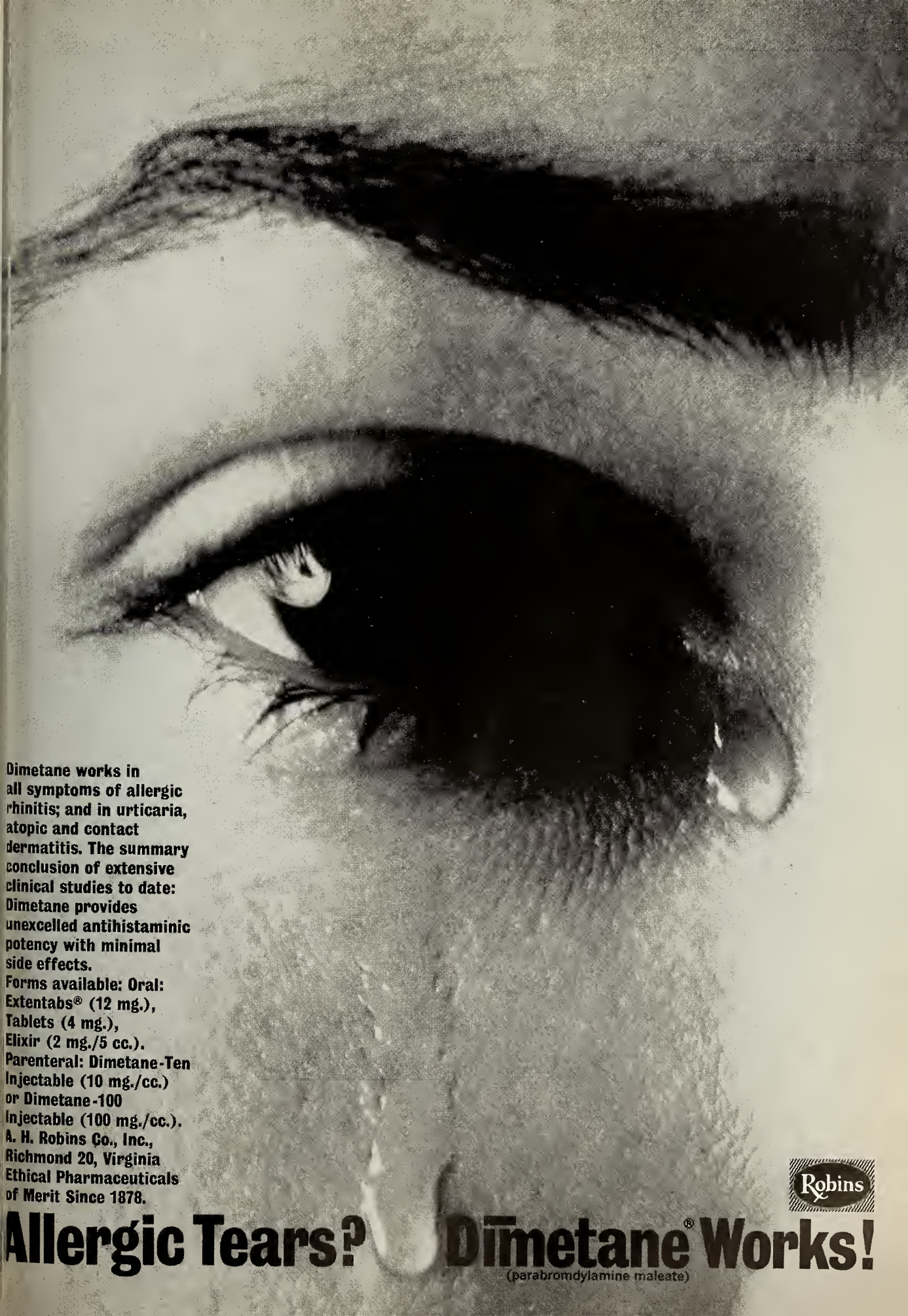
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Social Security for Physicians?

THOMAS PARKER, M.D.

Greenville, S. C.

IN THE CONSIDERATION of social security in general, it might be well to start with the premises upon which the social security program is based.

The first is that everyone upon attaining a given age or condition of decrepitude is entitled to federal benefits, primarily money, but possibly other services. As the grasshopper sang, "The world owes me a living." Under certain conditions the benefits may be denied because of excessive residual initiative or failure to comply with technicalities.

The next proposition is that it is right for everyone to be forced to provide these benefits for himself. This, of course, is the authoritarian concept that it is right actively to force people to do something someone else thinks is right, as opposed to the libertarian concept that force should be used only to prevent wrong-doing. One has to use force occasionally to train animals and children, but authoritarians treat adults as children.

Third, the force to be exerted for the provision of these benefits is taxation. It is assumed that this is a fair, democratic and desirable means.

Fourth, it has been asserted that since taxation is used for the provision of the benefits, those being taxed are paying their own way. It is becoming increasingly obvious, however, as Congress changes the law year after year increasing "benefits" and taxes, that the present beneficiaries did not provide that which they receive, but that it is in reality federal largesse, extracted from present taxpayers who will have to get theirs later from still other and younger taxpayers. For those who receive benefits to provide them for themselves, it is obvious that taxes should be collected before benefits are disbursed and that once a person becomes a beneficiary, his benefits are fixed, because he will never pay any more taxes. In a backhanded though important way, the federal government recognizes that social security payments do not represent earned income, since they are classified as charity and hence tax-exempt.

There are many reasons why doctors should oppose being included in social security. Perhaps the most obvious is that the system is financially unsound. Prior to this year, social security income exceeded outgo, primarily because eligible beneficiaries represented only a small percentage of those included in the system. The majority of those paying taxes were not eligible to receive benefits. This year, however, as more and more people became eligible to receive benefits, payments exceeded receipts. Although taxes are scheduled to rise progressively every few years for some time, there are many who feel that income will never again exceed disbursements for very long, even without the addition of extra benefits by Congress every year or two. Liability for present promised benefits will always exceed the estimated income. And how high can such taxes go? For the self-employed they are presently scheduled to reach 6% by 1975, but in some South American countries now they are 25% of payroll, and in France as much as 35% of payroll. Bill S. 3508, proposed by Senator Morse, would periodically increase the tax rate so that by 1975 the employee and employer each would be paying 5.5% on a wage base of $6,000, and self-employed would be paying 8.25%. Certain increased benefits in public assistance are

Reprinted from the October, 1958 number of The Journal of the South Carolina Medical Association, Vol. LIV, No. 10.

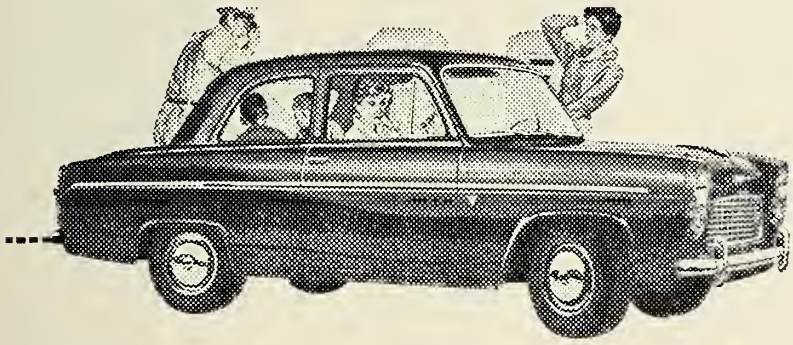
provided and the funds for this increase would come from increased appropriations from general revenues. One should realize that the social security taxes are deducted prior to income taxes and there are no allowances for dependents, etc., so that this is an additional tax on gross income. (JAMA, July 19, 1958, p. 1520.)

In addition, there are those equipped to calculate such things who estimate (for social security experience and practice do not permit sound actuarial computation) that the present obligations of the social security system exceed 280 billion dollars—more than the current, nominal national debt. This sum is represented by 20 million dollars in cash—the petty cash account which, with the tax income, keeps the present payments going—and the remainder in government bonds, the actual cash having been tranferred to the general treasury funds and spent. This means that when the social security system needs its money for payments, it must endeavor to redeem its bonds, which can only be done by collecting the cash a second time from the taxpayers.

In addition to the above financial consideration, it should be said that in other countries which have provided social security, such as Germany and England, the special taxes counted upon to support the system have proven inadequate and general tax revenues have had to be tapped. But what excess general revenues are available to the United States, currently operating annually billions of dollars in the red, and where shall we find a daft, rich uncle to subsidize our folly for free?

In addition to the disreputable financing described above, it should be realized that social security numbers have no cash surrender value or value as colateral, as conventional insurance policies do—since indeed, as explained, the so-called savings have already been spent, and benefits promised are not guaranteed, but dependent upon the whim of Congress which can change the law any time.

Further discussion of the premise that everyone is entitled eventually to a government subsidy is in order. At least in the world of nature, both amongst animals that operate as individuals and those that are organized into communities, in order to receive, one must produce. (We hope that the cosideration of man as an animal is not offensive, but in discussing sociological problems we must use sociological concepts; and in



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Social Security

Continued

the welfare state we are discussing animal husbandry, with no regard for morals.) By analogy at least, therefore, only individuals who are or who have been productive should receive such benefits—which in turn is the capitalistic concept, as opposed to the welfare state proposal. Nonproducers, therefore, if they receive benefits, would receive them as charity for moral reasons (again a capitalistic concept), and not as a right.

The proposal that individuals should be forced to provide for themselves is intriguing. One suspects that often the presentation of such schemes as good will toward men is quite the reverse, and is composed of a combination of a desire to do good with someone else's goods (assumption of unearned power), the unwillingness personally to provide for others, and contempt for the abilities and standards of one's fellow men. Surely all doctors have seen old people who prefer their own squalor to the opulence of institutional residence.

The necessity of forcing everyone to provide for himself is presented as the only alternative to a situation of distress otherwise intolerable. As a matter of fact, there are two traditional alternatives. The first is that the individual should be allowed to do without if he so chooses, like the grasshopper in Aesop's fable. The other is for wealthy philanthropists to alleviate the conditions through endowments, foundations and memorials. It is, of course, true that such charities do not alleviate all the existing distress—but it is also true that they are usually administered in such a way as not to create pauperism and additional need. Of course, for a confirmed socialist, both wealth and philanthropy are as objectionable as economic suffering; indeed they are themselves varieties of economic illness, and should be done away with.

As regards taxation, it should merely be mentioned that all methods of taxation are not fair and equal, and that one must always consider whether the purpose of taxation is to raise money for legitimate governmental functions, or to produce forcible economic change or redistribution of wealth under the guise of legal respectability. Whether the taxpayer is in fact paying his own way, or the way of another, would also seem pertinent.

The rules governing eligibility for social security benefits are so strange and changeable that they will not be discussed here. Suffice it to say that if the benefits are rights provided by taxation, or gifts provided by federal largesse, it hardly seems just to deny them to anyone superficially eligible on grounds of age or decrepitude because of minor technicalities.

The objections to the social security system given above are general and apply to people in all classes of life. There are, however, particular reasons that should cause doctors to wish not to be included. The first is that physicians rarely retire at the age of 65. If they don't, and earn $1200 per year from their profession, they will receive no benefits until they reach 72—so that the chances of their benefits equaling their payments are poor, given normal life expectancy and fair health. The second is that, barring trick situations such as that of the young physician who became the father of twins 18 months after he entered the social security system and then dropped dead, they can obtain better insurance cheaper from private companies, and this coverage, in addition, will have cash surrender and collateral value and a guaranteed eventual pay-

COOK COUNTY
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ANNUAL POSTGRADUATE COURSE
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UNITED STATES SECTION OF THE INTERNATIONAL COLLEGE OF SURGEONS
August 3-14, 1959

The United Stotes Section of the Internotional College of Surgeons will agoin offer its Annuol Postgroduote Course, in coaperotion with the Cook County Graduate School of Medicine. It will be a two-week intensive review course in Generol Surgery presented at the Graduate Schaal, ond in the words ond operoting rooms of Coak County Hospital.

The pragram will include illustrated lectures, onatomy demonstrations, operative clinics ond proctice surgery by the porticipants on onesthetized dogs. Considerotion will be given not only to surgicol technic, surgicol complications ond monagement of the surgicol potient, but olsa to on intensive review of the bosic sciences in relotian to clinical surgery.

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Social Security

Continued

ment regardless of the financial success the insured person may have achieved in the meantime.[1] A situation so much more common and probable that it can hardly be called trick is given in the *Journal* of the South Carolina Medical Association for July 1958: "Social Security says: 'A wife or widow under 62 or the divorced wife of an insured person may receive payments only while she has in her care a child (under 18 years of age) who is entitled to monthly payments.' Thus, many widows who married in their twenties and lost their husbands in their forties, would not receive any survivors' benefits until they reached age 62 because their children would be 18 or older." It cannot be denied that it is possible for physicians of 63 to enter the system, make payments for 18 months, and then retire and draw lifelong benefits; but surely most physicians are not looking for a chance to defraud their fellow citizens and descendents through legal technicalities.

The final reason for physicians is this: No one can in good faith and with honor seek to obtain federal cash benefits for himself and his family, but oppose on lofty moral grounds the provision of federal medical benefits (socialized medicine), such as are currently proposed in the Forand Bill, for example. No honorable person should exchange his birthright for a mess of pottage.

REFERENCE

1. Webster, R. C. and Coffey, R. L. *JAMA*: 162:231 (Sept. 15, 1956).

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JOURNAL

ADVERTISERS

Indiana State Board of Health

DIVISION OF COMMUNICABLE DISEASE CONTROL

A. L. Marshall Jr., M.D., Director

MONTHLY REPORT - APRIL, 1959

Disease	April 1959	Mar. 1959	Feb. 1959	April 1958	April 1957
Animal Bites	641	378	189	531	258
Chickenpox	636	915	752	562	832
Conjunctivitis	151	110	53	22	31
Diphtheria	1	0	0	4	3
Dysentery, Unspecified	17	13	19	19	15
Impetigo	67	65	65	23	19
Infectious Hepatitis	36	34	49	27	58
Infectious Mononucleosis	17	18	21	2	31
Influenza	2,992	10,674	1,011	675	323
Measles (Rubeola-Rubella)	998	843	755	5,130	1,951
Meningitis, Meningococcal	6	5	2	6	4
Meningitis, Other	11	9	7	14	3
Mumps	467	362	227	886	533
Pertussis	76	108	137	64	41
Pneumonia	331	196	257	141	97
Poliomyelitis	1	0	0	1	5
Streptococcal Infections	1,032	1,536	1,048	674	813
Tinea Capitis	35	20	45	19	10

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein.[1] Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy
64% of 42 pregnancies were salvaged by progesterone
83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.
108 (76%) of 142 babies of this birth weight survived without progestational therapy.
16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.
A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

Delalutin offers these advantages over other progestational agents:

- longer-acting and more sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requires injection of less vehicle
- unusually well-tolerated, even in large doses
- requires fewer injections
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

Administration and Dosage: Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

Supply: Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

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NEWS NOTES—from State and Nation

'To Succor the Ills - - -'

Dr. Green of N. Vernon Retires After 48 Years

After 48 years of serving the health needs of the residents of Jennings county and North Vernon, John H. Green, M.D., senior ISMA member, retired last month due to ill health.

He has sold the building that housed his office which was built by his grandfather, Dr. Charles H. Green. His father also was a physician, using the same building from 1884 until 1910.

Dr. Green took his pre-med at Purdue and then attended I.U. Medical School. He interned at St. Vincent's.

One of those from the horse-and-buggy era, he purchased his first auto, a used Hupmobile, in 1914, but still utilized the horse and buggy for winter calls on country roads which weren't in shape for cars without shock absorbers!

The *North Vernon Sun* quoted him as saying that he was going to retire in the manner stated by General Marshall upon his retirement: sit for a year in a rocking chair on his front porch and, after a year of repose, he then was going to slowly start to rock back and forth! One of the main activities in his future plans is that of catching up on his reading of books he has had to put back while delivering babies and tending to the ill.

Dr. Green has served terms as city and county health officer, was a member of the Indiana State Board of Health 8 years and Board president for 2, and an examiner for the Jennings draft board during WWII. He served in WWI as an Army medical officer.

He has been physician for the B&O and Big Four railroads for 30 years. He is a member of the North Vernon Methodist Church and a past commander of the local American Legion Post.

About Dr. Green, the *Sun* says:

"To succor the ills of others must remain one of the highest callings in life. And Dr. Green responded to this call with dignity, professional competence, unlimited energy and with a heart full of kindness."

Arthritis and Rheumatism Research Awards Announced

The Arthritis and Rheumatism Foundation is offering predoctoral, postdoctoral and senior investigatorship awards in the fundamental sciences related to arthritis for work beginning July 1, 1960. Deadline for applications is Oct. 31, 1959.

These awards are intended as fellowships to advance the training of young men and women of promise for an investigative or teaching career. They are not in the nature of a grant-in-aid in support of a research project.

The program provides for 3 awards:

(1) *Predoctoral Fellowships* are limited to students who hold a bachelor's degree. Each applicant studying for an advanced degree must be acceptable to the individual under whom the work will be done. These Fellowships are tenable for one year, with prospect of renewal. Stipends range from $1500 to $3000 per year, depending upon the family responsibilities of the Fellow.

(2) Postdoctoral Fellowships are limited to applicants with the degree of Doctor of Medicine, Doctor of Philosophy—or their equivalent. These Fellowships are tenable for one year, with prospect of renewal. Stipends range from $4000 to $6000 per year, depending upon the family responsibilities of the Fellow.

(3) *Senior Investigator Awards* are made to candidates holding or eligible for a "faculty rank" such as instructor or assistant professor (or equivalent) and who are sponsored by their institution. Stipends are from $6000 to $10,000 per year and are tenable for 5 years.

A sum of $500 will be paid to cover the laboratory expenses of each postdoctoral fellow and senior investigator. An equal sum will be paid to either cover the tuition expenses or laboratory expenses of each predoctoral fellow.

For further information and application forms, address the Medical Director, Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, N.Y.



Photo by A. W. Cavins, M.D.

I. U. Medical Science Building Dedicated

Indiana medicine took another huge step forward in April when the new 5-story Medical Science Building was dedicated at I. U. Medical Center in Indianapolis.

Already more than 1,100 students are utilizing laboratories and lecture rooms which include facilities for medical technology, dental hygiene and physical and occupational therapy.



Largest building on the Medical Center campus, it has a total area of 272,598 square feet (3,149,543 cubic feet) and is of fireproof construction throughout.

It features a library area of 14,200 square feet (with stack capacity for 75,000 volumes), air conditioned reading rooms, special study areas for students and faculty and two large lecture rooms. Each of the latter are 2-stories, air-conditioned, have a seating capacity of 200, seat-focused lighting, built-in public address and recording systems and a demonstration table.

There are huge teaching areas for microscopy, gross anatomy, physiology-pharmacology, biochemistry and dentistry.

Indiana University President Herman B Wells presided over the dedication ceremonies April 22. The program began with a processional to the dedication area.

Governor of Indiana, Harold W. Handley, presented the building which was accepted by Judge John S. Hastings, U. S. Court of Appeals of the Seventh Judicial Circuit and president of the I. U. Board of Trustees.

Speakers included Dean of the School of



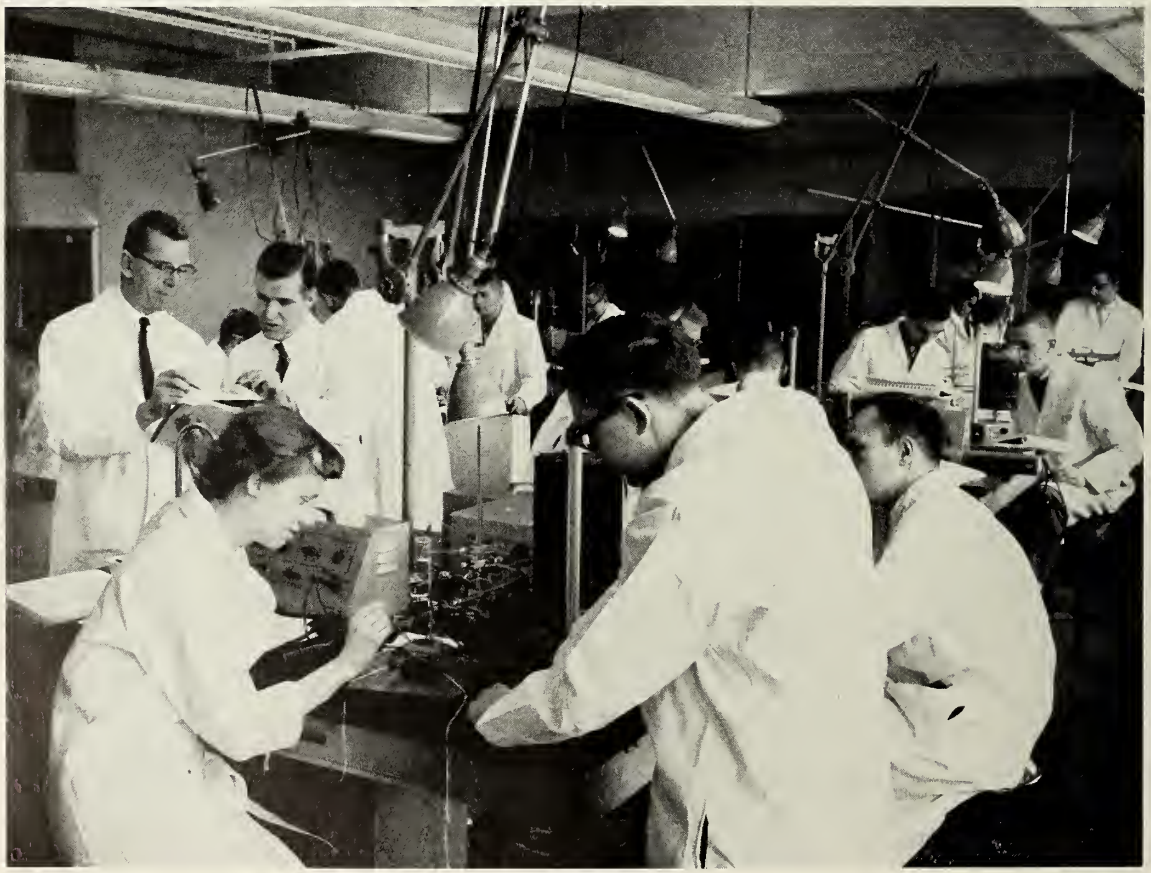
LIBRARY BOOKSTACKS—

Area of 14,200 square feet, Stocks 75,000 volumns.

Note student in background at study desk.

PHYSIOLOGY LAB SESSION—

Over 1,100 students are now taking advantage of laboratory facilities.



ANATOMY DISCUSSION—

Building features special student and faculty study areas, 2 huge lecture rooms.



DENTAL STUDENTS—

Microscopy, gross anatomy, physiology-pharmacology, bio-chem, dentistry teaching areas.



Medical Science

Continued

Medicine John D. VanNuys and Dean of the School of Dentistry Maynard K. Hine.

Invocation and Benediction were given by The Right Reverend John P. Craine, Bishop of the Episcopal Diocese of Indianapolis. Music was by the I. U. Symphonic Band, Ronald D. Gregory conducting.

Six honorary degrees were conferred by President Wells during the ceremony (see story elsewhere in "News Notes").

Six Hoosiers Presented I.U. Honorary Degrees

Bloomington, Ind.—Indiana University in dedicating the new medical science building at its Medical Center in Indianapolis in April conferred honorary degrees on 6 native or present Hoosiers in recognition of their contributions to the advancement of education and research in the health sciences.

The honorary degrees and their recipients were:

Doctor of Laws:

Perry W. Lesh, Indianapolis businessman, graduate of DePauw University, and member of the board since 1941 and president since 1947 of the James Whitcomb Riley Memorial Association which built Riley Hospital and has supported extensively research at the Medical Center.

James S. Adams, native of Brazil, alumnus of the University, general partner of Lazard Freres and Co., New York, honorary life director of the American Cancer Society, active in establishment of National Institutes of Health, co-organizer of movement for Congressional appropriation of $150 million for construction of medical research schools and laboratories, and president of the Indiana State Institute of Psychiatric Research.

Dr. Lon W. Morrey, native of Indianapolis, editor-in-chief of the American Dental Association, member of the board of directors of the National Society for Medical Research, and leader in dental education.

Doctor of Science:

Dr. Leroy E. Burney, native of Decatur County, graduate of I. U. and its School of Medicine, Indiana state health commissioner in 1945-54, and since 1956 surgeon general of the U. S. Public Health Service.

Dr. Isidor S. Ravdin, native of Evansville, John Rhea Barton professor of surgery and director of the Harrison department of surgical research of the University of Pennsylvania School of Medicine, who served as civilian consultant and assisted in President Eisenhower's ileitis operation in 1956.

Doctor of Humane Letters:

Dr. Russell J. Humbert, president of DePauw University, chairman of the 1955 Indiana White House Conference on Education, past president of the Indiana Conference of Higher Education, and active in private college work in pre-medical education.

The degrees were conferred at the dedication convocation held May 22 at the Medical Center.

Refresher Course Scheduled Aboard Ship and in Hawaii

University of Southern California's School of Medicine will offer another Postgraduate Refresher Course in Hawaii and on board the S. S. Lurline from July 29 through August 15, 1959.

Experience with last year's course indicated that the participating physicians were able to devote more concentration than usual on the program because they were away from the distractions of private practice. It was felt that the teaching-learning process was improved because of the informal and friendly relationship that grew up among the participating physicians and the faculty.

In addition to lectures, there will be workshops in ECG and X-ray interpretation as well as problems of water and electrolyte balance and the differential diagnosis of jaundice. During most hours, several programs run simultaneously so that the participating physician may pick and choose the topics most suited to his needs.

Further information about the course may be obtained by writing to the Director of the Postgraduate Division, USC School of Medicine, 2025 Zonal Avenue, Los Angeles 33.

Dr. W. L. Portteus, Franklin, director of the Sears Roebuck Foundation, was the principal speaker for the dedication of a medical facility at Germantown, Ill., May 17.

More news notes page 1013

Blue Shield Board Chairman Testifies Before Senate on Civil Servants' Insurance

CHICAGO, April 28, 1959—Blue Shield Plans throughout the country support legislation which would lend assistance to the financing of health care benefits for employees of the Federal government, Dr. Donald Stubbs, chairman of the Board of Directors of the National Association of Blue Shield Plans, told a Senate Committee on April 21.

Dr. Stubbs testified on behalf of the nationwide Blue Shield Plans before the Committee on Post Office and Civil Service, which is conducting hearings on Senate Bill 94, a bill providing for Government contribution toward health service benefits, including basic coverage and major medical insurance for civilian officers and employees in the U. S. Service and their dependents.

In his statement, Dr. Stubbs indicated that Blue Shield would generally favor legislation to provide:

1. That all qualified carriers have an opportunity to offer coverage.
2. That employees should have a free choice, subject only to the enrollment requirement of the carrier to select the plan of coverage which seems best to fit his needs.
3. That a Government contribution toward the cost of coverage be sufficient to enable employees to get better coverage than they may now have.
4. That payroll deduction be made available to assist the employee in paying his share of the cost.

Dr. Stubbs emphasized that Blue Shield was strongly opposed to any legislation which would permit the Federal employee to select a program of basic coverage from one source, and impose upon him major medical insurance obtained through another source. "It is in the best interest of the employee, the Government and the insurer that the health care services which each employee procures be obtained through a single source," Dr. Stubbs stated.

Dr. Stubbs further suggested that the proposed bill "be changed with respect to that section which limits the agencies qualified to provide major medical programs to a small handful of insurance companies and thus prohibits Blue Shield and Blue Cross Plans from creating a package of basic and major medical benefits to be offered Federal employees through a single source." And, finally, he urged that provision be made for a combination of basic and major medical coverage to be offered by any qualified carrier under the provisions of the bill.

Largest Employer

In his testimony, Dr. Stubbs indicated that the Federal Government is the largest employer which does not now contribute to or make available by means of payroll deduction some form of health benefits for its employees. Blue Shield stands ready to provide a nationwide program of health care benefits for Government employees, Dr. Stubbs announced, and its ability to do so is readily expressed by the successful servicing of Blue Shield medical care prepayment programs for more than 40 million Americans. Among these, he concluded, are hundreds of thousands of Federal employees who are currently participating in Blue Shield programs of their own volition.

Postgrad Gastroenterology Course Announced

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given at The Biltmore in Los Angeles, Sept. 24-26, 1959.

Faculty for the course will be drawn from the medical schools in and around Los Angeles. Subject matter to be covered from a medical as well as surgical viewpoint, will be essentially, the advances in diagnosis and treatment of gastronintestinal diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum.

There will be a clinical session at the College of Medical Evangelists and this year, in addition to individual papers, there will be several panel discussions of interest.

For further information and enrollment, write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

Indiana Auxiliary Elects Officers At 15th House of Delegate Session

The Woman's Auxiliary to the Indiana State Medical Association held its Fifteenth Annual House of Delegates session April 22-24 at the Hotel Keenan, Fort Wayne.

New president, Mrs. J. M. Black, Seymour, was installed in office as well as other new officers. Mrs. Earl Bailey, immediate past president, presented the gavel and president's pin to Mrs. Black, who later made the inaugural address.

Mrs. Edward L. Rigley of South Bend was named president-elect. (See pictures of new officers and chairmen accompanying this story.)

Guest speakers for the 3-day session included, Dr. George Lull, AMEF Director; Dr. Kenneth Olson, ISMA president; and Mrs. Frank Gastineau, president-elect, Woman's Auxiliary to AMA. A reception in Mrs. Gastineau's honor was given April 24.

Award winners were as follows:

Scrapbooks: Wayne-Union (1st) and Allen (2nd) counties.



TWO WIVES (unidentified, we're sorry) added a touch of entertainment at the 2-day session.



NEWLY ELECTED AUXILIARY officers to ISMA are shown (front, l to r): Mesdames Jack Shields, corresponding secretary; Paul Merrell, 4th V. P.; Joseph Black, president; Edward L. Rigley, president-elect; Burton Kintner, 1st V. P., and George Wagoner, recording sec'y. Back row: Mesdames R. Case Hammond, 2nd V. P.; P. T. Holland, historian; Kenneth Brown, treasurer; M. O. Scamahorn, Dis. Coun. chairman, and William R. Tindall, parliamentarian. (Not available for the picture was Mrs. Richard Gripe, 3rd V. P.)

MRS. FRANK BLACK (rt), new Auxiliary president, accepts the gavel from MRS. EARL BAILEY, 1958-59 president.

Action took place at the 15th Annual House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association held at Fort Wayne April 22-24.



AMEF:

Largest donation—Vanderburgh ($1,570.50), Marion ($1,238.63) and Lake ($550).

Largest increase over last year—Allen ($283), Vanderburgh ($198) and Grant (58).

Percentage of quota—Carroll (341%), Kosciusko (186%) and Vanderburgh (185%).

Today's Health (for outstanding work): Marshall, Jay, Carroll, Dearborn-Ohio, Gibson, Henry, Tippecanoe, Bartholomew-Brown, St. Joseph and Marion Counties.



AUXILIARY COMMITTEE CHAIRMEN for 1959-60 as shown are (front, l to r): Mesdames I. S. Hostetter, P. R.; Wendell Stover, Finance; E. L. Rigley, Organization; Joseph Black, president; Florence Baxter, Convention; Russell Palmer, Recruitment, and Otis Bowen, Legislation. Back row: Mesdames Kenneth Schneider, Civil Defense; Harry Harvey, Rules; Frank Hogle, Mental Health; Robert Acher, Safety; H. R. Swihart, Today's Health; Eli Rubens, AMEF; Albert Marshall Jr., Program. Not shown are Mesdames D. H. Condit, AMEF treasurer; Frank Green, Editorial; Joseph Dudding, Medical Care Ins.; Dwight Schuster, Publicity; Sam Campbell, Rural & Com. Health, and Fielding Williams, Bulletin.

'Medicine—A Lifelong Study' Theme of Big Chicago Conference

CHICAGO—Patterns of success and patterns of failure in the great cooperative movement to improve the health care of people everywhere, will be exchanged and compared when medical educators from 50 different countries gather in Chicago for the Second World Conference on Medical Education, Aug. 29 to Sept. 4.

"This 7-day meeting, jointly sponsored by the great world bodies of medicine, will provide a common ground for the free exchange of scientific information and experiences between countries," said Dr. Louis H. Bauer, New York, secretary-general of the World Medical Association. "In this way, a treasure-house of ideas and a compendium of knowledge in the broad field of medical education will flow from the more advanced countries to those now moving into the full light of medical progress."

The conference is being held under the auspices of the World Medical Association, which was founded 12 years ago, one of its 7 objectives being "to assist all peoples of the world to attain the highest possible level of health." The association is now composed of 55 national medical associations, representing about 700,000 physicians.

Collaborating with the World Medical Association in sponsoring the Chicago conference are the World Health Organization, the Council for International Organizations of Medical Sciences, and the International Association of Universities.

President Eisenhower is Patron

President Eisenhower, who has been keenly interested in the financial problems of medical schools ever since his days at Columbia University where he helped organize the National Fund for Medical Education, is patron of the conference. He has been invited to address the opening plenary session on Monday, Aug. 31.

Dr. Bauer said that the Chicago meeting will mark the second time that the governments and the professions, working together, "have grasped the significance of health problems on an international scale for the benefit of all mankind." The First World Conference on Medical Education was held in London in 1953.

"This second conference," Dr. Bauer said, "will give medical educators an opportunity to examine the progress that has been made during the 5-year interval in extending medical education—the real basis of all medical care—and raising its standards."

Serving as president of the Chicago conference will be Dr. Raymond B. Allen, chancellor, University of California, Los Angeles, who foresees great benefits accruing from the Chicago meeting.

"Every country has something unique to offer in its experience in medical education," he said, adding: "No two schools of medicine and their programs are exactly alike. There is much to be learned from different experiences, and this second world conference can only advance the welfare of mankind in ways which are above political differences, race and creed.

"Doctors and educators meet on the common ground of the welfare of the individual human being wherever he lives. By opening our doors and minds and hearts to those who want to come and participate, American physicians are taking the leadership in teaching others the great advancements in medical science."

125 Speakers from 50 Countries

Between 1,500 and 2,000 persons from all over the world will attend the conference; there will be 125 speakers from about 50 countries, and all business, including lectures, will be translated simultaneously into English, French and Spanish.

Although not a member of W.M.A., Russia is expected to send a delegation to the conference and will have at least 2 speakers on the program. Poland, another non-member, will also send representatives to the meeting.

"Medicine—A Lifelong Study" is the conference theme, and Dr. L. Turner, secretary, Council on Medical Education and Hospitals, AMA, explained it this way:

"Today, graduation from medical school is only the first step for the young physician who desires to teach or follow a chosen specialty. If he is to serve his fellow human beings to the best of his ability, whether as a teacher or as a practicing physician, he must keep up with rapidly-changing scientific knowledge and face the challenge of medicine as a life-long study."

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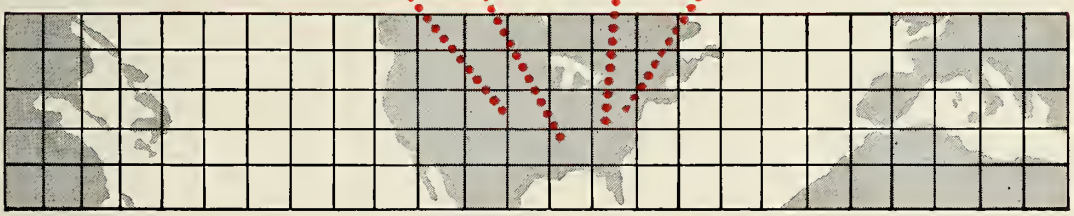
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For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6.Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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Science for the World's Well-Being

International Phy Med Congress To Be Held in U.S. Next Year

The Third International Congress of Physical Medicine will be held in Washington, D. C., from Aug. 21-26, 1960. This Congress will assemble physicians and other professional personnel from all parts of the world concerned with the furtherance and scientific development of physical medicine and rehabilitation.

This is the first International Congress of such character and magnitude to meet in the United States. International Congresses have been held in London in 1952 and in Copenhagen in 1956.

Convening this international session in the United States will provide to a large number of American physicians and other profesional personnel an opportunity to exchange with foreign visitors scientific information concerning physical medicine and rehabilitation.

Such exchange of scientific information is necessary and helpful for the continued improvement and expansion of physical medicine and rehabilitation services to the American public. Equally great will be the educational benefits to physicians and other professional personnel attending the Congress.

Further information concerning other aspects of the International meeting may be acquired by writing to Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical Medicine, 30 N. Michigan Ave., Chicago 2.

Phy Med, Rehab Congress Planned

The 37th annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held Aug. 30-Sept. 4, 1959 inclusive, at the Hotel Leamington, Minneapolis.

Scientific and clinical sessions will be given August 31, September 1, 2, 3 and 4. All sessions will be open to members of the medical profession in good standing with the American Medical Association and/or state or county medical association.

Full information may be obtained by writing to the Executive Secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

the "full-range"
oral hypoglycemic agent

DBI

Trademark, brand of Phenformin

in the management of
mild, moderate and severe diabetes
(juvenile and adult)

Hospital Safety Winners Announced for 1958 Contest

Chicago, April 16.—Roanoke Memorial Hospital, Roanoke, Va., has been announced as the Grand Award Winner of the 1958 Hospital Safety Contest, co-sponsored by the American Hospital Association and the National Safety Council.

The contest was judged on the basis of the lowest number of injuries among employees of individual hospitals in relation to the number of man-hours worked during the year-long contest.

The 280 hospitals which completed the contest reported a total of 367,075,000 man-hours worked during 1958, with a total of 3,042 injuries incurred resulting in at least one day lost from work. The contest is designed to encourage the observance of safety practices among hospital employees.

Roanoke Memorial Hospital, with 530 employees, operated 1,168,346 man-hours last year without a reportable injury to win the Grand Award.

Plaque Winners

Hospitals taking part in the Hospital Safety Contest were divided into eight groups according to the number of employees. Winners of first place plaques in each group were:

Rest Haven Rehabilitation Hospital, Chicago (less than 100 employees)

Orthodox Jewish Home for the Aged, Chicago (100-199 employees)

St. Mary's General Hospital, Lewiston, Me. (200-299 employees)

Alexandria Hospital, Alexandria, Va. (300-499 employees)

Veterans Administration Hospital, Fort Lyon, Colo. (450-599 employees)

St. Luke's Hospital, New Bedford, Mass. (600-799 employees)

Veterans Administration Hospital, Salisbury, N. C. (800-999 employees)

Valley Forge Army Hospital, Phoenixville, Pa. (1000 or more employees)

John J. Flick, Indianapolis, is the new president of the Indiana Academy of Ophthalmology and Otolaryngology.

DBI (N^1-β-phenethylbiguanide HCl) is an entirely new oral hypoglycemic compound, different in chemical structure, mode of action, and in spectrum of activity from the sulfonylureas. DBI is usually effective in low dosage range (50 to 150 mg. per day).

"full-range" hypoglycemic action — DBI lowers elevated blood-sugar and eliminates glycosuria in mild, moderate and severe diabetes mellitus...

brittle diabetes, juvenile or adult — DBI combined with injected insulin improves regulation of the diabetes and helps prevent the wide excursions between hypoglycemic reactions and hyperglycemic ketoacidosis.

stable adult diabetes — satisfactory regulation of diabetes is usually achieved with DBI alone without the necessity for insulin injections.

juvenile diabetes — DBI often permits a reduction as great as 50 per cent or more in the daily insulin requirement.

primary and secondary sulfonylurea failures — DBI alone, or in conjunction with a sulfonylurea, often permits satisfactory regulation of diabetes in patients who have failed to respond initially or who have become resistant to oral sulfonylurea therapy.

smooth onset — less likelihood of severe hypoglycemic reaction — DBI has a smooth, gradual blood-sugar lowering effect, reaching a maximum in from 5 to 6 hours, and a return to pretreatment levels usually in 10 to 12 hours.

safety — daily use of DBI in therapeutic dosage for varying periods up to 2½ years has produced no clinical toxicity.

side reactions — side reactions produced by DBI are chiefly gastrointestinal and occur with increasing frequency at higher dosage levels (exceeding 150 mg. per day). Anorexia, nausea or vomiting may occur — but these symptoms abate promptly upon reduction in dose or withdrawal of DBI.

supplied — DBI, 25 mg. scored, white tablets — bottle of 100.

IMPORTANT — before prescribing DBI the physician should be thoroughly familiar with general directions for its use, indications, dosage, possible side effects, precautions and contraindications, etc. Write for complete detailed literature.

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Hoosier Medical Assistants Association Holds Third Annual Convention at Fort Wayne

The Indiana State Association of Medical Assistants held their Third State Convention at the Van Orman Hotel, Fort Wayne, April 25-26. One hundred and twenty-one medical assistants from 9 component societies and 21 guests from 9 unorganized counties attended.

Saturday afternoon medical assistants attended 3 workshops: "What is Ahead for Medicine," speaker, Dr. Walter L. Portteus, Franklin; "Insurance and the Medical Assistant," Dr. John Langohr, Columbia City, and "The Medical Assistant is a Lady," Mrs. Bobbi Ray.

James A. Waggener, ISMA executive secretary, introduced speakers and spoke briefly. Each speaker was excellent in his field and stressed many valuable and interesting points.

At the Saturday evening banquet, Jeanne Woods, ISAMA president, presented Dr. Kenneth L. Olson of South Bend, an honorary membership. Dr. Olson, ISMA president, spoke briefly and presented charters to 3 new societies: Delaware-Blackford, Bartholomew-Brown and St. Joseph County Medical Assistants Associations.

Banquet speaker was Donnelly P. McDonald, who spoke on "Self-Hypnosis."

Other special guests included Dr. Margaret Ball, Fort Wayne; Dr. Robert Allyn Royster, Evansville; Charles Wise, executive secretary, Allen County Medical Society; Mrs. Marian Little, Cedar Rapids, Iowa, president-elect of the American Association of Medical Assistants, and Mrs. Mildred McBridge, Iowa.

A general business session convened Sunday morning and minutes of meetings and committee reports were read. A report of the Educational Program which is being outlined and planned by Virgil Hunt, director, Indianapolis I.U. Extension Center, was read and discussed. Many members and guests expressed interest in this program and are looking forward with a great deal of anticipation to having the program start in their city in the fall.

The Association also voted to contribute to the Indiana State Medical Education Foundation in memory of Mr. Albert Stump. This donation is to be given to the Indiana University Medical School.

Speaker at the luncheon on Sunday was Rev. George B. Wood, Trinity Episcopal Church, Fort Wayne. His talk was interesting, educational and humorous.

Officers elected and installed in a ceremony conducted by Mrs. Agnes Walker, Fort Wayne, were: president, Evelyn Sommers, Logansport; president-elect, Mrs. Jean Blance, Fort Wayne; recording secretary, Mrs. Trudy Cleckner, Fort Wayne; treasurer, Mrs. Evelyn Montgomery, Shelbyville; immediate past president, Jeanne Woods, Indianapolis. Directors elected for 2-year terms were: Mesdames Marjorie Beller, Muncie; Margaret Murphy, Columbus; Vivian Dodson, South Bend; Mary Webb, Indianapolis; Marcella Becker, Fort Wayne; Thelma Firsich, Shelbyville, and Izetta Blose, Richmond.

Convention comments from 90% of the medical assistants and guests attending were "well planned meeting, workshops were educational and interesting, and they hoped we would have many more of the same high-type caliber."

National Association News

The national association now has a central office and an executive secretary, Mrs. Stella Thurnau. Address is American Association of Medical Assistants, 510 N. Dearborn St., Chicago 10.

Mrs. Thurnau is well qualified and has the good wishes of Indiana State Association of Medical Assistants members.

Date to remember: national convention October 16-18, Benjamin Franklin Hotel, Philadelphia. It is hoped all medical assistants will make an effort to attend this meeting.

More Hill-Burton Projects Approved

Two new Hill-Burton projects were approved for Indiana in March, one for Methodist Hospital at Gary to give an additional 124 beds, the other for the same hospital with no additional beds.

A total of 47 projects have been completed in the Hoosier state and 29 are under construction with 7 approved but not under construction as of March 31.

The Federal share of the two newest projects totals $583,130.

A Message from

Hoosier Medical Assistants' President

In a scientific age when our dependence upon natural law is taken for granted, we pause to evaluate our present status. Space seems to have caught the fancy of young and old alike. We talk in terms of rockets and space travel. Frequently one hears the phrase "in orbit" in reference to a person or persons in the process of accomplishment.



Miss Sommers

The Indiana State Association of Medical Assistants is definitely in the process of accomplishment. In our less than 3 years of existence, we have grown under very capable leadership to a membership of 289 with 9 constituent associations in 8 of the 13 councilor districts.

Our Public Relations and Program and Education Committees, working with Dr. Harry Pandolfo, chairman of the Indiana State Medical Association Public Information Commission, has announced a training service to be available throughout the state by the fall semester of 1959 through Indiana University Extension Centers.

As a charter member of the American Association of Medical Assistants, now composed of 20 participating state associations, we were happy to be recognized by the appointment of Dr. Robert A. Royster of Evansville to the National Medical Advisory Committee, and by the election of Miss J. Marie Theobald of Indianapolis to the National Board of Directors, each to serve 2 years.

As we soar into the year's activities, with many plans for continued expansion and growth, we hope that your officers, Board of Directors and committee chairmen will make you aware of a "jet age" approach. Ours is the only organization for doctors' aides closely identified with the medical profession. Our aims and objectives have been officially endorsed by the American Medical Association.

We invite every medical assistant in Indiana to become one of us. Our "ground crew"—the membership committee headed by Miss Jeanne Woods, our immediate past president—will be happy to assist you with flight plans. (Address: 5240 Clarendon Rd., Indianapolis 8.) Six hundred members is our 1959-60 destination. Won't you come aboard?

Miss Evelyn Sommers
President, ISAMA

New Blue Cross Directors Elected

Dennis S. Megenhardt, M.D., Indianapolis; Lester H. Hoyt, M.D., director, Methodist Hospital Laboratory, Indianapolis; George Colwell, vice-president of the Indiana State AFL-CIO, Indianapolis; and Sister M. Gerald, general treasurer of Sisters of Holy Cross, Notre Dame, Indiana, have been elected to the Board of Directors of Blue Cross Hospital Service, Guy W. Spring, Blue Cross executive director, has announced.

The Norbury Sanatorium

Established 1901 — Incorporated
Licensed — Jacksonville, Illinois

FRANK GARM NORBURY, A.M., M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Physician

Operating

Maplecrest—

Restful, congenial homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

Hoosiers Participate In AMA Annual Meeting

Dr. John R. Cassady of South Bend read a paper entitled "Results of Iridencleisis in Negro and White Races" before the Section on Ophthalmology of the A.M.A. at the annual meeting at Atlantic City.

Dr. Eugene C. Klatte and Dr. John A. Campbell of Indianapolis presented a paper on "Clinical Applications of Cineradiography" to the Section on Radiology.

Dr. Lester Bibler of Indianapolis and Dr. Lall Montgomery of Muncie were delegates for the Sections on General Practice, and Pathology and Physiology respectively.

Dr. Myron Nourse of Indianapolis served as assistant secretary for the Section on Urology. Dr. Nourse also read a paper before this section on "Management of the Postoperative Patient Who Fails to Void."

Drs. William R. Kirtley, M. A. Root, A. S. Ridolfo, and R. C. Anderson of Indianapolis presented one of the exhibits in an exhibit symposium on diabetes. Their subject was "Oral Therapy of Diabetes: Metahexamide—a New Sulfonylurea." Dr. Kirtley participated in diabetes conferences on "Therapy of Sequelae and Complications," and "Diagnostic Problems."

Drs. Harold D. Lynch and W. D. Snively, Jr., of Evansville presented an exhibit on "Nutrition: The Core of Growth and Development" for the Section on Pediatrics.

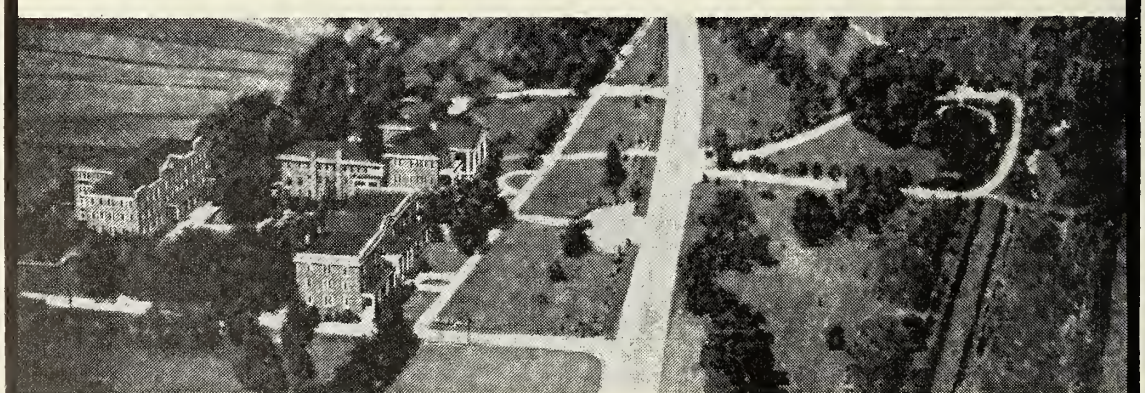
Dr. Lall G. Montgomery and Ruth Drummond of Muncie presented an exhibit on "Certification of Medical Technologists" for the Registry of Medical Technologists of the American Society of Clinical Pathologists.

Dr. W. D. Snively, Jr., of Evansville, presented an exhibit on "Medical Evansville in the 19th Century: Hugh McGary Memorial Exhibit" for the exhibit on History of Medicine.

In the House of Delegates, Dr. E. S. Jones, of Hammond, served on the reference committee on Amendments to the Constitution and By-laws. Dr. Lall Montgomery was a member of the reference committee on Legislation and Public Relations. Dr. Gordon Wilder of Anderson was on the reference committee on Miscellaneous Business.

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MILLEDGEVILLE, GA.



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Mrs. Sue H. Baldwin, R. N.
Superintendent

*Monthly Rates } Camellia Court from $150
Magnolia Hall from $210

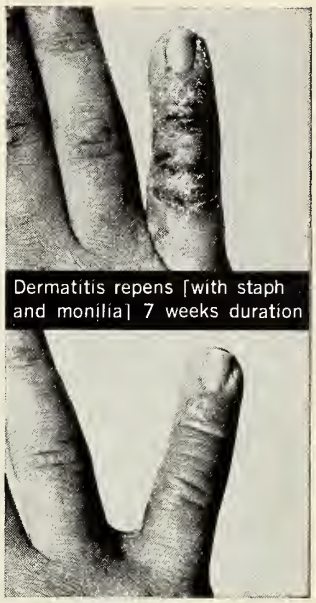
The South's Finest Health Resort for Elders

new for total management of itching,[1,2] inflamed,[3,4] infected[5,6] skin lesions

Mycolog ointment

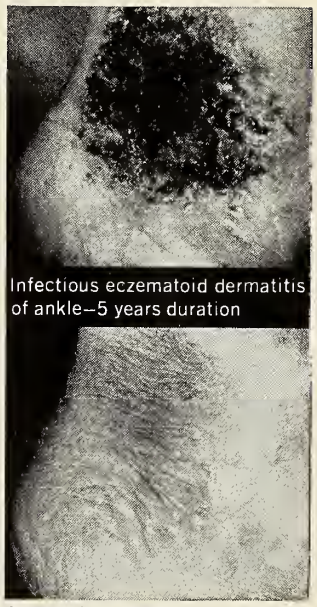
Kenalog, Spectrocin and Mycostatin in Plastibase

antipruritic/anti-inflammatory/antibacterial/antifungal



Dermatitis repens [with staph and monilia] 7 weeks duration

Cleared in 5 days



Infectious eczematoid dermatitis of ankle—5 years duration

Cleared in 20 days

Mycolog Ointment — containing the new superior topical corticoid Kenalog — reduces inflammation,[3,4] relieves itching,[1,2] and combats or prevents bacterial, monilial and mixed infections.[5-7] It is extremely well tolerated, and assures a rapid, decisive clinical response for most infected dermatoses.

> "Thirty-one of 38 patients . . . obtained excellent or good control of dermatological lesions . . . [Mycolog] was highly effective, particularly in the management of mixed infections. Several recalcitrant eruptions which had not responded to previous therapy were remarkably responsive to the daily application of this preparation over periods of 2 to 3 weeks."[5]

For total management of itching, inflamed, infected skin lesions, Mycolog contains triamcinolone acetonide, an outstanding new topical corticoid for prompt, effective relief of itching, burning and inflammation[1-4] — neomycin and gramicidin for powerful antibacterial action[7] — and nystatin for treating or preventing Candida (Monilia) albicans infections.[8,9]

Application: Apply 2 to 3 times daily. Supply: 5 Gm. and 15 Gm. tubes. Each gram supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base, 0.25 mg. gramicidin, and 100,000 units nystatin in PLASTIBASE.

References: 1. Shelmire, J.B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Derbes, V.J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R.C.V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T.H.; Newcomer, V.D., and Reisner, R.M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: Monographs on Therapy, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr.; Zawisza, R.J., and Blank, H.: Monographs on Therapy, 3:111 (Nov.) 1958. • 7. Monographs on Therapy, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: North Carolina M.J. 19:449 (Oct.) 1958. • 9. Bereston, E.S.: South. M.J. 50:547 (April) 1957.

And whatever the topical corticoid need, a suitable Squibb formulation is available—Kenalog-S Lotion—7½ cc. plastic squeeze bottles. Each cc. supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base and 0.25 mg. gramicidin. Kenalog Cream, 0.1%—5 Gm. and 15 Gm. tubes. Kenalog Lotion, 0.1%—15 cc. plastic squeeze bottles. Kenalog Ointment, 0.1%—5 Gm. and 15 Gm. tubes.

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'SPECTROCIN'®, 'MYCOSTATIN'®, 'PLASTIBASE'®, 'MYCOLOG' AND 'KENALOG' ARE SQUIBB TRADEMARKS

American College of Obstetricians and Gynecologists Installs New Officers

The American College of Obstetricians and Gynecologists at its seventh annual clinical meeting in Atlantic City, April 6-8, installed Dr. John I. Brewer of Chicago, professor of obstetrics and gynecology, Northwestern University Medical School, as its president. Dr. Brewer succeeded Dr. R. Glenn Craig of San Francisco.

Dr. C. Paul Hodgkinson, gynecologist-obstetrician-in-chief at the Henry Ford Hospital, Detroit, was chosen president-elect.

Other officers elected are:

Dr. Edward C. Hughes, Syracuse, first vice president; Dr. Ralph W. Jack, Miami, second vice president; Dr. Axel N. Arneson, St. Louis, treasurer; Dr. Craig W. Muckle, Philadelphia, secretary; **Dr. Sprague H. Gardiner, Indianapolis,** assistant secretary.

District officers elected are: Drs. Robert A. Cosgrove, Jersey City, and F. J. Hofmeister, Milwaukee, chairmen; Dr. S. Leon Israel, Philadelphia, and Dr. Harry K. Waddington, Chicago, vice chairmen.

Dr. Donald F. Richardson, Chicago, executive secretary of the College, was elected an Associate Fellow of the College.

Dr. Brewer received his M.D. degree from the Rush Medical College (University of Chicago) in 1928, and his Ph.D. from the University of Chicago in 1935. He has been professor of obstetrics and gynecology at Northwestern since 1930.

He is editor of the *American Journal of Obstetrics and Gynecology,* chairman of the board of commissioners of the Joint Commission on the Accreditation of Hospitals, a past president of the Central Association of Obstetricians and Gynecologists and Chicago Gynecological Society, and a founding fellow of The American College of Obstetricians and Gynecologists.

Dr. Hodgkinson is a graduate in pharmacy from the University of Pittsburgh, 1925, and practiced pharmacy for a time before taking up the study of medicine. He obtained his M.D. degree from Temple University School of Medicine, Philadelphia, in 1936. He took postgraduate work at the University of Michigan Medical School and obtained his M.S. in obstetrics and gynecology.

Ob-Gyn Exams Open for Application

Applications for certification (American Board of Obstetrics and Gynecology), new and reopened, Part 1, and requests for re-examination Part II are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is Aug. 1, 1959. No applications can be accepted after that date.

Candidates are requested to write to the office of the Secretary for a current Bulletin if they have not done so in order that they might be well informed as to the present requirements. Application fee ($35.00), photographs, and lists of hospital admissions must accompany all applications. Write: Robert L. Faulkner, M.D., Secretary, 2105 Adelbert Road, Cleveland 6, Ohio.

Hoosier GP's Elect Officers

Newly elected president of the Indiana Academy of General Practice is Dr. Bernard E. Edwards of South Bend. Dr. Harry Pandolfo, Indianapolis, was named president-elect.

Others elected include Drs. Francis L. Land of Fort Wayne, delegate to the American Academy of General Practice, and Hugh S. Ramsey of Bloomington, Joseph M. Black of Seymour, Richard J. Purcell of Gary and George R. Bloom of Elkhart, directors.



"Been tinkering around under the hood of your little foreign car, eh?"



when pollen allergens attack the nose...

Triaminic provides more effective therapy in respiratory allergies because it combines two antihistamines[1,2] with a decongestant.

These antihistamines block the effect of histamine on the nasal and paranasal capillaries, preventing dilation and exudation.[3] *This is not enough;* by the time the physician is called on to provide relief, histamine damage is usually present and should be counteracted.

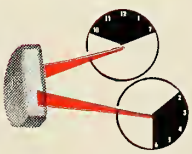
The decongestive action of orally active phenylpropanolamine helps contract the engorged capillaries, reducing congestion and bringing prompt relief from nasal stuffiness, rhinorrhea, sneezing and sinusitis.[4,5]

TRIAMINIC is orally administered, systemically distributed and reaches *all* respiratory membranes, avoiding nose drop addiction and rebound congestion.[6,7] TRIAMINIC can be prescribed for prompt relief in summer allergies, including hay fever.

References: 1. Sheldon, J. M.: Postgrad. Med. **14**:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy **19**:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.E.N.T. Monthly **37**:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. **112**:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. **5**:1183 (Sept.) 1958.

Triaminic®

TRIAMINIC provides around-the-clock freedom from hay fever and other allergic respiratory symptoms with just one tablet q. 6-8 h. because of the special timed-release design.



Each TRIAMINIC timed-release tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Also available: TRIAMINIC SYRUP for those patients of all ages who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet. TRIAMINIC JUVELETS provide half the dosage of the Triaminic Tablet with the same timed-release action for prompt and prolonged relief.

STOP *running noses* *and open stuffed noses orally*

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Latest Volume Available on Hypertension Proceedings

Proceedings of the annual meeting of the American Heart Association's Council on High Blood Pressure Research, held in November, 1958, are now available at $2.50 a copy. Orders may be addressed to the Association at 44 East 23rd Street, New York 10, N.Y.

The 143-page volume, seventh in a series, includes discussions by leading authorities on drugs, epidemiology and hemodynamics and reports to the public on hypertension and coronary heart disease.

In addition, 4 volumes of the Council's Proceedings, covering the years 1953 and 1955-56-57, may be purchased at a special group price of $6.00.

Drug NMEF Gifts High

New York.—Contributions of $228,355 were made to the National Fund for Medical Education by the pharmaceutical industry in 1958, John E. McKeen, chairman of the Fund's Drug and Pharmaceutical Division, has announced.

Donations from 53 individual companies brought the overall division total to $1,255,505 since its inception in 1953, Mr. McKeen said in a report to S. Sloan Colt, president of the National Fund for Medical Education.

Beyond these direct cash gifts, the industry has responded to the growing need for private support of medical education by making grants of approximately $20,000,000 for various fellowships, individual financial aid and specified research projects during 1958, the report disclosed.

Drs. John A. Campbell and V. K. Stoelting of Indianapolis were guest speakers at the Annual Meeting of the State Medical Society of Wisconsin, held in Milwaukee May 5 to 7.

Dr. M. Richard Harding, Indianapolis, was main speaker at the regular meeting of the Rotary Club of Indianapolis April 14. He spoke on "The Eyes Have It."

Dr. Richard B. Moore, who has been a fellow in medicine at Mayo Foundation, Rochester, Minn., has left that city to begin practice in Indianapolis.



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Add 1

by corki

May 11, 1959

Last week I had the distinct pleasure of joining 20 youngsters and their teacher-sponsors on a trip to Hartford, Conn., to take part in the National Science Fair of 1959. My job: to cover the story for the *Journal*. At this date it is too late for the big story and pictures of what took place there, as *Journal* deadline stares us in the face. We couldn't do it justice while hanging on that deadline.

But in July we hope to cover it with a splash—for these youngsters deserve every headline we can give them. This was a sophisticated group of "teeners" who, although seeming brilliant in the face of their highly scientific exhibits, were square on the ground, well-rounded kids.

And, although our 20 were picked as the best of hundreds and hundreds who entered the local science fairs throughout Indiana, I have a strong hunch they aren't really so much different than those who didn't get a "Finalist" blue ribbon. I have a wonderful hunch they are representative of the vast majority of our citizens of tomorrow in this country—and it's a mighty good, secure feeling to have!

No names for now—we had six winners, one a double award winner—but look for the National Science Fair spread in July. We just hope we can do these youngsters justice.

And keep it in mind that in 1960 this National Science Fair will be in Indianapolis with ISMA a co-sponsor.

Incidently, one 17-year-old girl got off a good one on the plane. It was a smooth flight for the most part, but at one point we hit a few downdrafts that bounced the plane a little, leaving that peculiarly empty feeling in the stomach. The young lady's comment: "Hey, dig this crazy elevator!"

Modern Knights in Shining Armor! Couple of years ago I had reason to write an article on gentlemen of San Francisco in a small paper I edited there. Now comes one from Indianapolis to prove the Sir Galahads are still around tho' their charging white steeds have turned to shiny automobiles!

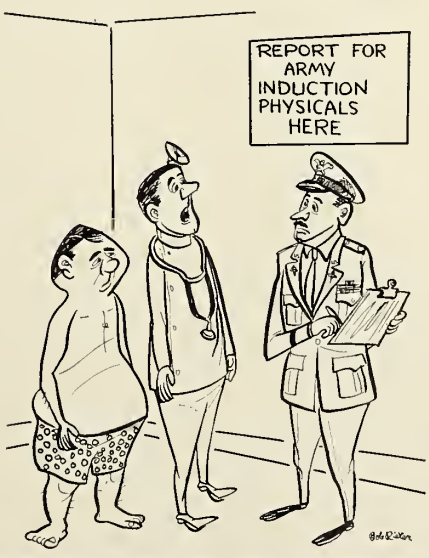
Made a couple of stops on the way home the other evening (and a hot day it was!) when, upon walking out of a bakery, I find my Green Monster II won't start. There it sets with frozen food in the back seat reaching the cooking point.

Walked to the Service Station at New York and Sherman Drive. Garage man walked back with me. Tried to start the Monster. No go. Wouldn't budge. If it was the starter locked, she was *really* locked. He finally tried to push me (after, in desperation, I had made an unfriendly remark about the "gentlemen" who were impatiently driving around me!) with his new car but it popped over my old, beat-up bumper.

Then a young man, who at first had refused to push me because his transmission wasn't too good, took pity on me and my Monster sitting in the middle of New York St. at commute hour. He pushed me down to another garage, a station at New York and Denny, where there was a mechanic.

Suddenly, I had 3 men with their heads poked under the hood trying to figure out what was

Continued on page 1032



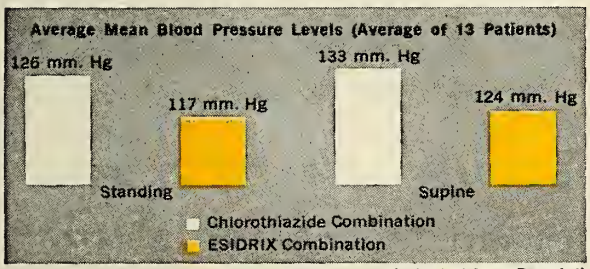
"We'll have to reject this one . . . after all, where can you get a helmet to fit that head?"


NOW...
for congestive heart failure
for other edematous states
for hypertension...

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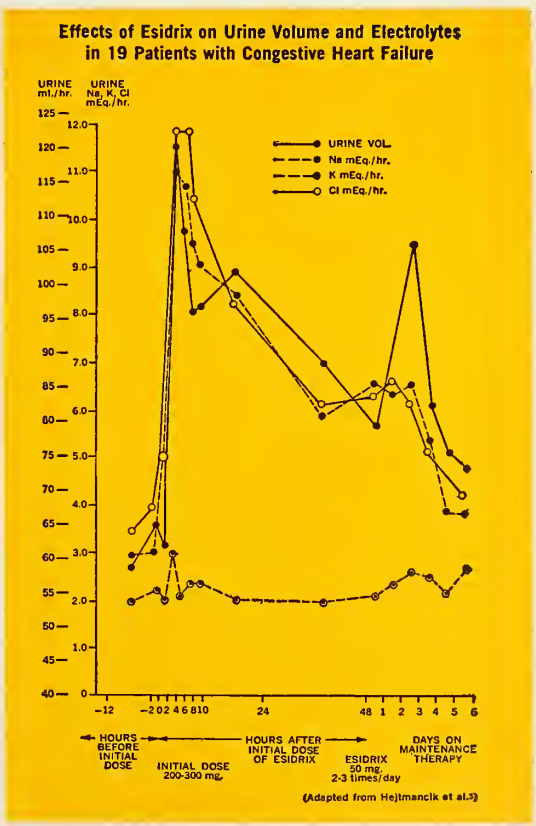
(hydrochlorothiazide CIBA)

Produces greater average reduction in blood pressure: Eleven of 13 hypertensive patients[4] were treated initially with a chlorothiazide-mecamylamine-reserpine combination (10 patients had 1000 mg. and 1 patient 500 mg. chlorothiazide daily); 1 patient had been treated with hydralazine and 1 had no previous medication. Nine were then transferred to an Esidrix-mecamylamine-reserpine combination and 4 to an Esidrix-reserpine combination for periods of 3 to 7 weeks (12 patients had 100 mg. and 1 patient 50 mg. Esidrix daily). Average mean blood pressure levels were recorded in the standing and supine positions. As shown in graph below, left, there was a further drop in blood pressure after patients were transferred to Esidrix.



(Adapted from Dennis[4])

Exceptional safety . . . reduced likelihood of electrolyte imbalance: While Esidrix markedly increases sodium and chloride excretion, it has far less effect on excretion of potassium (see chart at right) and bicarbonate. Hence, there is little likelihood of disturbing electrolyte balance when recommended procedures are followed.



DOSAGE: Esidrix is administered orally in an average dose of 75 to 100 mg. daily, with a range of 25 to 200 mg. A single dose may be given in the morning or tablets may be administered 2 or 3 times a day.

SUPPLIED: *Tablets,* 25 mg. (pink, scored); bottles of 100 and 1000. *Tablets,* 50 mg. (yellow, scored); bottles of 100 and 1000.

Add 1

Continued

wrong. They put the Monster up on a rack and began taking the starter apart—and there I stood. A friend drove by; I flagged her down, hitched a ride. And another "knight" moved all my groceries, laundry, etc., into the other car!

So, believe me, I found several Sir Galahads that evening and my thanks to them all!

(Note: the starter *was* stuck and they had to tear it down to get it unstuck! The Monster and I haven't been on such good terms since!)

Salute to our new states. Gotta get into the act on this Alaska-Hawaii bit. First, welcome . . . especially to Hawaii, since that's where my good friend Miki Wilson Gibson lives. She's the artist who is (I hope!) working on a special art cover for the *Journal.*

And then there's the quote in *Quote* by Sister Mary Gilbert that fits the situation.

"Opportunity in the 49th state had so impressed one of the college girls that she was boring her dorm friends with glowing descriptions of her homeland.

"Unable to remain silent, an Hawaiian student protested: 'If all the ice melted, Alaska would probably be the smallest state in the Union.'

"Without changing expression or raising her voice, the booster answered: 'Yes, and if all the ice melted, there wouldn't be any Hawaii!' "

Of course, something should be said about Texas loosing her spot as the biggest state; but from the delegation in Texas at the National Science Fair, I'd say Texans can still make up in noise (applause) for what they now lack in size! Only the combined efforts of the South brought more noise at the playing of "Dixie" than the playing of "Yellow Rose of Texas" brought.

A Laugh Cures Many Ills Dept.: "Quotable Quotes" from *Brevities,* published by Glen L. Campbell Printing, Inc.

A pink elephant, a green kangaroo and two yellow snakes strolled up to the bar.

"You're a little early, boys," said the bartender, "he ain't here yet."

"So you bought a home in the country?"

"Yes, five rooms and a path."

The nervous relatives were all gathered in the lawyer's office early, waiting for him to read Uncle Jasper's will.

The lawyer read: "Being of sound mind, I spent all my money."

The woman who insists upon making a match for her daughter probably intends to referee it as well.

Two can live as cheaply as one—they usually have to.

If your wife wants to learn to drive, don't stand in her way.

Doting mother: "And what did mama's little boy learn at school today?"

Eight-year-old: "I learned two guys not to call me mama's little boy!"

Since by the time this issue of the *Journal* crosses your desk, I hope to be rooting for the Giants and soaking up some San Francisco fog, will say: See you when I get back.



and
blood pressure
is controlled
safely and
effectively

The hypertensive under treatment is frequently burdened with side effects of therapy including states of depression, fatigue, and lethargy. He finds little joy left in his life and laughter is almost a forgotten experience.

With RAUTENSIN and RAUVERA, two unique and dependable antihypertensive agents, patients feel better, have a brighter outlook and blood pressure is safely reduced.

in mild hypertension

RAUTENSIN provides smoother antihypertensive action with no sudden rebounds or abrupt declines, and can be given over long periods of time without impairing mental alertness, producing excessive lethargy or drowsiness. When tachycardia is present, RAUTENSIN slows heart rate 10 to 15 per cent. RAUTENSIN is less likely to cause mental depression.[1] The apprehensive hypertensive is calmed, yet side actions are " . . . either completely absent or so mild as to be inconsequential."[2]

RAUTENSIN®

each tablet contains 2 mg. of the purified alseroxylon complex of Rauwolfia serpentina

Dosage: For the first 20 to 30 days, 2 tablets (4 mg.) once daily, at bedtime. Thereafter, a maintenance dose of 1 tablet (2 mg.) daily will suffice for most patients.

in moderate to severe hypertension

RAUVERA produces smooth and steady antihypertensive action which persists over the entire twenty-four hours without peaks and valleys . . . no "saw tooth" effect. Patients show a marked subjective as well as objective improvement with a significant drop in blood pressure, yet with a very low incidence of side effects.[3] Abrupt rise in blood pressure does not occur even when therapy is interrupted.[4] Tolerance does not develop on prolonged administration. Sensitization reactions or postural hypotension do not occur. Headaches, fatigue, insomnia and "heart consciousness" rapidly disappear, leaving the patient feeling well and asymptomatic.

RAUVERA®

each tablet contains 1 mg. of purified alseroxylon complex of Rauwolfia serpentina and 3 mg. alkavervir (Veratrum viride fraction)

Dosage: One tablet 3 or 4 times daily, ideally after meals, at intervals of not less than 4 hours.

1. Moyer, J. H.; Dennis, E., and Ford, R.: Arch. Int. Med. *96*:530, 1955.
2. Terman, L. A.: Illinois M. J. *3*:67, 1957.
3. La Barbera, J. F.: M. Rec. & Ann. *50*:242, 1956.
4. Bendig, A.: New York J. Med. *66*:2523, 1956.

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Abstract:

THE BIRTH OF NORMAL BABIES

Lyon P. Strean, Ph.D., D.D.S., F.A.P.H.A., F.A.A.A.S. Twayne Publishers, Inc., 31 Union Square West, New York 3

The author of this book is a full-time research scientist with degrees in dentistry, public health and basic sciences but is not a physician. He has devoted many years to the study of etiology of congenital malformations. Since the discovery of the etiological relationship between rubella and fetal malformations intense interest has been manifested in the broad aspects of the subject. Many epidemiological studies have been made and reported in medical literature.

Sixty case histories are presented in the book where infants were born with major congenital defects to mothers who gave a history of being subjected to some form of critical stress during the first trimester of pregnancy. It is the opinion of the author, and other investigators, that the mechanism of abnormal fetal development is essentially due to hypoxia as the result of stress. The nature of the trauma involved in the reported cases was either traumatic, physiologic or emotional.

In the discussion of precautionary measures to prevent fetal malformations the author presents "The Ten Commandments of Genesis." These precepts recommend such sensible measures as: avoidance of injury and infections; adequate nutrition; emotional tranquility; if possible the avoidance of radiation and general anesthesia; careful blood typing and exposure of girls to rubella.

One chapter is devoted to the importance of hereditary factors in the development of congenital defects. The author considers stress factors to be of greater importance than genetic defects in mongolianism and all other forms of fetal malformation.

Since stress factors, certain infections, trauma and emotional disturbances are considered by many observers to be the major cause of fetal malformation, this book is of particular interest to physicians. It is non-technical to the extent that it is easily readable for the layman, although it obviously would not be recommended reading for expectant mothers. While the evidence presented by this book may appear quite conclusive, more extensive research is needed to establish the stress factors mentioned as the definite and likely etiology of fetal death and malformation.

David A. Bickel, M.D.
South Bend

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Deaths . . .

Charles L. Amick, M.D.

Dr. Charles L. Amick, 74, a senior ISMA member, died April 5 in Goshen General Hospital where he had been hospitalized 4 days for his third heart attack.

A Scottsburg native, Dr. Amick graduated from Valparaiso University in 1906 and from University of Louisville Medical School in 1911.

He set up his medical practice at Fillmore, going to Wakarusa in 1914. He had practiced there since except for 19 months during WWI when he was with the Army Medical Corps in France. He attained the rank of captain.

Dr. Amick was a charter member of the Lions Club, an American Legion member of which he was a past commander. He was past chef de guerre of Elkhart county 40&8, and member of the Elkhart County Medical Society, ISMA and AMA.

His interest in youngsters made him instrumental in getting athletics started and a school building erected in the Wakarusa school system. He served as a part time school physician. He was presented a plaque for his service to the school and community.

Fred M. Applegate, M.D.

Dr. Frederick M. Applegate, 56, past president of Floyd-Harrison Medical Society in Indiana, died April 17 at Monahans, Texas.

A native of Corydon, Ind., he attended Indiana University and graduated from I. U. Medical School in 1929. Dr. Applegate practiced medicine in Corydon from 1931 to 1947 except for 4 years when he served as a lieutenant colonel in the Army Medical Corps in England during WWII.

After receiving EENT training at New York Polyclinic, he went to Monahans. He was a member of TMA, AMA and Reeves-Ward-Winkler Medical Society, of which he was a past president. He also was past president of Monahans Rotary Club.

On the staff of Ward Memorial Hospital, Monahans, he also was presiding elder of First Presbyterian Church and member of the Pisga Masonic Lodge.

Robert E. Baker, M.D.

Dr. Robert E. Baker, 97, an Orleans physician 60 years and senior and 50-Year Club ISMA member, died May 3 at his Orleans home.

Dr. Baker had been in semi-retirement since 1946 when he no longer was able to drive on house calls. However, he has kept office hours since then.

After teaching school in rural Washington county schools 10 years, he attended University of Kentucky Medical School to obtain his M.D. in 1892. He practiced at Harrodsburg until 1899 when he moved to Orleans.

Interesting note about Dr. Baker is that he interned with his father, Dr. Thomas Baker, who practiced 30 years in Washington county.

Dr. Baker was a member of Orleans Methodist Church where he taught a men's bible class, and member of Orange County Medical Society, ISMA and AMA.

Aaron D. Burge, M.D.

Dr. Aaron D. Burge, 87, who practiced in Grant County more than 50 years, died April 25 at Warren Methodist Home after five years of ill health.

He attended Valparaiso University and was awarded his M.D. from Eclectic Medical College, Cincinnati in 1897. He first practiced at Sweetser, beginning his practice at Marion in 1947.

He held the 50-Year Club membership in ISMA and was a member of Grant County Medical Society. He also was a member of Sweetser Methodist Church.

Asa H. Fender, M.D.

Dr. Asa H. Fender, 46, died April 11 at St. Vincent's Hospital, Indianapolis, following surgery. He had been ill two weeks.

Dr. Fender, a native of Lawrence county, obtained his M.D. from I. U. School of Medicine in 1947. He interned at Indianapolis General. He began his practice at Worthington in 1939. During WWII he was a captain in the U. S. Air Force.

Dr. Fender was a member of Worthington Christian Church, Greene County Medical So-



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Deaths

Continued

ciety, ISMA, AMA, Worthington Greene Lodge No. 577, F. & A. M., Scottish Rite and Shrine of Indianapolis and Elks Lodge No. 866 at Linton.

Charles J. Rothchild, M.D.

Dr. Charles J. Rothchild, 77, past president of Allen County Medical Society, died April 28 at his Fort Wayne home.

A graduate of the University of Michigan in 1905, Dr. Rothchild was a senior member and 50-Year Club member of ISMA. He had been chief of staff of St. Joseph's Hospital. He was a member of the Allen County Medical Society and AMA.

An obstetrician and gynecologist, he had studied in Europe from 1908 to 1910.

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- **Acts fast to relieve depression and its common symptoms:** sadness, crying, anorexia, listlessness, irritability, rumination, and insomnia.
- **Restores normal sleep**—without hang-over or depressive aftereffects. Usually eliminates need for sedative-hypnotics.



EFFICACY AND SAFETY CONFIRMED IN OVER 3,000 DOCUMENTED CASE HISTORIES.[1, 2, 3]

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: Each light-pink, scored tablet contains 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

References:
1. Alexander, L.: J.A.M.A. 166:1019, March 1, 1958.
2. Current personal communications; in the files of Wallace Laboratories.
3. Pennington, V.M.: Am. J. Psychiat. 115:250, Sept. 1958.

for depression

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County Society and District Reports

Boone

Dr. Robert Rogers presented a paper entitled "Erythroblastosis" at the April 7 meeting of Boone County Medical Society. Thirteen were present for the session held at Witham Hospital, Lebanon.

Fifteen members were present at the May 5 meeting which was held at the same place.

Clay

Elks Club at Brazil was the meeting place for Clay County Medical Society March 17 where 9 members heard Mr. Carty of the Terre Haute Social Security office speak.

Greene

Greene County Medical Society met at Roosevelt Hotel, Linton, May 14, where 23 members heard L. E. Converse of Blue Shield and a report on the action of Indiana General Assembly by the field secretary.

Henry

Fourteen members of Henry County Medical Society met April 16 at Henry County Hospital to hear Dr. Fred Lawrence speak on Alcoholism.

Jefferson-Switzerland

Twenty-one members of Jefferson-Switzerland County Medical Society met April 7 at Madison Country Club to hear a report on Indiana General Assembly action by the field secretary.

Johnson

V. K. Stoelting, M.D., of Indianapolis, discussed Emergencies in the Operating Room before 49 Johnson County Medical Society members May 13 at Hillview Country Club, Franklin.

Montgomery

Culver Hospital, Crawfordsville, was meeting place for 25 Montgomery County Medical Society members March 19 to hear Lt. Charles Davis of the Indiana State Police discuss the

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Counties

Continued

police lab. Members voted to participate in a TB skin testing program for 9th and 12th grade Montgomery county school children.

John B. Thompson, M.D., presented the subject, "Present Status of Cardiovascular Surgery," at the April 16 meeting. Twenty-five were present at Culver Hospital.

Orange

Nine members of Orange County Medical Society met March 31 at French Lick-Sheraton Hotel.

Owen-Monroe

Twenty-seven members and 29 wives and guests were present at the Owen-Monroe County Medical Society meeting March 26 to hear L. E. Converse of Blue Shield discuss Medical Economics. It was held at Bloomington Country Club.

Perry

Dr. E. R. Snyder discussed Stocks and Stock Brokers before 9 members of Perry County Medical Society April 17 at Nursing Center, Cannelton.

On May 5, R. Gordon Gilbert, M.D., discussed Pulmonary Cysts at the same center.

Putnam

DePauw's Student Union building, Greencastle, was meeting place for the April 10 meeting of Putnam County Medical Society where 15 members heard a child psychiatrist from I. U. Medical Center discuss Child Guidance. The field secretary reported on Indiana General Assembly action.

Randolph

Randolph County Medical Society met April 13 at Randolph County Hospital to see an Upjohn Grand Rounds film. Eleven members were present to vote a $25 contribution to the Science Fair fund.

On May 11, 13 members saw another Upjohn Grand Rounds film entitled "Acute Abdominal Problems."

Rush

Rush County Medical Society met April 9 to hear Richard M. Nay, M.D., Indianapolis, present the scientific program on Endocrinology. The field secretary reported on Indiana Gen-

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eral Assembly. Fourteen members were present at Rush County Hospital for the meeting.

Shelby

W. S. Major Hospital, Shelbyville, was the April 8 meeting place for 17 Shelby County Medical Society members who heard Dr. Miller discuss their hospital construction progress and present color slides on the construction. The field secretary reported on Indiana General Assembly action.

Vanderburgh

Vanderburgh County Medical Society scheduled Dr. J. H. Charbonneau, M.D., Montreal, president of the Canadian Pediatric Society, to speak on "Stevens-Johnson Syndrome" at the May 12 meeting.

Washington

Washington County Medical Society met May 12 at Washington County Hospital to hold a round table discussion and hear the field secretary's report on Indiana General Assembly action and problems facing medicine today.

Wayne-Union

A special meeting was held by Wayne-Union County Medical Society April 7 to hear a discussion of the need for a full-time health office in Richmond by Mr. Yoho and James McCoy. Twenty-seven members were present.

At the regular meeting April 14, 35 members were present to hear Dr. Morris Green, Indianapolis, speak on Considerations of Chronic Reoccuring Abdominal Pain in Children. A constitution was adopted at this meeting.

On May 12 George J. Thomas, M.D., professor of Surgery and chairman of Section of Anesthesiology, University of Pittsburgh, discussed "Fire and Explosion Hazards in Hospitals and Their Control."

Whitley

A movie was presented by Drs. Roth and Luckey on Fluothane Anesthesia before 14 members of Whitley County Medical Society April 14. The meeting was held at Whitley County Memorial Hospital.

G. F. Ward, urologist from Fort Wayne, discussed Nephrectomy before 11 members and 1 guest at the May 12 meeting.



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Rutin	25 mg.
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Calcium (as $CaHPO_4$)	157 mg.
Phosphorus (as $CaHPO_4$)	122 mg.
Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF_2)	0.1 mg.
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to the editor:

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for

Your Letters!

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your comments.

Lighter Vein—

Pioneer legislation of the week: A bill passed by the lower house of the Iowa legislature provides for a year in jail, $1,000 fine or both for drunken water skiing. —*Sports Illustrated.*

The science of medicine has advanced to the point where an ounce of prevention is worth about $18.50.—*News and Views,* General Motors Acceptance Corp.

Mothers are required to be convincing actresses. They must produce little cries of pleasure while sampling mud pies. They love tea parties with imaginary tea. . . .

Mothers love the clang of cymbals made from pot lids. They are sent by kazoos, toy xylophones, drums and the lectures of disk jockeys with wind-up record players. . . .

Mothers climb trees to look for pirates and rescue kites. They can outdraw Wild Bill and make noises like machine guns and rockets blasting off.

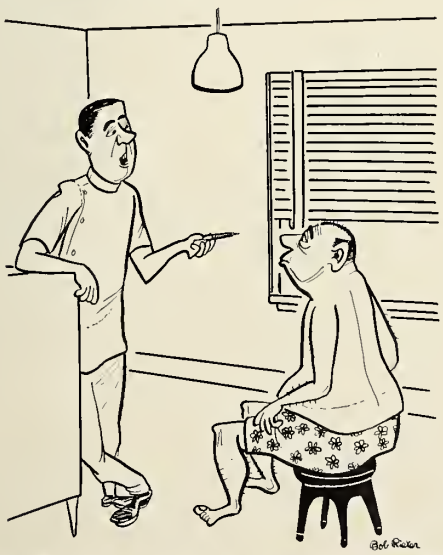
Mother can often cook, make beds, press shirts and arrange budgets. But her other skills are more important.—Louis Cook, *Detroit Frce Press.*

If things ever get back to normal we'll probably wonder what's wrong.—*Try Square,* Vonnegut Hardware Co.

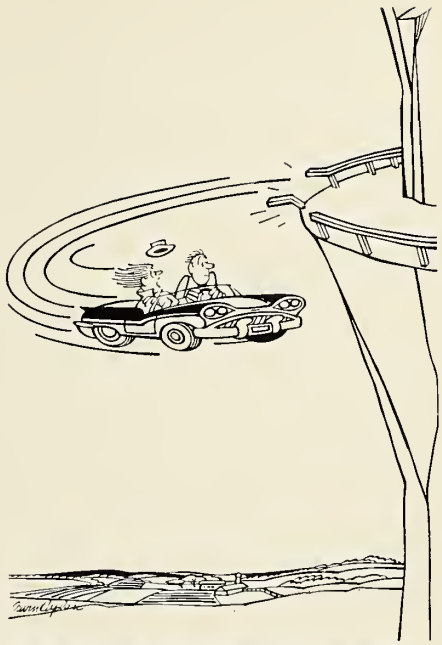
It's funny how the people who like to live dangerously always seem to do it behind the wheel of a car. —Dan Bennett, *Quote.*

A sin used to be called a sin; now it's called a complex.—Eva Bartok, *Weltbild,* Munich (*Quote* translation).

A good speech, like a woman's dress, should be long enough to cover the subject and short enough to create interest.—*Automotive Dealer News.*



"If you were a TV set, sir, I could say your picture tube had burned out."



"THE ONLY THING THAT WILL SAVE US NOW IS IF YOU WERE GOING FAST ENOUGH TO PUT US IN ORBIT."

Then there was the luncheon orator who stood before his audience and said, "Before I start my speech, I would like to say something."—*Advertising Age.*

Golf, some 70 years old in the U.S., has been sedate and fairly safe. Now that golfmobiles have added new hazards, insurance is paying more claims for accidents on fairway, tee and green.—*Jnl. of American Insurance.*

The picture of humanity all of the same type, all under the same institutions, all possibly wearing blue Chinese dungarees, is a nightmare of which you can get a faint foretaste from modern air travel. You can go from airport to airport all around the world and wonder where you are. They all look exactly alike. This standardizing tendency in our modern industrial system makes one all the more eager to cling to any sense of separate personality, culture or tradition. — Barbara Ward, *Five Ideas That Change the World* (Norton).

Perhaps we would be more patient about our hopes for achieving world understanding if we fully grasped the great distances between the ways people of different cultures think—and the symbols thru which they organize their thoughts.

For instance, in India it is a great compliment to tell a woman that she is "graceful as an elephant." And in Iran a common expression of disdain reads: "stupid as an owl."—*Property,* Merchants Nat'l Bank, Topeka.

Parents of teen-agers rightfully wonder if puppy love isn't one of the most widespread children's diseases for which there is as yet no innoculation.—*Schweizer Illustrierte,* Zofingen (*Quote* translation).

Association Reports

The Executive Committee

April 4, 1959

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Kenneth L. Olson, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; O. W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of *The Journal;* Robert Hollowell, attorney.

Guests: LeRoy Staunton, Wolf Management Engineering Company; P. T. Lamey, M.D., secretary, State Board of Medical Registration and Examination; G. O. Larson, M.D., councilor, Thirteenth District.

Membership Report

Number of members as of March 31, 1958		3,945
1959 members as of April 3, 1959:		
Full dues paying	3,469	
Residents and interns	188	
Council remitted	335	
Senior	385	
Military	43	
Honorary	1	
Total members as of April 3, 1959		4,121
Gain over last year		176
Number of members December 31, 1958		4,201
Delinquent members as of April 3, 1959		80
Number of AMA members as of April 30, 1958		3,894
1959 AMA members:		
Dues-paying	3,303	
Exempt, but active	698	
Total 1959 AMA members as of April 3, 1959		4,001
Gain over last year		107
Number of AMA members as of December 31, 1958		4,052
Delinquent AMA members as of April 4, 1959		188*

The membership report is to be called to the attention of the Council at its meeting on April 5, 1959, with the suggestion that the Council discuss the advisability of making AMA membership mandatory for members of the component county medical societies and the Indiana State Medical Association.

Headquarters Office

Mr. Staunton of the Wolf Management Engineering Company reviewed the report of his organization on the study made of the Indiana State Medical Association, and upon motion of Drs. Owsley and Mericle, it was voted that the first portion of the report be accepted and referred to the Council with the recommendation that the Association offices in the Hume Mansur Building be remodeled.

Upon motion of Drs. Owsley and Covalt it was moved that the second portion of the report be adopted and that it be referred to the Council with the recommendation that the provisions of this portion of the report be implemented by the executive secretary.

The third portion of the report was accepted on motion of Drs. Owsley and Covalt and ordered referred to the Council with no recommendation.

The secretary reported on the estimated expense of remodeling but stated the building management was not ready at this time to make a definite estimate on this cost. A report was made as to the availability of the suite currently occupied by Dr. Alan Sparks and upon motion of Drs. Mericle and Olson the secretary was instructed to continue negotiations for this space, to get costs of remodeling and moving Dr. Sparks to a new space, and to report back to the committee.

The secretary reported on the number of cases processed by Medicare during the past month.

Treasurer's Office

The treasurer's report on the financial condition of the Association was accepted on motion of Drs. Mericle and Covalt.

Upon motion of Drs. Olson and Mericle the treasurer is to investigate the bonding of employees and discuss with the attorney as to what employees should be bonded and for what amounts under the reorganization plan.

Discussion was had regarding the recommendation of the Wolf Management Engineering Company that an investment counselor be obtained for the Association. The chairman reported that he and the executive secretary had talked to J. E. Vollertsen, president of Scudder, Stevens & Clark, Inc., of Chicago. Following discussion it was moved by Dr. Mericle and accepted by consent that the chairman of the committee and the executive secretary invite representatives of the various organizations in this field to meet with the committee at a future date so that these organizations might be interviewed and their proposals heard by the committee as a whole.

Statements of Receipts and Expenditures for March, 1959, for the Association and *The Journal* were approved on motion of Drs. Owsley and Covalt.

Legislative Matters

Upon motion of Drs. Owsley and Mericle it was moved that the treasurer make the trip to Washington, D. C., to meet with the Indiana delegation in Congress.

The chairman of the Commission on Legislation

* 125 of these have paid state dues but have not paid AMA dues.

reported on the results of the state legislature and important legislation pending before Congress.

The president stated there was some difficulty in the interpretation of the new law covering TB testing of school teachers, janitors, bus drivers, etc. Following discussion it was advised that this matter should be referred to the Commission on Voluntary Health Agencies for further study.

Organization Matters

The chairman reported that he and the executive secretary had done some preliminary work in investigating the establishment of a provision for the Association to implement the Keogh Bill, if and when the bill becomes a law.

Dr. P. T. Lamey, secretary of the State Board of Medical Registration and Examination, appeared before the committee and discussed the provisions of the new law concerning citizenship requirement for licensure for Indiana physicians and the provisions of the new law concerning temporary permits for graduates of foreign medical schools. Dr. Lamey also discussed the attorney general's ruling with respect to the opinion concerning the interpretation of the 1955 law governing the licensure of chiropractors in the State of Indiana.

Dr. G. O. Larson, councilor of the Thirteenth District, discussed the osteopathic question and read a resolution which he was considering for submission to the Council and the House of Delegates of the Indiana State Medical Association. He made it clear that this resolution was merely a suggestion and no action was required at this time, but he did think that the committee should be giving thought to a resolution similar to the one he read.

A letter from Mr. K. L. Kaufman, general chairman of the 1960 Science Fair, which is to be held in Indianapolis, was read, in which he asked the Association to be a financial contributor to the expense of this program. Dr. Mericle will talk to Mr. Kaufman regarding what he has in mind as far as the Association is concerned and report back to the next meeting of the committee.

Letter from E. H. Lamkin, Jr., vice-president of Region IV, Student American Medical Association, was read in which he expressed the appreciation of his organization for the financial assistance given toward the recent regional meeting in Indianapolis.

A statement in the amount of $44.66 as the Association's pro rated cost for publication of a booklet on "Nursing Facts for Indiana Citizens" was approved for payment by consent.

A request from the St. Joseph County Medical Society for the refund of dues of Dr. James A. Duggan, South Bend, who passed away in February, was ordered referred to the Council by consent.

The secretary suggested the committee might adopt a policy concerning the refund of dues so that the headquarters office might administer this properly. On motion of Drs. Mericle and Owsley this question was to be referred to the Council on April 5 with the recommendation that refunds be made on a pro-rata basis in case of death.

The Journal

Report of the State Journal Advertising Bureau was read to the committee for their information.

The request of Dr. James H. Hutton of Chicago for the insertion of a professional card in the Indiana *Journal* was referred to the committee, and upon motion of Drs. Owsley and Sicks it was voted that the professional card section of the Indiana *Journal* was reserved for the use of physicians practicing in the State of Indiana and therefore this ad would not qualify.

The editor of *The Journal* discussed the policy of inviting the Indiana Association of Pathologists to contribute articles for *The Journal* and this was approved on motion of Drs. Owsley and Mericle.

Future Meetings

Notice of a meeting of the Joint Council to Improve Health Care of the Aged at Washington, D. C., on Friday, Saturday and Sunday, June 12-14, 1959, was read and by consent the executive secretary was authorized to represent the Association at this meeting, and the chairman of the Commission on Public Health is to be requested to attend, or to select someone to represent him.

Arrangements for the Indiana hospitality room at the AMA meeting in Atlantic City, June 7 through June 12, 1959, was reviewed for the information of the committee.

A letter from the State Journal Advertising Bureau calling attention to the annual State Medical Journal Conference, to be held in Chicago October 26 and 27, was read and by consent it was agreed that the editor, assistant to the editor, and the business manager and editorial board members be invited to attend this meeting.

There being no further business, on motion of Drs. Olson and Covalt, the committee adjourned to meet again at 3:00 p.m. on May 27, at the I.U. Student Union Building, Indianapolis.

EXECUTIVE COMMITTEE

April 22, 1959

Present: Don E. Woods, M.D., chairman; Kenneth L. Olson, M.D.; O. W. Sicks, M.D., and Wendell E. Covalt, M.D. Dr. Guy A. Owsley joined the meeting by long distance telephone.

The secretary presented a five-year lease from the Hume Mansur Company for the headquarters office space, with an annual rent of $9,756.00, including the additional space to be rented (room No. 1023). The lease contained a clause which would permit cancellation at the end of three years with the payment of liquidating damages in the amount of $1,000.00, or cancellation at the end of four years with a liquidating damage of $500.00. In either case six months' advance notice would be required.

The estimated cost of remodeling the entire area, exclusive of wood paneling, acoustical ceilings and special lighting, is not to exceed $3,799.00. It was the consensus that the remodeling cost would total between $7,000.00 and $10,000.00. Rent for the five-year period would amount to $48,780.00.

In view of the foregoing figures, on motion of Drs. Olson and Covalt, the Committee voted that

the plans for remodeling and the renting of more space be held in abeyance until the membership has been informed and the Executive Committee receives some direction as to what action should be taken.

There being no further business the meeting adjourned.

INDIANA STATE MEDICAL ASSOCIATION
THE COUNCIL

April 5, 1959

The Council of the Indiana State Medical Association convened for its spring meeting at 10:00 a.m., Sunday, April 5, 1959, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Guy A. Owsley, chairman, presiding.

Roll call showed the following present:

COUNCILORS

First District—William B. Challman, Mount Vernon
Second District—Sam I. Rotman, Jasonville, alternate
Third District—John M. Paris, New Albany
Fourth District—J. E. Dudding, Hope
Fifth District—Robert K. Webster, Brazil; V. Earle Wiseman, Greencastle, alternate
Sixth District—Harry P. Ross, Richmond
Seventh District—Not represented
Eighth District—Guy A. Owsley, Hartford City
Ninth District—Kenneth O. Neumann, Lafayette
Tenth District—Ralph C. Eades, Valparaiso, alternate
Eleventh District—Max R. Adams, Flora
Twelfth District—Maurice E. Glock, Fort Wayne
Thirteenth District—G. O. Larson, LaPorte

OFFICERS

Kenneth L. Olson, South Bend, president
Earl W. Mericle, Indianapolis, president-elect
Okla W. Sicks, Indianapolis, treasurer

JOURNAL

Frank B. Ramsey, Indianapolis, editor
A. W. Cavins, Terre Haute, associate editor

EXECUTIVE COMMITTEE

Don E. Wood, Indianapolis, chairman
Wendell E. Covalt, Muncie, member

GUESTS

Wendell C. Stover, Boonville, AMA delegate
Harold C. Ochsner, Indianapolis, AMA delegate
E. S. Jones, Hammond, AMA delegate
James H. Gosman, Indianapolis, AMA alternate delegate
Edward B. Smith, Indianapolis, chairman, Commission on Convention Arrangements
Edward T. Edwards, Vincennes, chairman, Commission on Medical Economics and Insurance
Philip B. Reed, chairman, Grievance Committee
Burton E. Kintner, chairman, Building Committee
Mr. LeRoy Staunton, Wolf Management Company

STAFF

Robert Hollowell, Indianapolis, attorney
Robert J. Amick, field secretary
Howard Grindstaff, field secretary
J. A. Waggener, executive secretary

By consent the minutes of the January 18, 1959, Council meeting were approved as printed in the March 1959 issue of THE JOURNAL.

REPORTS OF COUNCILORS

The councilors announced dates, time and places of their spring district meetings. Discussion was had concerning the many conflicts on dates, following which Dr. Larson, at the request of the Commission on Constitution and Bylaws, offered the motion "that each district society before finally setting a date for its annual meeting clear the date with the executive secretary of the State Medical Association." Motion seconded by Dr. Paris, and carried.

Dr. Larson stated that the Commission on Constitution and Bylaws, at the next annual convention, will present definite recommendations for changes in the Constitution and Bylaws concerning setting dates for annual district meetings, and proposals for better cooperation and more help for the district medical societies in their relationship with the State Medical Association, also their component county medical societies.

Dr. Larson read two communications from the Elkhart County Medical Association for the information of the Council and for inclusion in the records:

(1) "At the last meeting of the Elkhart County Medical Association there was a discussion relative to the unit-fee schedule system. A vote of the members was taken, and they were in favor of this type of program." Signed by Page E. Spray, M.D., secretary-treasurer.

(2) "The Elkhart County Medical Association recently conducted a survey regarding whether each member was or was not in favor of social security for the medical profession. The results of this survey were as follows:

"Letters were sent to 91 active, practicing members. Seventy-two cards were returned. Forty-three were in favor of joining social security, 27 were opposed to joining social security. One reply is worth quoting, 'I am too proud to like to join it, but too helpless to be against it.'" Signed, Page E. Spray, M.D., secretary-treasurer.

Osteopathic Problem. Dr. Larson presented a resolution on osteopathy, suggesting the Council might give some thought to the subject discussed therein.

The Council took no action on the resolution at this time, as it was for their consideration.

REPORTS OF OFFICERS

DR. KENNETH L. OLSON, president: I've made a few trips around the state. I was in Evansville last month to attend a civic dinner in which the county medical society entertained civic leaders in the community and had a speaker there for the evening. I think it was a good public relations gesture and am reporting it as this is a public relations angle which some of you might want to consider and work on.

I would like to report on some of the activities of the Commissions. You will hear from one later today, namely, the Medical Insurance Commission. Dr. Edwards has been working very diligently on the whole program and will give that report.

The main report that I am speaking of here is in regard to the vaccination program that I am endeavoring to put on. I had an article in the President's page, and asked the Commission to study this and come up with some sort of a program. I am going to issue a news release in regard to vaccinations, particularly for polio, and will send a copy of that along with some information to

the county secretaries throughout the state. (Here Dr. Olson read the proposed news release and asked the Council for criticism of it.) . . . I just don't know whether I've gone too far in putting this kind of publicity out to the public, but we are really not getting all the people immunized that should be immunized. We feel that some program should be instituted by the Association. Does anyone have any particular objection to what has been said in this release?

(Dr. Paris expressed the belief that the medical profession would be accused of soliciting business if this type of publicity were released to the press. Dr. Webster stated that the Sub-committee of the Commission on Public Health, of which he is chairman, had expressed the same feeling. "We don't feel that polio is any more important than diphtheria and tetanus or smallpox.")

Dr. Olson continued: Along with the proposed program, the idea would be to send along some of these medical records. This one has the family health records in which they would be sent to each doctor's office so that they could be distributed to the patients, as well as personal health information cards on which to record all immunizations.

I don't want to get into a mess and that's why I'm bringing this matter to your attention. I feel that even though we're being aggressive in promoting, soliciting business, that that is the only way we can get people immunized. We will be doing the patient a good turn if we do solicit that type of business especially when we have a large number of people not immunized. I only quoted polio, but we plan to include all immunizations of people. I believe that it is our duty to do something about encouraging people and encouraging doctors to sell immunization. It's such a simple thing, it's hard to believe anybody could be against immunization. I don't see how a doctor could be criticized for promoting immunization.

(Dr. Larson said that he thought that "the only way we are going to get anywhere in this is by constant advertising, and I think this is good advertising, and I am in favor of it." A poll of the councilors revealed that $3.00 and $4.00 constitute the average charge over the state for polio shots.)

Dr. Olson: We do intend to work through the Public Health Service, as well as anybody else who will help us get people immunized as far as that's concerned. But it's my feeling that we, as a state medical organization, should be the leaders in this problem of public health instead of somebody else.

Now in regard to another problem, and that is a similar sort of thing, is the rehabilitation program. Several organizations now are trying to promote rehabilitation centers and are getting in a complicated situation, in duplication, and I've asked the Commission to study that problem and see if we can't be the leaders in helping to organize rehabilitation activity in local communities. We intend to do something about the rehabilitation program.

Another thing that's going on is an Internship Program Study. I don't know whether you are aware of it or not, but Indiana has the lowest number of internships filled that are available of any state in the Union. I don't know why, but we are hoping that the Commission will try to find out what we are doing different in Indiana that we are not getting the interns to accept our internship program.

You have heard that the tuberculin tests, Mantoux tests, have been passed by the legislature as a means of testing for tuberculosis of teachers and food handlers in schools. It seems at the present time the Tuberculosis Leagues in some areas are starting to get active and want to get into that program. I believe that this program belongs to the doctor and I have instructed our Commission to get active in studying how this should be handled and make a recommendation by the time of our House of Delegates meeting, so that we will be set for next fall. It will have to come up even before the House of Delegates meeting because that will meet after school starts. At least we want to have some concrete proposal come from the state medical organization, so that this is handled by doctors and not done by lay people.

I have nothing more special except that I have been working with the Building Committee and with the management consultant several times during the interval since the last meeting. Everything, as far as I can see, seems to be going very satisfactorily. I want to commend personally the Legislative Commission, especially Dr. Wood and Mr. Waggener, for the fine job that was done with the State Legislature.

DR. EARL W. MERICLE, president-elect, reported that he had attended the medic-civic dinner at Evansville. "It was a most enjoyable occasion, and certainly points up what this Medical Society can do in a community toward providing a good public relationship."

DR. OLKA W. SICKS, treasurer, reported total investments in United States Treasury bonds, bills and certificates of indebtedness of $301,000.00, and a cash balance of $22,900.00 in the General Fund as of April 5, 1959, and investments totaling $28,000.00, plus a cash balance of $1,459.00, in the Medical Defense Fund. THE JOURNAL fund has $26,538.00 in cash in the bank.

Investment, all funds, amounted to $329,000.00, and cash, all funds, including the General Fund, Medical Defense, Student Loan, JOURNAL, and petty cash, totals $53,250. The return from investments runs from 2.5 to 4 per cent.

"If you want to figure on a building program, there is somewhere between $275,000.00 and $290,-000.00 that would be available for this purpose."

DR. FRANK B. RAMSEY, editor of THE JOURNAL: I don't have anything special to report on except the fact we would like to mention again that we do need some outdoor photographs. They can be black and white. This last picture on the cover was reproduced from a straight black and white photograph, so that if any of you have any yourself or know doctors who are skilled at

photography, we would be very glad to have some good outdoor pictures.

Asked to comment on the recommendations regarding THE JOURNAL which were made by the Wolf Management Company, Dr. Ramsey said:

In general, I agree with all the recommendations. There's one that I thought was probably an impractical thing for us to attempt, and that was to publish more on the socio-economic side of medicine. The basis of the popularity of all these things depends not only upon the fact that that type of a subject is good for doctors to read, but also in Medical Economics, it's the backbone of the entire magazine and is responsible for the fact that it's one of the most successful advertising medical journals.

I once heard Richardson, who is the Managing Editor of Medical Economics, describe how they wrote those articles which they have in there. It's an expensive and time-consuming process. They have a staff about the size an ordinary newspaper has, and any article that you see in Medical Economics hasn't just been written, it's been worked on for several months. It's been researched from end to end; it's been sent to consultants and reread and revamped. They have about five or six editorial conferences on each one of those articles. To that extent, I don't believe it's practical for us to do it. I don't believe we have the money to do it or the staff, either. But in general, I think that the recommendations for THE JOURNAL are very good.

UNFINISHED BUSINESS

(1) **Grievance Committee.** Dr. Philip B. Reed, chairman of the Grievance Committee, read the form letter which is sent to physicians on whom complaints are received by the committee and asked the councilors to write him their reactions and suggestions to the letter. "This really seems to be doing the job, and it has cut down the time lag, and, therefore, it has cut down the number of cases coming up at an average meeting from some 16 or 20, counting both carry-over cases and new cases, to something like 12 cases. . . . I do want to say that since this letter has been used, we have received prompt, courteous, full reports from all of the doctors who have received it. We appreciate it very much."

(2) **Building Committee.** Dr. Burton E. Kintner, chairman, reported that his committee had held two meetings. "At the conclusion of the first meeting we were of the opinion that we should do the foot work of finding out the facts and then presenting them to the membership, and that this should be done with an explanatory questionnaire.

"We reached the conclusion as a committee that the present headquarters office space is inadequate, and we felt that either additional space should be rented in the Hume Mansur Building or that space outside of the Hume Mansur Building should be rented, or that some place should be purchased which is already constructed, or there should be new construction. This new construction might be grouped into two categories: either on the campus of the Medical Center, or at some other place. Other places were considered.

"Now, at the present time, it is felt that the method of informing the membership of the Indiana State Medical Association should probably be through a series of letters showing the progress of the committee. The reason for this is that some form of information sheet should be in the hands of the membership so that they know what is going on, so that they can turn the information over in their minds, and so that they will not be taken unawares. It was felt that a direct letter to the membership would probably be the most satisfactory, since, although it would be ideal to perhaps have it published in THE JOURNAL and everybody read it there, many of them might not read it. We felt that it would be better to send a letter directly than to send the information to the delegate and depend on the delegate getting the information as it was given to him to the county society members. So at the present time that's what we plan to do.

"I think we have an unusually good committee. . . . We have done a great deal in threshing out a lot of the questions. One question which has been presented as early as the first Building Committee's proposals was whether or not it would be advisable to have the building built on the Indiana University campus. There is, as a matter of record, opposition to this idea, very strong in some quarters and not so strong in others. We do not, as a committee, know what the desires and wishes of the membership at large are on this particular point. We aren't in a position to state. We did talk over a number of implications that might result from building on the campus that would not need to be dealt with if we did not build on the campus. We felt that we should have some help perhaps from the Council on this particular point.

"There may be other ways of accomplishing what we feel is the problem, that is, providing the state headquarters with adequate space which they do not now have. Are there any questions from the members of the Council that either I or the members of the committee who are here might answer?"

DR. OLSON: Is it your plan to send out this letter, or letters, of information and then subsequently follow with a questionnaire as to what the members' desires are as to having a building, or not?

DR. KINTNER: We felt that we would send out the information stating what the progress of the Building Committee was, and, after studying the facts, make certain decisions and present the decisions to the delegates assembled at the next meeting, and to the Council.

CHAIRMAN OWSLEY: Dr. Kintner, today we have been listening to the results of the professional survey that was bought by the State Association and this morning all portions of that survey were approved with the exception of that part which

had to do with the recommendations of the management firm as regards building. Mr. Staunton is in the process of preparing that supplemental report now, along with two or three other things that are closely related. Would the members of your committee be interested in hearing the recommendations in this supplemental report?

DR. KINTNER: Mr. Staunton met with us after leaving the Council and presented us with these four questions which would have to be answered: Does the membership want it? Can they afford it? Do they need it? And where should it be put?

DR. OLSON: I believe that one of the specific things that the House of Delegates wanted answered was that the membership should be polled as to whether or not they believed the building should be built.

CHAIRMAN OWSLEY: Dr. Rusche ought to be able to answer that. He was chairman of that committee.

DR. RUSCHE: The idea, whether or not they expressed it properly, was that this committee should obtain the pro and con information, and every member of the State Society should be informed by letter as well as publication in THE JOURNAL of its report. This should probably be done no later than August. The members are to have the information at hand so that they can discuss it on their local level and instruct their delegates to act accordingly. In other words, it seems to me that it is the obligation of this committee to get all the facts and reach its conclusions in time to have them distributed through THE JOURNAL and in the mail by August.

CHAIRMAN OWSLEY: Are there any other comments from the Council which Dr. Kintner or other members of the Committee might answer? If not, we certainly want to thank you for your presentation and wish you well.

SUPPLEMENTAL REPORT OF WOLF MANAGEMENT COMPANY ON HEADQUARTERS BUILDING

MR. STAUNTON:

The Executive Committee has asked for specific recommendations from Wolf Management Engineering Company regarding the building of a permanent Association-owned Home for the Indiana State Medical Association.

The four major questions to be answered are:—

(1). Do the majority of the Association members want a headquarters building?

(2). Can the Association afford to build a headquarters?

(3). Does the Association need a headquarters building of its own?

(4). Where should the building be located?

To determine a realistic answer to question #1, "Do the majority of the Association members want a headquarters building?", we suggested and submitted to the Building Committee a questionnaire and letter to be sent by Wolf Management Engineering Company, on its stationery, to all members. Replies were to come to our Chicago office for analyses. A consolidated report, showing no individual or society names, was to be prepared and sent to Mr. Waggener, the Executive Secretary. This plan was turned down by the Building Committee as being presented too early to get a true picture. The Committee wished to better inform members regarding an Association-owned building before sending a questionnaire. This leaves the answer to question #1 in the hands of the Building Committee, or a higher committee.

Our opinion is that the membership is not sufficiently informed to express an opinion. We then recommended to the Building Committee that they send a series of six or eight letters direct to the membership, presenting the advantages of owning a headquarters building. This plan is now under consideration.

The answer to question #2, "Can the Association afford to build a headquarters?" is inferred, we think, in Section 1.4 of our report of March 20, 1959, although it is not specifically stated. The following will clarify the situation.

The Association now has invested in securities about three hundred and twenty-nine thousand dollars, as of April 4, 1959. In our report, Section 1.4, Paragraph G, we established building costs at fifteen to twenty dollars per square foot, not including land. Eight thousand square feet, which is an agreed requirement, will, therefore, cost one hundred and twenty thousand to one hundred and sixty thousand dollars, plus land. Land can apparently be purchased for eighty to one hundred thousand dollars. Approaches, parking facilities, landscaping, etc., might cost thirty thousand dollars. This presents a total of two hundred and thirty thousand to two hundred and ninety thousand dollars. Thus, it is evident that there is more than enough Association money currently invested in low interest bonds to buy the property, build and landscape, without borrowing, if it is so desired. In our opinion, the Association can afford to build a headquarters building.

Question #3, "Does the Association need a headquarters building of its own?", is much more difficult to answer in positive terms. One man's need is another man's luxury.

You have established yourselves as professional men of dignity. Learning and skill are your principal assets. Association with others in the same profession is a part of keeping up to date on the forward steps of the profession.

Specialists in some areas of the profession are often required on very short notice. More person to person association gives the members more intimate knowledge upon which to base recommendations. A conveniently located, well arranged headquarters will encourage such interchange of ideas and knowledge. The profession is constantly forced to defend itself from other less educated and less dedicated people and groups. Prestige in general business and governmental circles is required today. An adequate headquarters building, dedicated to this profession in the State of Indiana, will lend

prestige to your business activities and increased strength to your legislative activities through better recognition of the united front that the organization presents. The word "need" is a word of degrees. The Wolf Management Engineering Company thinks the Association has grown to a point of importance within the State where your need exists. This is why we expressed the kind of building you "need" in terms of fifteen to twenty dollars per square foot building cost only. We recommend nothing less than this.

Much has been said in answer to question #4, "Where should the building be located?". It is our considered opinion, after examining many pieces of available property and their surroundings, that the headquarters building should be located immediately adjacent to the Indiana State University Medical Center, either on the school property or adjacent to it. In making this recommendation, we are aware of the dissenting vote of some groups, and ask—"what is to be lost by locating as above recommended vs. locating somewhere else?"

We admit the validity of the opposing groups' complaint, and then ask—"Can the situation be healed by refusing to locate on the University grounds?" It seems to us that refusing to locate on the University grounds, under the circumstances, might aggravate the situation and cause more undesirable, aggressive action.

From what we can learn and observe, your Association must learn to live with the problem which you see as existing. Possibly, it can be cured at some future time. We doubt it. We find most people agreeing with us. Therefore, it is best that you rise above it and use every means at your disposal, including all the human conveniences of the Medical Center (we list below) to increase the usefulness of a new Association-owned headquarters at the Medical Center.

The actual step of buying the property, completing the building, etc., should not be taken until the majority of the members are ready to accept the idea as a sound, forward step in Association progress.

CHAIRMAN OWSLEY: May I ask, Mr. Staunton, whether this was read to the Building Committee?

MR. STAUNTON: No, only in part. It was about half through when I was in there and they asked me what questions had been raised and I told them that but I didn't have the last sentiment.

CHAIRMAN OWSLEY: I'll ask for approval or disapproval of this portion of the report, the supplemental report of the Wolf Management Company, at this time. Do I hear a motion?

(Dr. Glock moved that the supplemental report of the Wolf Management Company be approved. Motion seconded by Dr. Eades. Following discussion, Dr. Glock withdrew his motion and Dr. Larson offered the substitute motion "that the report be accepted but be neither approved or disapproved at this time," which was seconded by Dr. Neumann, and carried.)

(On motion of Drs. Neumann and Glock, the Council voted that the report, when implemented, shall be referred to the Building Committee and the Council, and the Building Committee shall present it to the membership at large.)

CHAIRMAN OWSLEY: Mr. Staunton.

MR. STAUNTON: I just want to comment that I think that sometimes an outsider's viewpoint is of value to people who are closely associated to a problem and the things they want to do. That's why I'm giving it to you for whatever it's worth.

I have looked over all the literature and everything that I can find anywhere about the establishment of a new building. I think that your problem centers in two positions. 1) There is a group who are opposed to building on the Medical Center. 2) The Association at large knows, apparently, very little about the building and what they are supposed to buy. The move was made very fast, and they just refused to swallow it. I think you've got a very big job of education to do, and I think when you do that job of education you'll get whatever results you decide are best.

Now, I do think this, that to send to the membership a large report will get the same treatment of, I don't know who it was, I'm not accusing anybody but somebody said this morning, "Well, I haven't had time to read the Wolf Report." My biggest problem is I don't have time to read things when they come in in big chunks, but I will read individual letters. That's why I'm recommending to the Building Committee that they send a series of individual letters, each one dealing with some specific phase of this problem, so as to educate them in whatever program you decide before you ask for a vote. Because, remember, they are located out there and they haven't got the benefit of all the information that you have. Thank you.

CHAIRMAN OWSLEY: Thank you, Mr. Staunton.

(3) **Student Loan Fund.** Dr. Ross, chairman, reported that six applications for a total of $2,950.00 are pending. The balance in the fund is $1,118.29. The Committee on Student Loan will meet within the next two weeks to interview applicants.

(4) **Medical Care for Military Dependents.** Mr. Waggener reported payments to physicians by Medicare, as follows:

January, 1959	$ 59,040.57
February, 1959	24,262.15
March, 1959	47,134.75
Total	$130,437.47

(5) **Liaison Committee between Council and Blue Shield.** The Council went into executive session to hear the report of Dr. Challman, chairman of the Liaison Committee between the Council and Blue Shield.

(6) **Commission on Medical Economics and Insurance.** Dr. Edward T. Edwards, chairman, pre-

sented the following recommendations from the Commission on Medical Economics and Insurance:

1. The Indiana Relative Value Study as prepared by the Commission be printed and circulated to Indiana physicians prior to the meeting of the House of Delegates in October '59. (It should be ready for printing by July of '59.) The Council is requested to furnish sufficient funds for this purpose. We felt that it should have a separate mailing.

2. The next recommendation was that the Indiana State Medical Association should not endorse or underwrite any individual or group plan of insurance for life, health and accident, or office expense insurance pending evidence of greater demand from the membership that such coverage was desired and needed.

The Commission has prepared the following answer regarding full choice of physician:

A. The definition: FREE CHOICE OF PHYSICIAN IS THE RIGHT OF THE RESPONSIBLE ADULT INDIVIDUAL TO SELECT WHOEVER HE CHOOSES, OF HIS OWN FREE WILL AND ACCORD, TO CONTRACT WITH TO PROVIDE HIM WITH MEDICAL CARE, TREATMENT OR RECOMMENDATIONS.

And under the remarks describing this, it was stated that no one questions this right when an individual is responsible directly for the payment of the services. It is equally true in those cases where, 1) through the selection of an insurer, he delegates the responsibility for such payment by furnishing cash premiums to the insurer or, 2) where the individual's employer agrees to receive contributions from the individual, in the form of withholdings from wages or as payment in lieu of wages; the employer thus acts as the insurer of the insurer's agent.

This is a difficult thing to define, so we thought that more remarks and explanations were necessary. The Commission has approved the following:

(1) Where the premiums are paid entirely by the individual, either directly to the insurer or indirectly in the form of withholdings from wages, there can be no question as to his freedom of choice of physician.

(2) Where the employer contributes a portion of the premium payment, in lieu of wages, there can be no question as to the individual's freedom of choice of physician.

(3) Certain categories of individuals are, by law, not expected to exercise free choice of physician. For these persons, someone else stands responsible. Examples are 1) Minors, 2) Members of the Armed Forces, 3) Persons to whom someone stands *in loco parentis*. These are persons serving prison terms, persons committed to mental institutions, or other persons whom the courts have designated incompetent. And 4) Persons, who by virtue of their employment, come under the Workmen's Compensation Laws, which laws make the employer assume responsibility for the occupational injury or disease, the costs of treatment, the loss of wages and any resultant permanent disability do not have free choice.

B. The second question was concerned with Closed Panel Systems. Following is the statement adopted by the Commission defining our attitude toward Closed Panels: "Closed Panel Systems within the practice of medicine have existed for many years in many hospital staffs (Community, private, and university) and in many clinics with out-patient departments. These systems do not restrict free choice of physician in our opinion. It is deemed proper that other legally constituted bodies may also organize closed panels on the basis of accepted professional medical standards, evaluation, and direction. Physicians so included are judged to be practicing fully within the principles and ethics of the medical profession. No panel which involves (a) incompetent medical care, (b) economic exploitation of the patient, or (c) a deficiency of professional direction of the panel's administrative operations is acceptable to the profession."

4. The next item which we desired the Council to take favorable action upon is the establishment of Liaison function with the Health Insurance Council, as stated in Dr. Scoin's letter to Dr. Olson on 30 December 1958. The Health Insurance Council of Indiana proposed instrumenting AMA-HIC intent of discussing mutual problems and disseminating information pertaining to those problems.

5. The next recommendation was that the Commission condemned the practice of private life insurance companies requesting information from physicians' records if the purpose is to avoid an insurance physical examination.

6. The Commission requests Council approval of two letters regarding the St. Paul Fire and Marine Insurance Company and St. Paul Mercury program for professional malpractice liability insurance. (Dr. Edwards read the letters.)

That is the bulk of the requests that the Commissiaon had of the Council. We thought that you might be interested in the future activities that we have planned and we'd like to describe them briefly.

We are conducting a questionnaire and analysis on in-hospital medical benefits, including "double medical-surgical coverage," either in existing Blue Shield or Commercial Policies or in experimental policies in the nation, as proposed by Dr. Olson's letter.

Second, in April, we intend to discuss the insurance problems involved in insuring persons over 65 with the Indiana Blue Shield.

In May, we plan to do the same thing with the Health Insurance Council Representatives for private companies offering such coverage.

As mentioned earlier, we are continuing to work

on the Relative Value Schedule. We're still paying attention to the Union Health Center Plans, and we're always willing to accept suggestions, recommendations, constructive or adverse criticism from the membership of the ISMA. Thank you.

Drs. Glock and Edwards discussed the proposed two letters to be sent to the membership concerning the St. Paul Mercury Indemnity Company malpractice insurance program, but the Council took no action.

Drs. Olson and Edwards discussed the closed panel system.

The chairman called attention to the fact that the A.M.A. House of Delegates had asked for approval or disapproval of closed panel systems by April 1 of this year, hence it would be necessary to take some action on this question.

Dr. Ross moved that the Council not approve the closed panel system. Motion seconded by Dr. Glock.

Dr. Challman offered the amendment "that we send in a report to the effect that we recognize that closed panels do exist. We do not approve them and we hope that no more will be created." Amendment accepted by Drs. Ross and Glock.

On voting the Council approved the amendment, and Dr. Ross's motion that the Council not approve closed panels was carried.

Medical care and insuring of the over 65 age group was discussed by Drs. Edwards, Glock, Jones, Stover and Neumann. The Council took no action on this matter, inasmuch as the Commission on Medical Economics and Insurance is to meet with the Blue and private carriers in April and May to try to determine what is a feasible program; and further, it was the consensus that this is a problem that should be presented to the House of Delegates for its consideration and decision.

1959 ANNUAL SESSION, INDIANAPOLIS, OCTOBER 6-9, 1959

Dr. Edward B. Smith, chairman, Commission on Convention Arrangements, outlined the program in brief, as follows:

TUESDAY, OCTOBER 6, 1959

9:00 a.m. First meeting of House of Delegates.
Noon and afternoon Reference Committee meetings.
Evening Stag party.

WEDNESDAY, OCTOBER 7, 1959

MORNING

8 to 9:30 a.m. Instructional courses.
9:30 to 10:30 a.m. General scientific program. (4 speakers)
10:30 to 11 a.m. Time allowed to view technical and scientific exhibits.
11:00 a.m. Panel discussion, led by speakers of the morning session.

AFTERNOON

2:00 to 3:00 p.m. General scientific program. (4 speakers)
3:00 to 3:30 p.m. Time allowed to view technical and scientific exhibits.
3:30 p.m. Panel discussion, led by speakers of the afternoon session.

EVENING

Annual banquet.
Speaker: Dr. Carl Winters, Public Relations Department of General Motors Corporation.

THURSDAY, OCTOBER 8, 1959

MORNING

8 to 9:30 p.m. Instructional courses.
9:30 to 10:30 a.m. General scientific program. (5 speakers)
10:30 to 11:00 a.m. Time allowed to view technical and scientific exhibits.
11:00 a.m. Panel discussion, led by speakers of the morning session.

AFTERNOON

2:00 to 3:00 p.m. General scientific program. (5 speakers)
3:00 to 3:30 p.m. Time allowed to view technical and scientific exhibits.
3:30 p.m. Panel discussion, led by speakers of the afternoon session.

EVENING

President's Night.
Indiana University Glee Club.

FRIDAY, OCTOBER 9, 1959

MORNING

9:00 a.m. Final meeting of House of Delegates.

AFTERNOON

Sports events.

Following discussion, it was taken by consent that the entertainment as listed above would be sufficient.

MEMBERSHIP MATTERS

1. Dr. Wood, chairman of the Executive Committee, read the following membership report and asked that the councilors note that 125 members of the Indiana State Medical Association have not yet paid 1959 A. M. A. dues. He asked that the councilors consider discussing this with the societies in their districts to the end that more counties might make A. M. A. membership mandatory, or do a better job in encouraging their membership to support the A. M. A.

Number of members as of March 31, 1958		3,945
1959 members as of April 3, 1959:		
Full dues paying	3,469	
Residents and interns	188	
Council remitted	35	
Senior	385	
Military	43	
Honorary	1	
Total 1959 members as of April 3, 1959		4,121
Gain over last year		176
Number of members December 31, 1958		4,201
Delinquent ISMA members as of April 3, 1959		80
Number of AMA members as of April 30, 1958		3,894
1959 AMA members:		
Dues paying	3,303	
Exempt, but active	698	
Total 1959 AMA members as of April 3, 1959		4,001
Gain over last year		107
Number of AMA members as of December 31, 1958		4,052
Delinquent AMA members as of April 3, 1959		188*

*125 of these have paid state dues but have not paid AMA dues.

2. **Refund of state dues.** By consent, the request received from a secretary of a county medical society for refund of dues of a member who paid 1959 state dues early in 1959 and who died in February was turned down.

The chairman appointed a committee, consisting of Dr. Glock, chairman, Dr. Neumann and Dr. Webster, to study the matter of refund of dues.

Following lunch, Dr. Glock reported that the above committee had met during the noon recess and the members were unanimous in their opinion that there should be no refunds made of dues in the event of either death or disability, and he so moved. Motion seconded by Dr. Neumann, and carried.

3. **Remission of state dues.** On motion of Dr. Challman, duly seconded, the Council voted remission of state dues of a member of the Vanderburgh County Medical Society who has been retired from practice for several years because of ill health.

On motion of Dr. Mericle, duly seconded, the Council voted remission of state dues of a physician who had applied for membership through the Marion County Medical Society, and who is leaving May 1 for British East Africa to become a medical missionary.

On motion of Drs. Neumann and Eades the request for remission of the state dues of a member of the Marion County Medical Society because of retirement and removal from Indiana was referred back to Dr. Everly for consideration and report to the Council at its next meeting.

On motion of Drs. Larson and Eades the Council voted to refer the question of remission of dues to the Commission on Constitution and Bylaws for further study and clarification, and recommendation back to the Council.

LEGISLATIVE MATTERS

Dr. Don E. Wood, co-chairman of the Commission on Legislation, reported in detail on legislation of interest to the medical profession which was either passed, amended, or failed to pass as recommended, during the 1959 General Assembly. (Full legislative report has been published in the News Flash).

Dr. Wood also discussed the status of national legislation, the Keogh Bill in particular.

"I want to take this opportunity on behalf of the co-chairman and myself to thank you, the members of the Council, and certainly all of your constituents in the various county societies, for their help in this last State Legislature. The entire commission worked hard, and we appreciate all of your efforts. I am sure that you all understand a little bit more about the problems, and I think that our future in legislative matters will be much better handled. I want to also thank Mr. Waggener, Mr. Amick, Mr. Grindstaff and the entire headquarters office for their untiring effort."

NEW BUSINESS

1. **Matters referred to Council by Executive Committee.**

a. **Investment of surplus funds.** Dr. Wood read Section 1 of Chapter XXIX of the Bylaws which states "The investment of all surplus funds of this Association shall be under the direct control and management of the Executive Committee subject to instructions in regard thereto which may be given by the Council at its option."

The request of the Executive Committee for authority to interview and select an investment counselor to advise the Committee on an investment program for the Association was granted by consent. Employment of anyone in this capacity is to be approved by the Council.

b. **Professional Insurance Administrators, Inc.** The request of this organization that the Association issue a letter making them an "agent of record" for the purpose of soliciting the insurance industry to submit proposals for insurance for the Indiana State Medical Association membership in the fields of health, accident and retirement benefits, etc., was presented by Dr. Wood and discussed by Dr. Edwards. (See report of Commission on Medical Economics and Insurance.) It was taken by consent that this matter should rest with the Commission on Medical Economics and Insurance until further study is made.

c. Dr. Wood reported that Remington Rand fireproof membership files had been ordered as recommended by the Wolf Management Company, and also that the membership records and minutes of the Council and House of Delegates meetings were being microfilmed.

(On motion of Drs. Paris and Ross the report of the chairman of the Executive Committee was accepted as a whole.)

2. **Management survey.** The Council went into executive session to discuss the report of the Wolf Management Engineering Company.

(On motion of Drs. Ross and Paris, the Council voted that Dr. Sicks shall prepare the minutes of the executive session, and the chairman of the Council shall use his discretion in distributing them.)

3. **Nominations for members on the Editorial Board** (to be voted on at the fall meeting of the Council) were deferred until the summer Council meeting.

4. **The 1959 Budget** for the Association and THE JOURNAL was accepted on motion of Drs. Eades and Webster.

5. **Summer meeting of the Council.** By consent, the next meeting of the Council will be held on Sunday, July 12, 1959, at the Indiana University Student Union Building, Indianapolis.

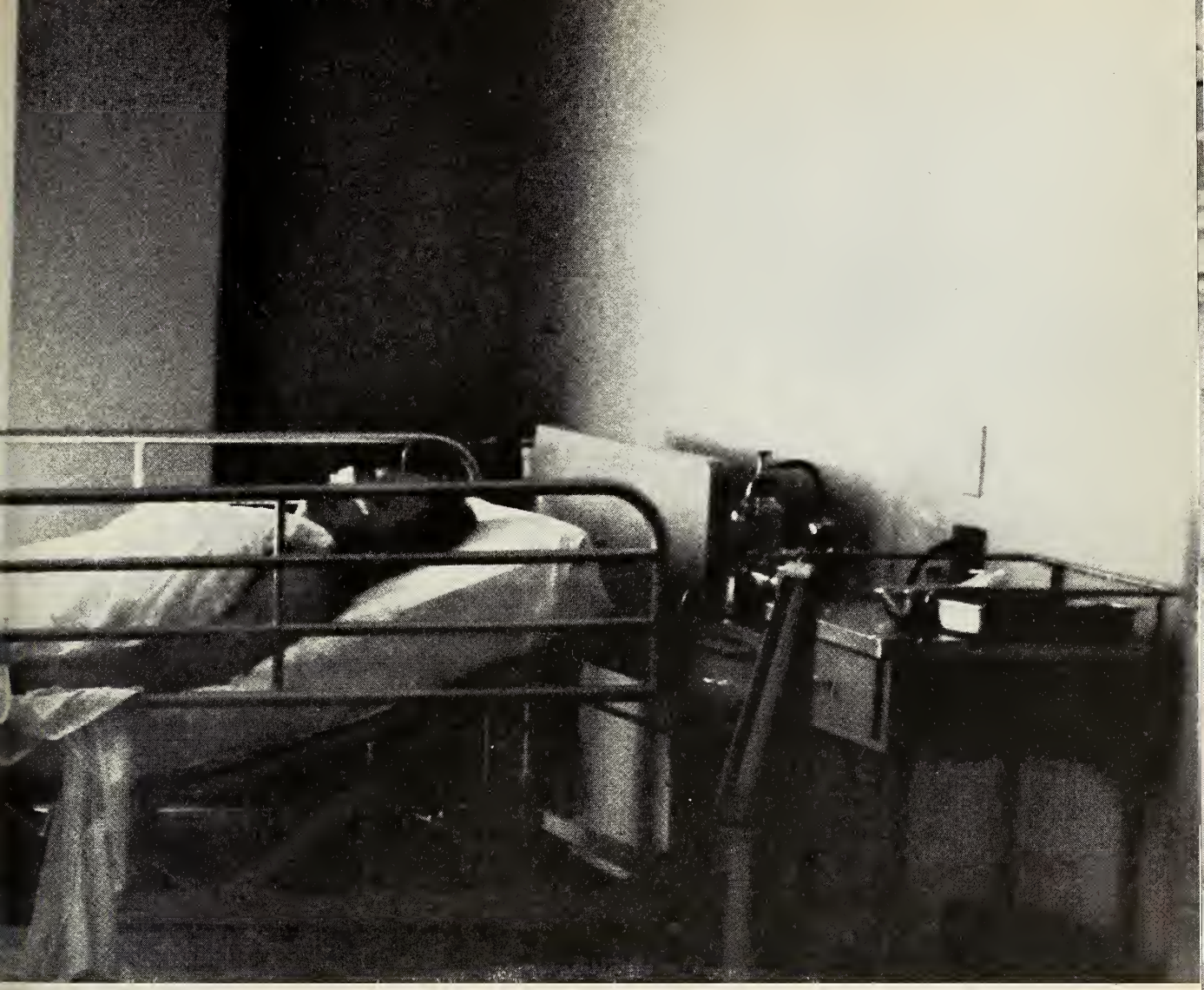
There being no further business, the meeting was adjourned.

MEMO TO: I.S.M.A. Members

The JOURNAL is interested in full-length scientific papers and case reports for early publication. This is an open invitation to you to submit such work. Each paper is given careful consideration.

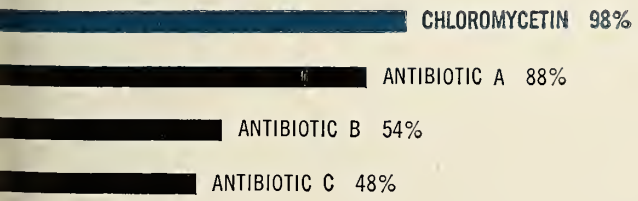
A few regulations regarding publication of papers are printed on the Contents page.

This announcement is made following a decision to increase the number of scientific papers published if sufficient material is available.

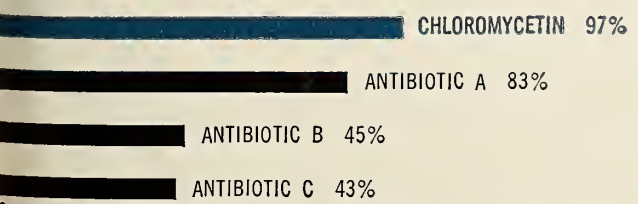


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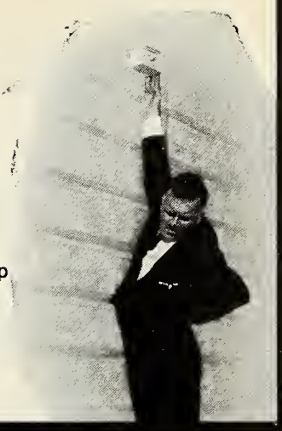
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3.	P. T. Hodgin, M.D., Orleans	(to be appointed)	Fench Lick, 1960
4.	Robert M. Reid, M.D., Columbus	David L. Adler, M.D., Columbus	French Lick, May 11, 1960
5.	Gilbert Rhea, M.D., Greencastle	James B. Johnson, M.D., Greencastle	Greencastle, 1960
6.	Kenneth G. Hill, M.D., Newcastle	John A. Davis, M.D., Flat Rock	Shelbyville, May 11, 1960
7.	Leon Gray, M.D., Martinsville	Herbert L. Egbert, M.D., Indianapolis	Fall, 1959
8.	Richard C. Swan, M.D., Anderson	M. P. Benoit, M.D., Anderson	Anderson, June 8, 1960
9.	Harry E. Klepinger, M.D., Lafayette	Forrest J. Babb, M.D., Stockwell	Lafayette, May 18, 1960
10.	Martin O'Neill, M.D., Valparaiso	John R. Frank, M.D., Valparaiso	1960
11.	Eugene Cook, M.D., North Manchester	C. L. Wise, M.D., Camden	Monticello, Sept. 16, 1959
12.	Harold F. Zwick, M.D., Decatur	Stephen C. Michaelis, M.D., Fort Wayne	1960
13.	Richard W. Holdeman, M.D., South Bend	James M. Wilson, M.D., South Bend	South Bend, Nov. 18, 1959

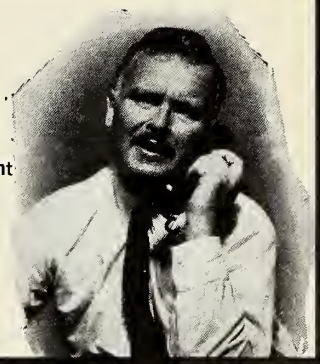
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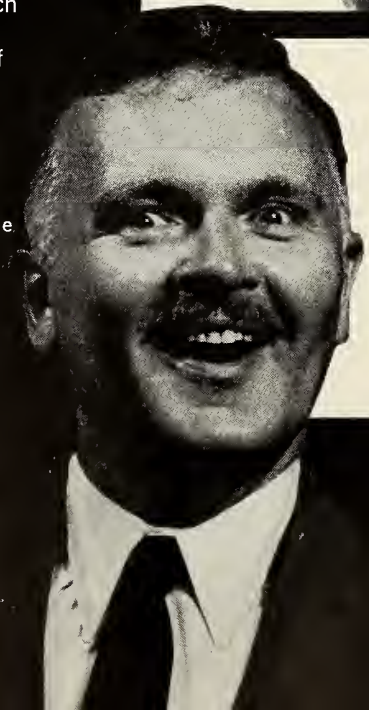
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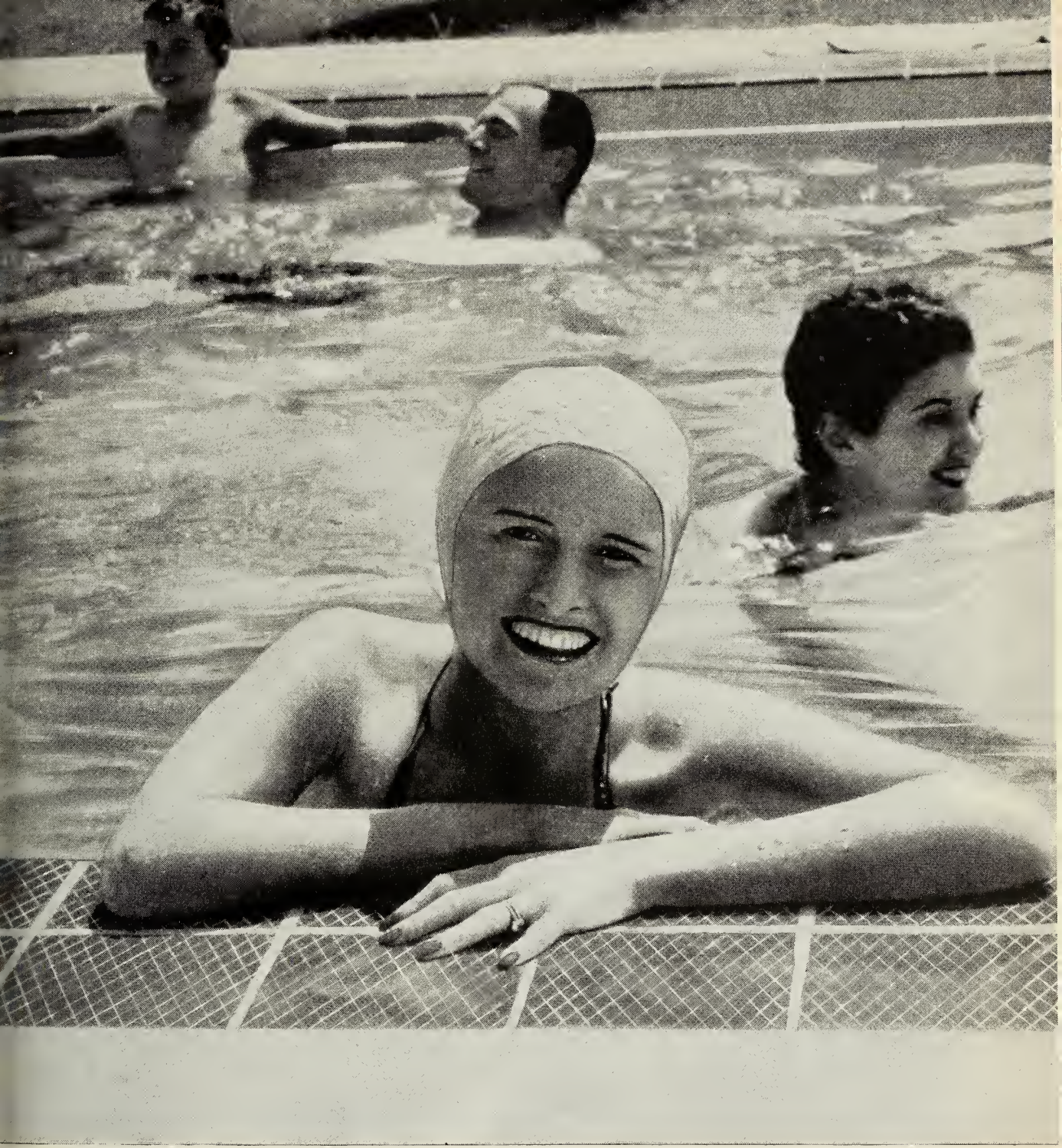
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Randolph	C. R. Slick, M.D., Winchester	M. E. McClure, Union City
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Vanderburgh	Patrick J. V. Corcoran, Evansville	Mr. Arthur P. Tiernan, Evansville 109½ S. E. 3rd Street
Vigo	William O. Baldridge, Terre Haute	Hubert T. Goodman, 410 Rose Dispensary Bldg., Terre Haute
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Washington	I. E. Huckleberry, Salem	H. G. Coleman, Salem
Wayne-Union	Paul Dingle, Richmond	Morris Wertenberger, Reid Memorial Hospital, Richmond
Wells	Robert G. Cook, Bluffton	Charles E. Jackson, Bluffton
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THE SIDE-EFFECTS PROBLEM WAS MINIMIZED IN MOST PATIENTS:

Chart shows gratifyingly low incidence of side effects in 233 patients given Singoserp with no other antihypertensive medication

Side Effect	Number	Per Cent
Lethargy	7	2.9
Headache	6	2.5
Gastrointestinal upset	3	1.2
Vertigo	2	0.8
Nasal congestion	1	0.4

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This summary of what is happening in Washington is prepared by A.M.A.'s capital office and airmailed to THE JOURNAL on the ninth of each month preceding month of issue.

THE MONTH IN WASHINGTON

Washington, D.C. — Congress went into the final months of this session with a heavy workload of appropriation bills and foreign aid legislation to be acted upon before adjournment.

Congress must act upon the appropriation bills before adjournment to provide money for operation of the federal government during the 1960 fiscal year. Foreign-aid legislation also is generally put in the "must" category now.

With so much "must" legislation requiring action and Congress hoping to adjourn by late August or maybe earlier, many bills of varying importance will be left for further consideration next year.

An upsurge in the national economy strengthened the position of the Administration and economy-minded members of the House and Senate in their opposition to big-spending bills. Supporters of a Senate - approved $465 million airport bill conceded in advance that a House-Senate conference committee would approve a figure closer to the $297 million version which the House passed.

Substantial gains in industrial production, corporate profits, employment and other key economic factors raised Administration hopes for only a small deficit, if not a balanced budget, in the fiscal year 1960 which began July 1. There also was some talk in influential quarters of a possible tax cut next year. But at this stage, it was highly speculative. And it appeared most likely that if there is one, it will be small.

During the first 5 months of this session, Congress completed action on only two appropriation bills. They provided funds for operation of the Treasury and Post Office Department in fiscal 1960, and additional funds for various government activities during 1959.

Early in June, the House approved, 393 to 3, a $38,848,339,000 Defense Department appropriation which included $88.8 million for care of certain dependents of military personnel in civilian hospitals. In recommending the Medicare appropriation, the House Appropriations Committee commended the Defense Department "for its response to the intent of Congress...that dependents of military personnel have the benefit of prompt and adequate medical treatment at all times wherever they may be."

This contrasted with the Committee's criticism about 2 months ago. The Committee then expressed concern at what it termed "the high costs of care for military personnel and their dependents in civilian hospitals and the high fees allowed in the program."

In another Medicare development, the Surgeon General of the Army ruled (ODMC Letter No. 7-59) that a patient under the program who has suspected or proven malignancy is acutely ill and qualifies for care. The government will pay for urgently required treatment in such cases when certified by the attending physician.

But it was made clear that payment would be based "solely on the medi-

Continued

cal requirement for immediate hospitalization." Qualifications of urgency can not be based on mental anguish, emotional attitudes or socio-economic factors.

The Defense Department rejected two proposals of the Florida Medical Association for changes in the Medicare program. The Florida Medical Association proposed that a health insurance program be provided for dependents of military personnel or that control of the Medicare program be transferred to the Department of Health, Education and Welfare.

Dr. Frank B. Berry, Assistant Secretary of Defense for Health and Medicine, said the present program could be handled best by the military service because military dependents "are a highly transient population."

* * * * * *

Dr. F. J. L. Blasingame, Executive Vice President of the AMA, suggested to the House Subcommittee on Administration of the Social Security Laws that it consider the advisability of a single Public Assistance medical program at the prerogative of individual states. There are now four such programs covering the blind, the aged, dependent children, and the permanently and totally disabled.

In a letter to Rep. Burr P. Harrison (D., Va.), Chairman of the Subcommittee, Dr. Blasingame also suggested consideration of:

Whether the medical staff of the Bureau of Public Assistance is now sufficient to provide adequate counselling to states on their individual programs, and

Whether "sufficient liaison has maintained with the various professional organizations actually providing medical care.

Another suggestion of Dr. Blasingame was that a special medical advisory committee might be established in view of the fact that there are no physicians on the recently-appointed Social Security Advisory Committee. ◄



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— OPEN STAFF —

DONALD R. KINZER
Manager

The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Not Even Perfunctory Opposition

In response to a request of the House ways and means committee, Secretary Arthur S. Flemming of the department of health, education, and welfare has submitted a cost estimate on extending old age hospitalization to the social security rolls. Flemming's estimate is that the added cost to start the program would be at least a billion dollars a year and would require another ½% increase in the social security payroll tax levied against both employe and employer.

By the reckoning of others, the billion dollar estimate for first year operations is far short of the mark, and a discreet silence is preserved all around on the eventual costs of this undertaking.

With Mr. Eisenhower publicly and often announcing the necessity of balancing the budget, restraining spending, and looking to free enterprise to provide the motive power in the nation, one might expect his secretary of health, education, and welfare to object to a proposal which would add to the burdens of the taxpayers, if not put a direct strain on the budget. The reason that it would not bulge the budget is that social security is collected thru a separate tax and goes into a so-called "trust fund."

But Mr. Flemming does not object, altho the social security clout has been increased in every election year since 1950 as the wage base upon which the tax falls has been broadened and the rates have gone up.

Nor does the secretary point out the obvious—that the pending bill, offered by Rep. Forand, a Rhode Island Democrat, is the opening gambit in the campaign to socialize medicine. The plea that something more must be done for "our senior citizens" is intended to lead in the end to the regimentation of the medical profession. The costs would be enormous and the further restriction of liberty immeasurable.

Secretary Flemming is not punching against this development. He is a believer in the gospel of having government do more and more for everybody while each person does less and less for himself. The more the government undertakes to do, the less the individual will be able to do, for as the march toward total federal dependence proceeds, the citizen won't be left with much more than carfare to get to work so that he may pay the taxes with which government will support him.

Chicago Tribune
April 16

Fallout Danger Increasing?

Early in May a congressional subcommittee on atomic energy will make a new attempt to find out how much danger mankind is in from radioactive fallout.

The subcommittee, headed by Rep. Chet Holifield, Democrat of California, is uneasy over reports that the fallout picture is more alarming today than it was two years ago when the group first conducted hearings.

There are reports that radioactive ashes are dropping from the stratosphere faster than had been predicted. Average "stay-up" time of Strontium 90 may be as short as two years, instead of 10 as first believed.

Disturbing, too, is the evidence indicating that when Soviet bombs are fired in North Polar regions, fallout settles in less than a year, and that all of it comes down in our Northern Hemisphere.

Strontium 90 is the most feared of the radioactive materials produced by nuclear explosions. Entering the body through food, it can attack bones and become the cause of bone cancer, the scientists say.

Researchers are seeking a way to extract Strontium 90 from the body or lock it in the soil so it doesn't get into food. As yet they haven't come up with answers. Many believe that the best way to end the danger would be to stop nuclear tests or hold them underground.

The public has a stake in all this. Up to now, the Atomic Energy Commission has taken

"It is concluded that the addition of buffering agents to acetylsalicylic acid in the concentrations used serves no clinically detectable useful purpose."[1]

[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:183, August, 1958.

Nonbuffered Material Used—Bayer® Aspirin.

the attitude that there isn't much danger from fallout as a result of nuclear tests, but one member of the commission, Dr. W. F. Libby, is saying that this danger is now much greater. If Dr. Libby is right, the public's stake is in being kept informed by the commission, candidly and without any reluctance. Maybe Rep. Holifield's hearings will oblige the commission to take the public more into its confidence if the danger is indeed increasing.

Kokomo Tribune
March 26

How's That Again?

Wigs, hearing aids, wooden legs, and aspirin, as is well known, are dispensed by the British ministry of health under socialized medicine. The other day a client announced in the public prints that as his hearing aid didn't seem to be getting good reception, he had lodged a complaint with the ministry, only to be advised that in future he should not refer to his hearing aid but to code file number ["IV[V][1] RHB5/19/2C/219. Sr."]

The fellow has been struck dumb as well as deaf. The welfare state, having already reduced him to a number, has done even better by that companion of the tympanic membrane, his hearing aid. It has reduced it to an indecipherable hieroglyphic.

Chicago Tribune
April 24

Horizons in Rural Health

A short time ago the 14th National Conference on Rural Health was held in Wichita. Sponsored by the American Medical Association's Council on Rural Health, and attended by 700 representatives of medicine, farm organizations, governmental agencies and other lay groups, its apt and important theme was "Horizons in Rural Health."

As speakers made abundantly plain, these horizons have been vastly broadened over the years.

The job, of course, is far from done. The chairman of the council, at the recent conference, called for a "wholesale approach and a mass appeal" in health education for rural people.

He noted that "health education, to be effective, has to be promoted in the home. It must become part of the daily life experience." It includes realizing and stressing the advantages of having a family doctor, of maintaining careful health records over long spans of time, and of having periodic physical examinations and immunizations.

The rural health movement has come a long way. And now is the time to keep on pushing it ahead with increased vigor and enthusiasm.

Anderson Bulletin
May 7

An Outstanding Accomplishment

The praise of all residents should go to the 1,000 men and women who have worked so diligently on the county general gifts committee of the Howard County Hospital fund drive.

Their remarkable job in raising nearly 50% more than their assigned quota of $100,000 is a remarkable achievement.

One could credit the successful task to the 4 hard-working co-chairmen—Dale Fawcett, Hubert Woodmansee, Dale Milburn and Miss Helen Smith—but without the assistance of the community and township chairmen, the team captains and all the workers the goal would never have been reached, let alone exceeded.

Not to be forgotten, of course, are the hundreds of citizens throughout the county who have been so generous with their subscriptions to the united campaign. The workers appreciate their undivided response.

The most outstanding report, shown by the hospital foundation's latest audit, is the one from Jackson Township where workers achieved 89% more than their goal. Five other groups surpassed their minimums, and leaders said they expect all county groups to at least meet their goals.

The county general gifts organization's accomplishment is the best all-out giving ever made in Howard County, at least in the memory of many long-time residents. It sets a standard that will be hard to equal.

As Herb Beitz, chairman of the Kokomo general gifts group, pointed out after announcement of the county's contributions: "Their dedication to the hospital cause results in a chal-

Through the centuries, Medicine has measured its most significant advances in terms of human benefits. Parke-Davis, through its "Great Moments in Medicine" series, continues to remind millions of people throughout the world of Medicine's constant efforts to promote the welfare of mankind . . . from the very outset of recorded history to the wonderful realities of today. The advertisement you see here will be the fifth in this striking institutional series, and will soon appear in LIFE, SATURDAY EVENING POST, TIME, READER'S DIGEST and TODAY'S HEALTH.



HIPPOCRATES—Medicine Becomes a Science—reproduced here is one of a series of original oil paintings commissioned by Parke-Davis.

Great Moments in Medicine

Diagnosis of disease by means of touch, hearing, and close observation was advocated by Hippocrates. This kindly, dedicated Greek physician practiced in the fifth century B.C. He is revered worldwide as the "Father of Medicine." There emerged from his teachings a system of professional practices based on natural study and rational inquiry, which replaced older systems based on magic and superstition.

The ethical principles laid down by this ancient preceptor guide the modern physician, whose chief concerns are the welfare of his patients and careful study of their individual needs. With the aid of today's scientific discoveries, your physician is able to provide the finest medical care the world has ever known.

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Fourth Estate

Continued

lenge which city workers will strive to meet with similar success."

The 100-bed hospital can be built for Howard County if everyone cooperates as he should. The county group proved that. Will Kokomo residents make it unanimous?

Kokomo Tribune
April 12

The Welfare Carrot

A proposal that has seemed to gain ground for several months here would, at first glance, make medical and hospital care almost ideally free-and-easy for unfortunate folk who require public welfare assistance from the taxpayers.

Submitted by a committee headed by Mrs. Elta M. Sargent, a Welfare Board member, it would allow welfare recipients to go to any doctor or dentist of their choice, or to any hospital and not just General Hospital as now required; doctors, dentists and hospitals would submit their bills to the Welfare Department according to an approved fee schedule, and they would be paid with federal and state-aid funds which Marion County doesn't receive now.

Sounds fine, doesn't it?

The only trouble with the plan is that, according to a Medical Society board which rejected it this week, it would increase present welfare costs an estimated 150%—up to $1.25 million a year as compared to less than $500,000 now. And probably it wouldn't assure any welfare recipient more or better medical assistance than he gets now.

Doctors, now, serve General Hospital welfare patients as part of their professional duty, at no cost at all. Use of General Hospital is more efficient and convenient for them, and usually for patients, than use of hospitals all over town. Marion County "goes it alone" on medical services, unlike most metropolitan communities, without state-federal help—and our system, while not perfect, has seemed to work satisfactorily.

For these reasons we are glad the medical Society turned the new federal-state-county plan down. Shouldn't the taxpayers be considered, if humanly possible, along with medical welfare recipients? Dangling this $1.25 million relief carrot before the needy of this community was no service to the public. In the end, it could mean a costly and inefficient socialized-medicine bureaucracy that probably would collapse from its own weight without materially improving our health services.

Indianapolis Times
April 11

For Paying Future Bills

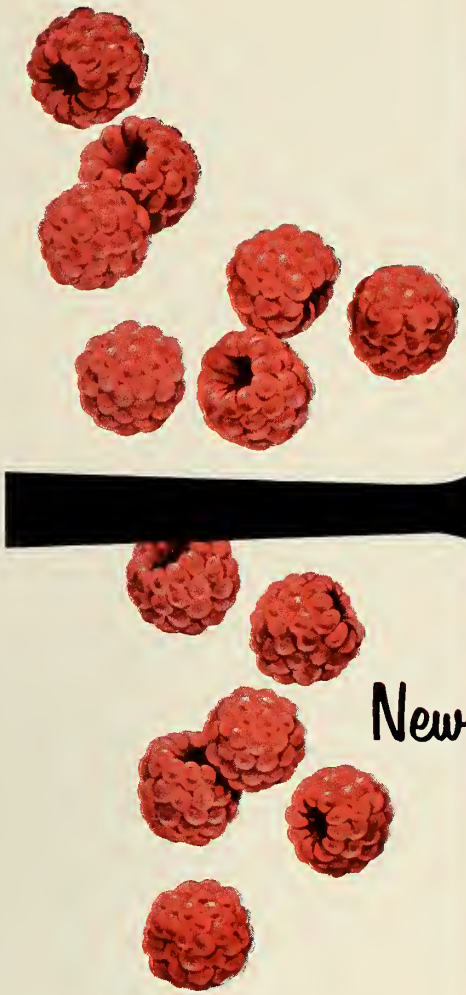
Columnist Porter Williamson recently was asked why the social security tax goes up. His reply was that the tax rises to match the increase in benefits the worker will receive when he retires. That brief answer didn't go deeply enough into the workings of social security. But it brushed against a problem which is very important to everyone who is working toward an income for his retirement years.

The problem is that retirement incomes of fixed amount, determined during the working years, will be less adequate when retirement time comes than they appear to be now. Further, they will become even less adequate as time passes. This will happen—that is—unless inflation is checked. If the cost of living continues to increase year after year, a fixed pension or other retirement income will cover less and less of it year after year.

It would be a most unhappy mistake to accept the pleasant notion that by paying progressively higher social security taxes now a worker takes care of benefits that will increase after he retires, as they have increased for persons now receiving them. The rise in the tax now is to take care of the increases already made. The tax paid now is to cover benefits being paid now. When today's worker retires, in 10 or 15 years, other people who are working then will have to be taxed to cover his social security benefits. If his benefits then are to rise as the cost of living rises, the tax will have to rise some more.

The problem of rising prices and fixed pensions brought on the recent act which raised pensions of railroad workers. These raises were not provided for by past taxes on the railroads and the pay of employes. They have to be covered by higher taxes now.

Retired military personnel of higher rank have bumped into the problem recently. They have been accustomed to having retirement pay



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Available on Prescription Only.

DOSAGE:

ADULTS: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

CHILDREN: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

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Fourth Estate

Continued

geared to the current pay for their rank, so that as inflation pushed the pay scale up their retirement pay also went up. But when military pay was boosted last year, chiefly for the higher ranks, the raise was given only to active personnel, not to those on retirement pay. Hence comes a demand now from spokesmen for retired personnel, for a raise in retirement pay to match the raise in current pay.

Millions of persons now working in private employment are going to face this same problem when they retire. Their retirement income, both from social security and from virtually all private pension plans, is going to be based on the rates of pay at which they worked. But if inflation continues the current rates of pay will go up and up and their old pay scales—and their pensions—will look smaller and smaller.

The obvious answer is to stop inflation. The persistent upward trend of prices can be stopped by removing its root causes. These include the equally persistent upward trends of the wage rates which make up a substantial part of all prices, of taxes, of diversion of production and money into government activities, and of government borrowing. If all these upward trends were stopped, the price level could be kept on an even keel and today's worker would get a fair break when he retires. If government diversion and taxes can be turned downward, the individual benefits of productivity gains could be increased and everybody—including the retired worker—could get more for his work and for his money.

Indianapolis Star
May 27



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When News is News

[New Orleans *Times-Picayune*]

Additional evidence that the American Cancer Society may be asking for trouble in its public relations has come from Excelsior Springs, Mo. Roy J. Gibbons, science editor of *The Chicago Tribune,* was asked to leave a scientific meeting at Excelsior Springs. The reason? Mr. Gibbons wrote and sent his news stories about talks at the meeting soon after they were delivered instead of at a later hour selected by a spokesman for the American Cancer Society.

The society attempted to require a 24-hour lag between the delivery of reports at the Excelsior Springs meeting and publication of news of these reports. Its spokesman explained that its requirement was intended to provide "more time for writing and personal interviewing."

The Chicago Tribune responded that its science editor "doesn't require 24 hours to evaluate what he hears. We will give *Chicago Tribune* readers a daily report of what happens, when it happens."

Seeking to justify its attempt to say when news of the Excelsior Springs meeting may be printed, a cancer society spokesman said: "This is not an open meeting. It is a private seminar for invited science writers sponsored by the American Cancer Society."

If the American Cancer Society, supported by the public, undertakes to hold "private" seminars for science writers of its choosing, it appears to us that it is abusing its power.

Obviously, if information about a paper delivered Friday at 3 p. m. is news Saturday at 3 p. m., when the society says it may be printed, it also was news Friday at 4 p. m.—if a com-

RESEARCH:

key to Kent's popularity

In 1958, Kent made the greatest gain in popularity ever recorded by any filter cigarette in any year—a sales increase of 20-billion cigarettes.

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These, then, were the objectives. The first scientific breakthrough in the project was the development of the exclusive Micronite filter, patented by Lorillard. This filter was created because of newly-discovered principles in the field of filtration, which have been previously described in these pages.

Though this filter satisfied everyone on its ability to reduce tars and nicotine to the lowest level among the largest selling brands, there was still work to be done in the areas of taste and draw. After additional months of research, a new tobacco blend was developed which delivered rich taste *after* the smoke had passed through the filter. Next in the series of laboratory triumphs was a method of improving the draw to compare with the most free-drawing of all filter brands.



The rest of the Kent story is a legend in the tobacco industry. Outside, independent research studies confirmed the fact that Kent had achieved its objectives. Smokers responded. In fact, during the past year, more smokers changed to Kent than to any other cigarette in America.

A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!

Continued

petent writer could get it to his newspaper at that time.

Chicago Tribune
April 11

Medical Facilities Inadequate?

Are Kosciusko county medical facilities inadequate to meet the needs of an expanding population?

This is a question that was poignantly raised this week, and it brought into the open a question that many people have been wondering about for a long time. The question, curiously enough, was raised by county medical men themselves, in the body of the Kosciusko County Medical Society.

Many laymen have often raised the questions, the medical society last week (line of type dropped from original article) city of Warsaw take their patients to hospitals outside Kosciusko county? Isn't our county good enough? Aren't our facilities adequate?"

Without attempting to answer these questions, the medical society last week passed a resolution asking for an impartial survey of our county medical facilities.

Such a survey can be made by competent survey companies who know how to gather information, and who know how to evaluate such information, setting aside all personality clashes and personal and private interests.

Health is a public matter, not a private matter. And personality clashes, if any exist, have no place in a county health program.

This paper goes on record as favoring the impartial survey asked for by county medical men. Let's know the facts and see just where we stand, healthwise.

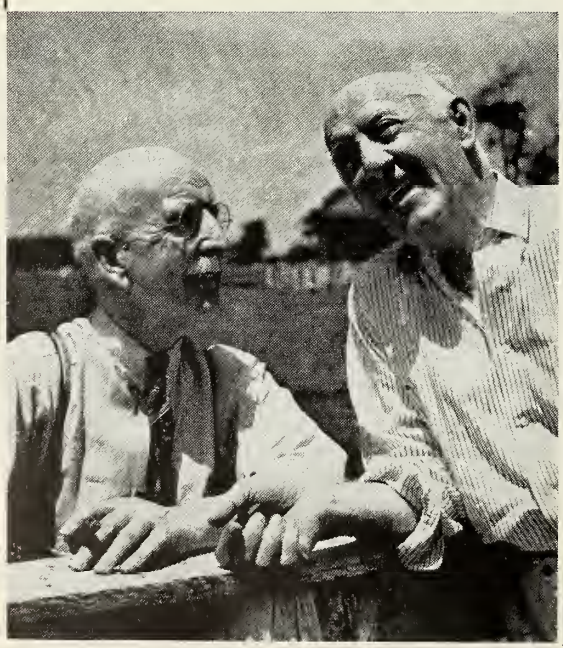
Milford (Ind.) Mail
April 16

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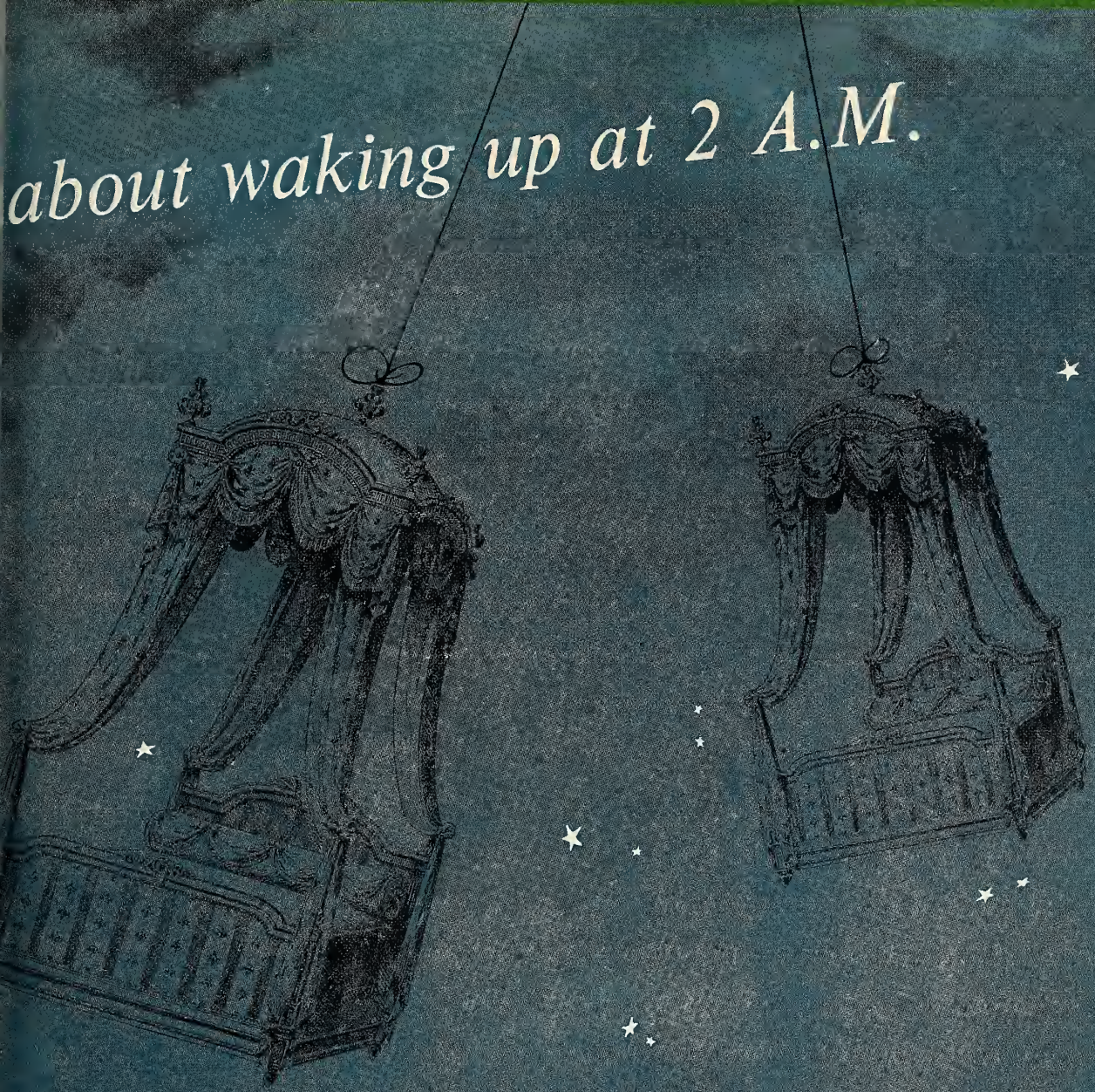
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1 Schlesinger, E. B.: Tr. New York Acad. Sc. 2:6, (Nov.) 1948.
2 Richards, R. K., and Taylor, I. D.: Anesthesiology 17:414, 1956.
3 Shideman, F. E.: Postgrad. Med. 24:207, 1958.
4 Berger, F.: Pharmacol. Rev. 1:243, 1949.

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Over 65 Health Care Financing— A Community Problem

This article is the fifth in a series prepared by Blue Cross—Blue Shield dealing with the cost of health care and trends in the financing of health care.

The economic impact of the cost of hospital care has fallen heavily on persons over age 65. Yet, fewer than 40% of those over 65 are now covered by some form of hospitalization insurance.

Hospitalization costs rapidly increase with advancing age to a high point beyond age 65. With income of persons in this age group greatly reduced, some form of subsidy has always been necessary to provide hospital care. Today this subsidy is generally provided through taxes or through added charges to patients who pay their bills, either through insurance or individually. The rapidly increasing costs have strained this informal system to the limit. The strain is now so great that one wonders whether or not a voluntary hospital system can continue to exist.

Increased enrollment in hospitalization insurance plans is but a partial solution to this problem.

A study conducted by the Health Information Foundation in 1957 revealed that 25% of the persons over age 65 had not even thought about health insurance. For insurance to succeed, even the uninterested person must be enrolled.

The second limiting factor is that the application of customary insurance and underwriting principles automatically eliminates most of the people over age 65 as not insurable risks. The greater costs experienced by insurance companies in covering those over 65 make the premiums high. High premiums mean low enrollment. Low enrollment results in more frequent bad debt losses for the hospitals, which in turn results in pressures for tax subsidy to cover the losses. No hospital system can remain voluntary under these conditions.

So long as competition exists between insurance companies in the hospitalization insurance field, voluntary subsidy of the hospital care for persons over 65 cannot be a part of an insurance program. Competitive pressures for lower fees always result in the elimination of bad risks by strict underwriting practices.

How may the voluntary subsidy be continued? One of several ways is through the charging practices of the hospital. Ward accommodations could be used to differentiate between those who receive subsidy and those who pay the subsidy. Stabilizing or controlling the charges in ward beds would provide a means to subsidize the low income segment of our population.

Hospital construction in recent months has emphasized the addition of the 2-bedroom unit, and the elimination of wards. Unless this practice is reversed, the hospitals may be building themselves a governmental hospital system.

The need of subsidy for hospital care of the elderly citizen is realized. It may be provided by: (1) taxes, (2) compulsory health insurance or an assigned risk system and (3) by changing hospital charging practices and the practices of insurance companies. Should the first two methods of subsidy be adopted, our hospital system must inevitably become government controlled. The third method, if implemented in time, can preserve the voluntary hospital system.

To do this, these changes are necessary: (1) hospitals must develop more ward-type accommodations and restrict their use to lower income people who will require subsidy, (2) insurance companies must agree *not* to cancel or waiver coverage of any person because of age or physical deterioration, a guiding principle of Blue Cross—Blue Shield, (3) a hospitalized person must *not* be permitted to receive more from hospitalization insurance than the actual charges for hospital care and (4) insurance companies must enroll on a community wide basis and not limit coverage to selected groups and lower aged persons.

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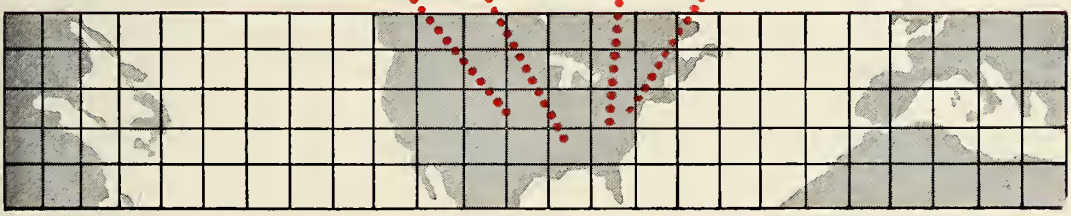
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- Board of Surgery Review Course, Part I, Two Weeks, October 5
- Fractures & Traumatic Surgery, Two Weeks, October 12

GYNECOLOGY & OBSTETRICS—
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- Vaginal Approach to Pelvic Surgery, One Week, October 12
- General & Surgical Obstetrics, Two Weeks, September 14

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Health Care

Continued

program. Nationally, Blue Cross—Blue Shield are protecting 65% of all those over 65 now covered by some form of hospitalization insurance.

In Indiana, 26% of those 65 and over are covered by Blue Cross—Blue Shield. Of these 105,000 members, 29,500 are 75 and over.

The voluntary hospital system can succeed in serving the community health care needs of our elder citizens. Positive action in this direction must be developed rapidly and vigorously based upon greater comprehension of the problem, upon the goodwill of all parties concerned, and through objective and effective leadership.

WARREN HUDDLESON
Public Relations

(This articles has been extracted from "Cost of Hospital Care in Indiana in 1956," by Harry Hineman. Blue Cross-Blue Shield Actuarial Division Director.) ◄

'The Advantages of the American Free Enterprise System'

1959 National Winner in the 13th Annual Essay Contest for High School Students Sponsored by the Association of American Physicians and Surgeons' Freedom Program.

CAROL PRYOR

Elizabeth, N. J.

OF ALL the freedoms enjoyed by Americans, one whose roots lie deep in tradition is that of free enterprise. From the earliest settlement of the new world, our ancestors had to develop means of providing for their daily needs. Food, shelter, and clothing had to be wrested from the natural resources found in this strange, new land which was to be their home.

Because these early settlers were fleeing the serfdom or slavery of their mother countries, they wished to insure freedom for their children in the years to come. In declaring their political freedom, they laid down in that immortal document, the Declaration of Independence, these principles: "We hold these truths to be self-evident: that all men are created equal; that they are endowed by their Creator with certain inalienable rights; that among these are life, liberty, and the pursuit of happiness." These men had set their goals and they meant to reach them. To them the possession of private property ranked in importance with freedom of speech, freedom of the press, the right to vote and the right to engage in whatever profession they chose. "The pursuit of happiness," therefore, implied free enterprise and private ownership.

Exercising their right of private ownership and free enterprise, these pioneers in industry made rapid progress. Before the coming of the railroad, in many communities little industries were carried on in a simple way—a flour mill operated by a water wheel; a wheelwright shop, a chair factory, a pottery, a tinsmithy. The blacksmith varied the routine of shoeing horses of the countryside with making tools for the farms and households. In the larger towns might be found a bakery or two.

In these early days the owner of the plant was also the master workman, employing either his sons or an apprentice or two. He carried his money in a leather bag attached to his belt, and did his bookkeeping at night by candle-light. He made his own deliveries by horse and wagon to his customers who lived at a distance.

With the advent of the railroad, many small units of industry found it more profitable to form one large unit. However, many of the local manufacturers preferred to carry on their own business, depending upon the loyalty of their customers. As late as 1850, a manufacturer of farm implements could have only five employees and yet be as large as the average. He could be an independent manufacturer, and yet have only two thousand six hundred dollars as his capital.[1] By 1910 it took four hundred thousand dollars to be an average manufacturer of agricultural implements. In 1859 there were 1,333 factories making farm implements; by 1910 the number had shrunk to 640—though quantity of goods turned out had grown in value from six million dollars to one-hundred forty-six million dollars.[2] This same change occurred in the cotton goods and steel industries. All this

James Snyder of Anderson, Ind., won second prize on the only other preselected subject, "The Advantages of Private Medical Care."

American Enterprise

Continued

was the result of the business man's freedom to consolidate or to remain independent.

Of the old-time businesses that continued independently one of the best known is the Du-Pont Company, founded as manufacturers of powder at Wilmington, Delaware in 1802. Du-Pont's is now a leader in many additional lines. The wide variety of products, nationally advertised and sold, is evidence of the skill, ambition, and inventive genius of the men who made Du-Pont one of the monuments to the system of free enterprise.

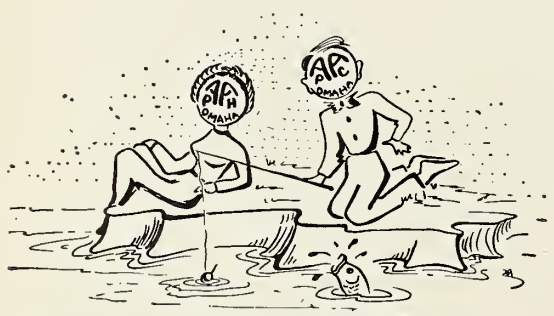
The automobile industry is another giant that grew out of man's freedom to use his inventive genius and skill. When man realized the need for more efficient transportation, he immediately went to work to design what was known as the "horseless carriage." Although he was laughed at, he was not discouraged. Suddenly the idea caught on and the demand was greater than the supply. With the development of the assembly line process, cars could be produced more rapidly, and eventually, at a cost within the average man's budget. Now the average family owns at least one and sometimes two cars.

In this half of the twentieth century, the supermarket, a distinctly American institution—spurred on by competition—is rapidly becoming bigger and better, offering more space for a greater variety of products. However, the small corner grocery store, the village bakery, and the delicatessen still have their rightful and necessary place in our American way of life. Both types of businesses serve the needs of a rapidly growing population more satisfactorily than any government "planned economy" system could.

Free enterprise is the basis of our American way of life, encouraging people to be creative and ambitious. It provides more benefits for the greater number of people than any other system yet devised by man, and keeps our standard of living high. By contrast, socialism kills incentive. It merely tends to take anything created by free enterprise and dispose of it for the "better interests of humanity" according to the false socialistic way of reasoning. The socialist would put all men on the same level, the hard-working tradesman, the skillful, inventive genius, and the shiftless, good-for-nothing loafer. A famous English scientist once said: "A capitalist is a man who, if he himself is doing well, doesn't mind if others are living better. A socialist, on the other hand, is a man who doesn't care how badly he himself is living as long as nobody else is allowed to live better."

A. M. Rosenthal, correspondent for the *New York Times* in Poland, made this comment in one of his articles published recently: "This reporter after years in a would-be socialist country and in a Communist area, finds himself influenced quite sharply by his experiences. Month by month his appreciation of the expansiveness and variety of American life, in contrast to the sort of drab prissiness in which socialism and communism wrap themselves, grows."[3]

West Germany has provided a good example of free enterprise. After the second World War, she had a choice between the European and United Kingdom socialist pattern (heavy control, rationing, tremendous emphasis on equality) or free enterprise (emphasis on incentive and free marketing). West Germany chose free enterprise and has risen to the status of an economic and financial king in Europe.



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In our own country, Government control in agriculture has proved a failure. Ezra Taft Benson, Secretary of Agriculture, has said that he felt the great majority of farmers would much prefer to have less government in agriculture, rather than more. He believes it is necessary to recognize that "controls are a failure; that you can't effectively control production by legislation."[4]

In spite of what experience has proved in our own country and abroad, there are many so-called Americans abusing the democratic system of free competitive enterprise. They contend that the government owes a living to any citizen or group of citizens; that it should provide special privileges and benefits to various communities. What they are actually clamoring for is the destruction of freedom of action and opportunity. Furthermore, they fail to realize that before the government puts a dollar into the hand of anyone, it must first take that dollar out of his pocket, plus the cost of collecting, bookkeeping, distribution, etc.

From the window of our school library I can see every day what I think is one of the greatest tributes to our American system of free enterprise. To me it represents free enterprise on the move—a well-used railroad transporting hundreds of freight cars daily, carrying State of Maine products, Florida fruits, oil, coal, livestock, scrap metal, and dozen of other raw materials, and finished products. Through the underpass of this same railroad runs one of America's busiest highways. Conveyances of all types pass here in a steady stream. It is a familiar sight to see a small truck farmer bringing his produce to market behind a giant trailer truck carrying four bright, new cars to their destination. In another lane a huge oil truck will pull up beside a gaily painted florist's delivery car. And so the endless procession goes on day and night—trucks of all sizes, shapes, and models, carrying the fruits of man's labor to all parts of the country. Would the picture be the same if all these industries represented were government controlled?

America has come a long way since the day of the village blacksmith, the country store, and the horseless carriage. She has amazed the world by her progress. Only by man's freedom to produce according to his capacity, and to consume or dispose of what he produces according to his own judgment, respecting the rights of others, has this progress been accomplished. Those who still believe in our constitutional democrary have a sacred responsibility to protect the right of the individual—"the right to life, liberty, and the pursuit of happiness" by fighting to hold fast to our American system of free competitive enterprise.

MISS PRYOR SAYS:

"I was born in Elizabeth, New Jersey, August 31, 1941. My parents are Mr. and Mrs. Joseph A. Pryor. My father is Inward-Freight Manager of Moore-McCormack Lines in New York City and Industrial Commissioner in the City of Elizabeth.

"I received my elementary education at St. Genevieve's Grammar School, Elizabeth, New Jersey, and will graduate from the Sacred Heart High School, Elizabeth, New Jersey, in 1959. I can honestly say that I owe my thorough education so far to the Benedictine Sisters and Priests, who have instructed me through these twelve years. I am a member of the National Honor Society, secretary of my class, a staff member of the school magazine, and a member of the yearbook staff.

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American Enterprise

Continued

"I am preparing to follow a secretarial career, and the money I have won will start me off in the business world with a feeling of security. It was my interest in the business field that prompted me to enter this contest. As a member of the Junior Achievement Organization, Elizabeth, I learned, through practical experience, some of the benefits of the free enterprise system. I was delighted when my essay was awarded a county prize, but I never dreamed of winning a national award.

"I wish to express my appreciation to my teachers, to Mrs. Edgar Weigel, Chairman of the Union County Contest Committee, and to the Association of American Physicians and Surgeons for giving me the opportunity to participate in this program. It is a source of inspiration and help to students throughout the country and an outstanding service to our country." ◄

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4. "United States News and World Report," Feb. 6, 1959, p. 46 ◄

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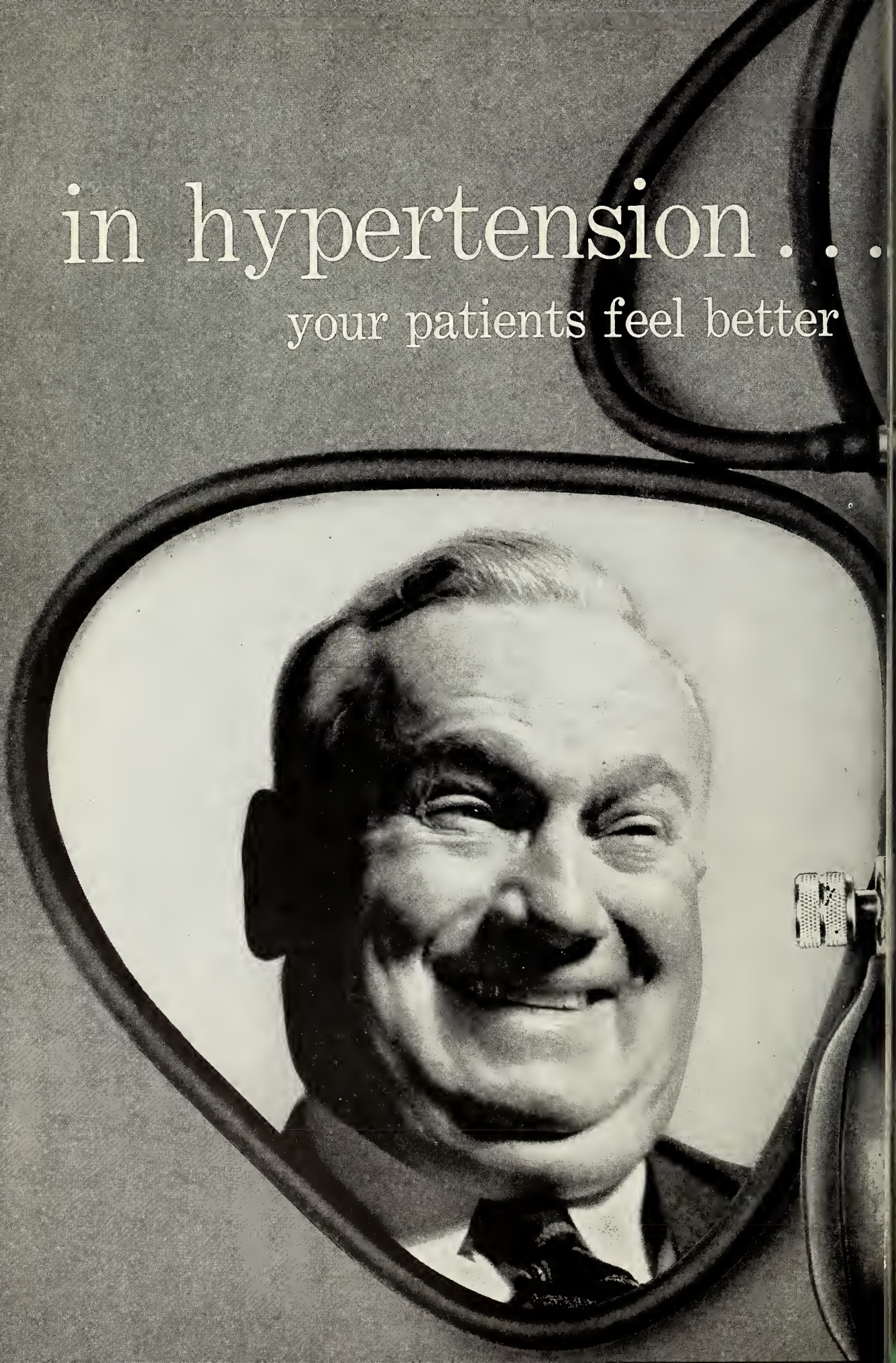
A. L. Marshall Jr., M.D., Director

MONTHLY REPORT – MAY, 1959

Disease	May 1959	April 1959	March 1959	May 1958	May 1957
Animal Bites	648	641	378	316	419
Chickenpox	346	636	915	444	583
Conjunctivitis	114	151	110	70	22
Diphtheria	1	1	0	0	0
Dysentery, Unspecified	14	17	13	6	11
Impetigo	70	67	65	17	21
Infectious Hepatitis	23	36	34	23	32
Infectious Mononucleosis	18	17	18	15	22
Influenza	498	2992	10,674	125	97
Measles (Rubeola-Rubella)	759	998	843	4527	2151
Meningitis, Meningococcal	2	6	5	6	4
Meningitis, Other	8	11	9	6	16
Mumps	299	467	362	734	492
Pertussis	91	76	108	164	91
Pneumonia	156	331	196	100	86
Poliomyelitis	3	1	0	1	3
Streptococcal Infections	495	1032	1536	453	434
Tinea Capitis	9	35	20	12	9

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Volume 52 — July 1959 — Number 7

Esophageal Obstruction Due to Anomalous Right Subclavian Artery

*THOMAS C. MOORE, M.D.**

Muncie

A VARIETY of aortic arch malformations may occur to produce symptoms of tracheal and esophageal obstruction. The great majority of symptom-producing malformations develop as constricting vascular rings and the onset of symptoms generally is in the early weeks and months of life. In an occasional case, difficulty resulting from esophageal obstruction may appear during adult years. This type of obstruction is most often produced by an anomalous right subclavian artery which arises from the descending thoracic aorta and passes upward and to the right between the esophagus and the spine.

The classical case of dysphagia lusoria, as described by Bayford[1] in 1794, was of this type. The symptoms in Bayford's case were of progressive dysphagia beginning in infancy. An abnormal right subclavian artery which arose from the descending thoracic aorta was found at autopsy. The term lusoria was chosen by Bayford to describe the intermittent and unpredictable nature of the dysphagia. The absence of a true vascular ring in these cases doubtless accounts for the observation that the majority of these cases do not produce symptoms.

Embryologic Development

A knowledge of the embryologic development of the aorta and the great vessels arising from the aortic arch makes possible a clearer understanding of the origin of these malformations. In the early embryo, the arterial bulb from which the heart develops is continued cephalad by two ascending aortae which pass along the ventral surface of the first branchial arch. These vessels curve in a dorsal direction and then pass caudad to form the descending aortae. The 5 anastomoses which form on each side between the ascending and descending portions of these

* From the Surgical Service, Ball Memorial Hospital, Muncie, Indiana and the Department of Surgery, Indiana University School of Medicine, Indianapolis, Indiana. Supported by a grant from the James Whitcomb Riley Memorial Association.

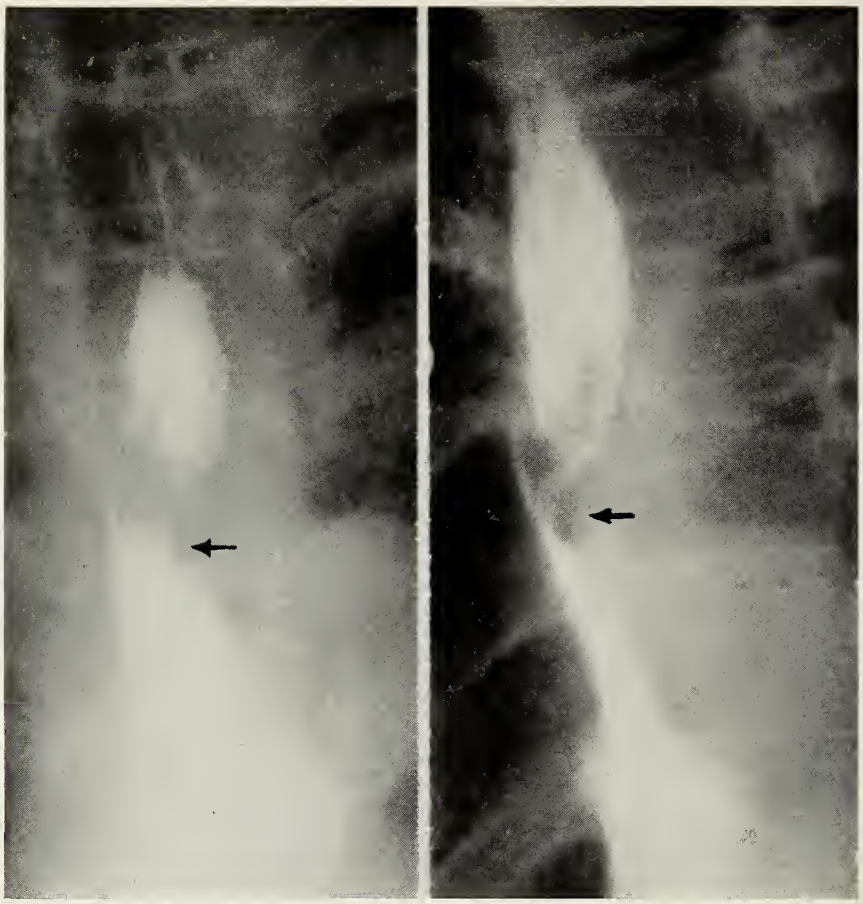


Fig. 1. Anterior-posterior and oblique roentgenograms (A and B) showing esophageal compression presumed to be due to an anomalous right subclavian artery in an asymptomatic case. This was an incidental finding.

aortae become the 5 primitive arterial or aortic arches. These arches subsequently disappear or are transformed. The normal human aortic arch has developed from the left ascending aorta, the left fourth aortic arch and the left descending aorta. The right subclavian artery normally is formed from the right fourth aortic arch. However, obliteration of the right fourth aortic arch may lead to the origin of the right subclavian artery from the primitive right descending aorta. As a result, the right subclavian artery arises from the posterior or descending portion of the aortic arch distal to the origin of the left subclavian artery. This malformation was found by Quain[3] to occur 4 times in a series of 1,000 postmortem examinations. The anomalous artery has been stated to pass behind the esophagus in 80% of the cases, between the esophagus and trachea in 15% and in front of the trachea in 5%.

As an increasing number of cases of anomalous right subclavian artery are discovered as incidental roentgen findings without symptoms of dysphagia, it has become apparent that this malformation seldom is of clinical significance. One such asymptomatic case recently was encountered by the author, and surgical intervention was not advised. (Fig. 1.)

In the occasional symptomatic case, ligation and division of the anomalous right subclavian artery near its origin from the aorta may be carried out with little risk and with good expectations for complete symptomatic relief. Gross[2] in 1952, reported division of an anomalous right subclavian artery in 11 children, from 3 weeks to 6 years of age, without mortality and with complete disappearance of the symptoms which had existed. Because so few symptomatic adult cases have been reported, it has seemed desirable to record a case of symptomatic esophageal obstruction in a 39-year-old woman due to an anomalous right cubclavian artery. The patient was managed successfully by ligation and

division of the anomalous artery at its origin from the posterior wall of the descending aorta.

Case Report

The patient, a 39-year-old white housewife, was admitted to the Ball Memorial Hospital on June 30, 1958 because of progressive difficulty with swallowing of two months duration. She had experienced great difficulty in getting food past an area of obstruction in her upper esophagus. Attempts at swallowing often were accompanied by a sensation of choking. She also, on occasion, suffered from a sensation of choking on lying down. There was no history of symptoms of this type prior to 2 months before her admission to the hospital, She had been managed by sedatives and antispasmodics by her family physician, without relief. Out-patient roentgen study of the upper esophagus with barium had demonstrated an area of esophageal obstruction, suggesting the presence of an anomalous right subclavian artery. (Fig. 2.)

There were no significant positive findings on physical examination. The blood pressure was 120/70. The admission urine and blood examinations were within normal limits. The blood serology was negative. Because of the severity of the patient's symptoms and their progressive nature, operation was decided upon. She was taken to the operating room on July 1. Under endotracheal anesthesia, the left chest was entered through the bed of the resected fifth rib. The arch of the aorta appeared to be normal. However, when the arch of the aorta and the proximal descending thoracic aorta were mobilized and retracted medially, a rather large artery, the size of a subclavian, was found to arise from the posterior wall of the descending thoracic aorta. This artery passed upward and to the right, behind the esphagus and the trachea. It appeared to produce some compression of these structures, especially the esophagus. Occlusion of this anomalous artery with a Potts coarctation clamp eliminated all palpable pulsation in the right radial artery as determined by the anesthetist. Although palpable arterial pulsation in the right upper extremity had ceased, it remained warm and of good color. The diagnosis of esophageal obstruction, dysphagia lusoria, due to an anomalous right subclavian artery, was regarded as established. The anomalous artery was ligated and divided at the point of its origin from the proximal descending thoracic aorta. Upon division, the distal end of the artery retracted as though under considerable tension. The incision in the pleura over the arch of the

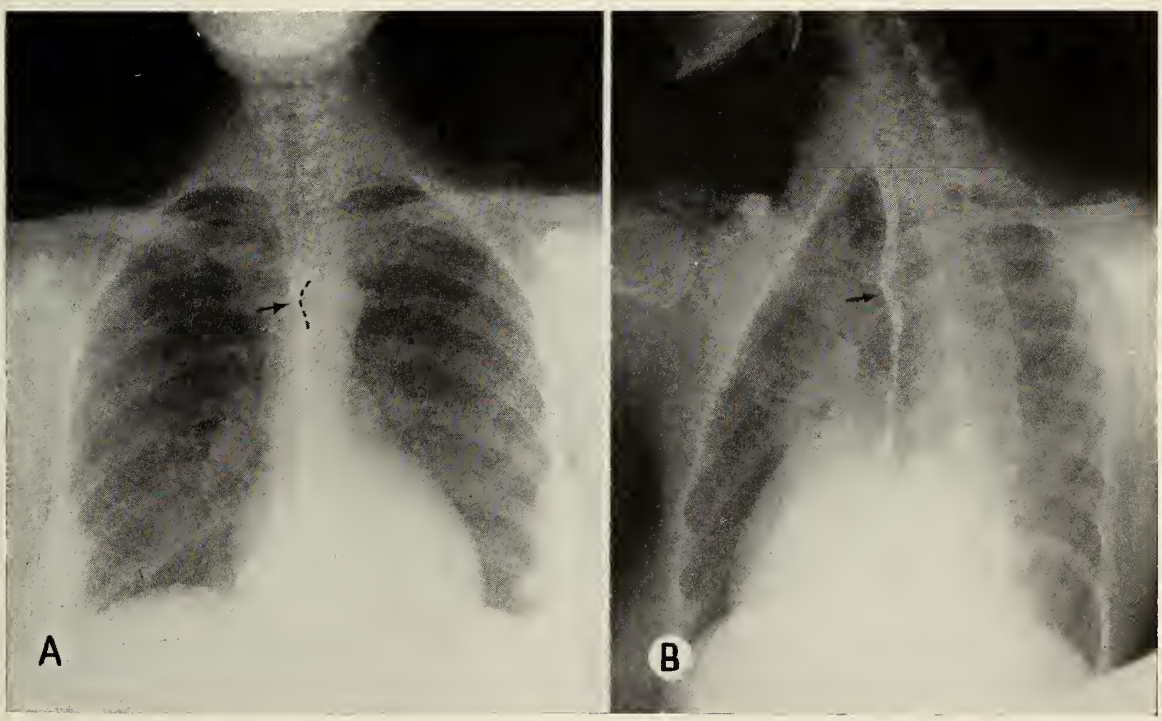


Fig. 2. Esophagograms in case of dysphagia due to anomalous right subclavian artery. Area of compression indicated by dotted lines in (A) and arrow in (B).

aorta and the mediastinum was closed with interrupted sutures of fine silk. The thoracotomy incision was closed in layers and a catheter, left in the chest during the closure, was aspirated and withdrawn.

The operation was tolerated well by the patient and her recovery was prompt. Her ability to swallow without difficulty was improving steadily at the time of her release from the hospital on July 13. She was last seen in October of 1958. Her symptoms of dysphagia had disappeared and roentgen examination of the esophagus showed no evidence of esophageal compression.

Summary

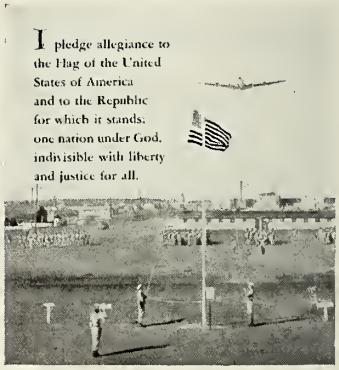
The literature and embryology pertaining to esophageal obstruction due to an anomalous right subclavian artery are reviewed briefly. A case of symptomatic esophageal obstruction due to an anomalous right subclavian artery in a 39-year-old woman is reported. The patient was managed by trans-thoracic ligation and division of the anomalous artery at the point of its origin from the posterior aspect of the descending thoracic aorta with relief of dysphagia and return to normal of the roentgen appearance of the esophagus.

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Commemorated Annually, Upheld Continuously . . .

This month we salute the Armed Forces—the men and women who stand ready 24 hours a day to protect the freedoms won by our forefathers. July 4, 1776, set an American tradition, commemorated annually, but upheld continually. On our cover are a few of the many thousands who stand prepared for an enemy attack. They are airmen of the former Great Falls Air Force Base in Montana, shown at retreat with a C-54 flying overhead.



The men and women of our Armed Forces cannot protect our freedoms and rights alone, however. The job is a continuing one—meant to be carried out by EACH AND EVERY AMERICAN. Not just the cold war (or a hot war) threatens us. Perhaps the biggest threat is from communist infiltration and indoctrination within our country . . . and from a slow eating away of those rights of independent men as set forth in the Declaration of Independence—rights which cannot exist in a socialist state where the government becomes father, mother, benefactor and dictator to the people.

Our cover is not only a salute to the active men and women of the Armed Forces; it is also a reminder to each individual that his right and duty is to reaffirm his pledge to his flag and nation and to actively work to retain that independence declaration of 1776. (United States Air Force photo, 1952.)

Drug Absorption and Elimination as Guide to Rational Therapy in Bronchial Asthma

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THE ASTHMATIC is always handicapped and may be invalided. In addition, his periodic acute illnesses require hospitalization and emergency care. The patient is sometimes difficult to manage or benefit. Persistent symptoms may induce pathological changes in bronchial tissue and result in emphysemia and its sequel of cor pulmonale.[1] The management of asthmatic patients is of considerable import.

In an acute severe attack of asthma, the parenteral administration of aminophylline or epinephrine is reliable to quickly terminate the attack.[2, 3] Other remedies for asthma, including hormones, are incapable of doing this. The usual slow absorption of theophylline and its salts from the gastro-intestinal tract made oral preparations of little value in an acute attack, until now. In patients with chronic asthma, particularly those presenting non-allergic, infectious or intrinsic asthma, bronchiolar obstruction and bronchospasm often persist between attacks. In such cases, though having lesser symptoms, the proper control often presents difficulty. Toxic side-effects are often encountered in attempting to provide more or less constant therapeutic effects.

Medications commonly used in asthma include sympathomimetic amines, anti-histamines, expactorants, antibiotics, xanthines and others. In consideration of all of the bronchodilators, the theophylline group is undoubtedly the most dramatic when administered intravenously.[4]

When 250 mg. of aminophylline are given intravenously, blood levels of over 5 micrograms per milliliter are quickly reached.[5] The efficacy of this procedure is universally recognized in texts and in practice.

Orally administered aminophylline, choline theophyllinate or other alkaline salts of theophylline are slowly absorbed and the prolonged contact with the mucosa often produces gastric distress. This slow absorption from the gastrointestinal tract has been reported to yield low ineffective theophylline blood levels as long as 30 minutes after the administration of 500 mg. doses of aminophylline and of choline theophyllinate.[6]

In contrast, it has been shown oral administration of solution of theophylline (Elixophyllin®) yields therapeutically effective blood levels in relatively short periods of time.[6] Administration of doses equivalent to 500 mg. of aminophylline did not cause gastric distress and such doses usually terminated acute, severe asthmatic attacks in 15 to 30 minutes.[7, 10] This difference is probably due to the fact that theophyllin is precipitated from aminophylline, choline theophyllinate and other alkaline salts in the presence of gastric acid. Whereas, the free theophylline in Elixophyllin is not precipitated by acid. Also, the presence of alcohol in Elixophyllin plays an extremely important role in faster and better absorption.[11] The blood levels attained with Elixophyllin are more predictable than those obtained with oral theophylline preparations.[6]

Administration of a 500 mg. suppository results in theophylline levels ranging from 0.46 to 15.1 microgram per milliter in adults.[12] In a child, weighing a half or a third of an adult's weight, a similar dose would be expected to produce blood levels as high as 30 to 45 microgram per milliliter or as low as 1.5 microgram per milliliter. The slow elimination of theo-

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phylline and the differences among individuals in blood levels attained by a single dose may produce dangerous cumulative effects.[13, 17]

Material and Method

The present study discusses the results obtained in a series of 40 asthmatic patients treated with Elixophyllin, a hydroalcoholic solution of theophylline containing 80 mg. of theophylline and 3 cc. of alcohol in each tablespoonful (15 cc.). The patients ranged in age from 4 years to 62 years. The duration of their asthma ranged from 9 months to over 10 years. All patients were seen in a private office practice and a follow-up on the progress of the patient was maintained. Patients presenting complications were not included in the study.

Separate schedules were used for emergency dosage and maintenance dosage. Adults in emergency situations where rapid attainment of therapeutic blood levels was indicated received one dose of 75 cc. (5 tablespoonfuls) of Elixophyllin. In chronic conditions where constant maintenance of therapeutic blood levels was indicated, they received 45 cc. (3 tablespoonfuls) of Elixophyllin three times daily for the first day or two of therapy. After two days, the dose was gradually decreased to adjust to the needs of the individual patient. In most cases a dose of 30 cc. (two tablespoonfuls) three times daily was found to be satisfactory after a few days of initial therapy. This provided the desired therapeutic effects with minimum risk of excessive cumulative levels, nausea or other symptoms of overdosage. The patients were advised to take the medication undiluted and preferably on an empty stomach.

In children, Young's Rule was applied to this dosage. A dose of 0.375 cc. Elixophyllin per pound of body weight was used, which corresponded to a dose of 400 mg. of Aminophylline in an adult of 160 pounds. Not more than 3 such doses were given in any one day.

Previously, the patients had been treated with a wide variety of medication, including aminophylline by mouth and by rectum, antihistamines, potassium iodide, epinephrine, newer synthetic sympathomimetics and others. No concurrent therapy was used when the patient was placed on Elixophyllin therapy.

Results and Discussion

Excellent results were obtained in all patients. The most dramatic results were seen in cases treated for acute asthmetic attacks. The severe acute attacks were usually terminated in 10 to 30 minutes on administration of a single dose of Elixophyllin. Only rarely, additional dosage was necessary in these cases.

In patients with chronic asthma the administration of regular doses of Elixophyllin completely or partly suppressed wheezing, dyspnea and coughing. In most adult patients it was possible to reduce the initial dose of 3 tablespoonfuls (45 cc.) three times daily to two tablespoonfuls (30 cc.) three times daily after 2 days. The children were prescribed one teaspoonful doses as necessary.

The following case reports are illustrative:

A 4-year-old female. A call was made to patient's home at 4 a.m. The child was terrified, cyanotic and screaming between gasps for air. Wheezing was loudly audible. The patient was rushed to the hospital and placed in an oxygen tent. ACTH (20 units) was given intramuscularly. A 7 a.m. the patient had improved only slightly. At this time 10 cc. of Elixophylin was given, and 5 cc. every hour until noon. Symptoms abated rapidly; wheezing began to disappear and patient became playful. When taken from the oxygen tent at noon, no rales could be detected. The patient returned home and was given 5 cc. of Elixophyllin twice daily. There have been no attacks in the four weeks since then.

A 4-year-old male with history of bronchial asthma for 2 years. He was alergic to dust and pollens. Antihistamines helped slightly. A call was made to patient's home to treat acute bronchial asthmatic attack which had persisted for over an hour. The patient was given 10 cc. of Elixophyllin. Substantial improvement was noted in 15 to 20 minutes. Four doses of 5 cc. each were given hourly. The following morning patient was entirely symptom-free. One teaspoonful doses as necessary were prescribed. There have been no recurrences and the patient is essentially symptom-free.

A 62-year-old male, machine operator who had had asthma for the past 3 years with chronic bronchitis. Severe coughing aggravated an old inguinal hernia, necessitating surgery. Coughing

was especially severe upon arising. The patient had lost much time from work. After 5 days of Elixophyllin therapy the coughing subsided and wheezing disappeared. The patient has been able to carry on normal occupation without interruption since. He now takes one to 3 tablespoonfuls daily.

A 59-year-old female with chronic wheezing and dyspnea for preceding 9 months. She had frequent acute attacks of asthma, and had been treated elsewhere with little relief. Initial dose of 2 tablespoonfuls of Elixophyllin was given 3 times daily. Wheezing was completely relieved in 2 days. Dose reduced to one tablespoonful. Upon examination a month later no abnormal pulmonary sounds were audible. The patient has had no asthmatic attacks since therapy started.

All patients were questioned for any untoward side effects. None were present in our series of patients. The patient acceptability of the medication was excellent in adults. Addition of a sweetening agent rendered the drug more pleasant to the children.

Some asthmatic patients suffer almost continuously from symptoms which may often incapacitate them. It is a rewarding experience when these patients are made symptom-free for long periods of time.

Summary

Forty patients ranging in age from 4 years to 62 years with bronchial asthma were treated with Elixophyllin, a hydro-alcoholic solution of theophylline containing 80 mg. of theophylline and 3 cc. of alcohol in each tablespoonful (15 cc.). Excellent results were obtained in all patients. Most dramatic results were seen in acute attacks.

No gastric distress or other side effects were observed in patients given Elixophyllin.

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Silent Myocardial Infarction

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SILENT and painless infarction are not synonymous. Only because pain, usually, is THE outstanding symptom of myocardial infarction, does one bracket these terms together. It is not uncommon in some instances of severe, clinically obvious coronary thrombosis, for the patient to have pain equivalents but not pain as such.

Unrecognized myocardial infarction is not infrequent[9]; true silent infarction is a rarity. P. Fisher,[1] in a recent report, details the case of a man critically ill with acute myocardial infarction who experienced no pain at any time. In presenting his criteria for painless myocardial infarction, Fisher stresses that pain equivalents such as "chest discomfort . . . pressure . . . ache . . . smothering . . . dyspnea," or any other aberration, might be elicited by asking leading questions. If the patient responds positively to any of these, his case cannot be classified as silent.

The patient must have clear control of his senses continuously. Psychotic individuals can lose pain appreciation;[2, 3] also, the aged[4] can present atypical symptoms. Because of congestive failure, cerebral anoxemia, and visceral congestion, these last can lose pain appreciation as they become senile.

Even such an apparently unrelated symptom as persistent hiccup led N. S. Gilbert[5] to take an electrocardiogram which, in turn, revealed the infarction. Of course, the finding at autopsy of ancient myocardial infarcts does not prove that they had been silent. Because the pathologist does not usually have available complete histories, whenever he reports such instances,[5] he usually places quotation marks around the word "Silent".

Let us, then, define genuinely SILENT infarction as myocardial infarction occurring in the entire absence of symptoms. The diagnosis rests solely on electrocardiographic findings. After a thorough search of the literature, Sambhi and Zimmerman[7] accept as authenticated only a single German report.[8] Rejecting all others, they claim their case as the first to be detailed in the English language.

This extreme rarity of reported cases of silent myocardial infarction seems to make our own three cases worthy of presentation. They meet fully Fisher's criteria. In spite of continuing with their jobs after having been warned to stop, they continue asymptomatic.

Case 1. A 21-year-old white married male. He denied any illness at any time whatever. Routine examination revealed an inconstant, systolic sound, varying in intensity and changing somewhat in quality with position and increased by exercise. Fig. 1 presents the electrocardiogram. Repeated leading questions brought only further and more emphatic denial of any symptom whatever. He has refused medical advice and has continued heavy labor. As far as known, there have been no ill effects.

Case 2. A 45-year-old Negro, married, male, 6 children living and well; gonorrhea in youth; all other illnesses or operations denied. He drinks heavily and smokes a pack of cigarettes daily. On Jan. 14, 1958, he was seen for a routine examination. The blood pressure was 140/90. The electrocardiogram was not noted as having any abnormalities.

On Oct. 15, 1958 he was seen at the request of his union. He was being transferred to a job requiring a physical check-up. The blood pressure was 175/115. Exercise brought out a systolic murmur at the apex. Fig. 2 presents his electrocardiogram. The SGTO (serum transaminase) was reported as 44 units. Serology and the hemogram were entirely within normal limits. The patient was indignant when a temporary stay at home was suggested. He signed

From the Mid-town Medical Group—Harold H. Lefft, M.D., Director.

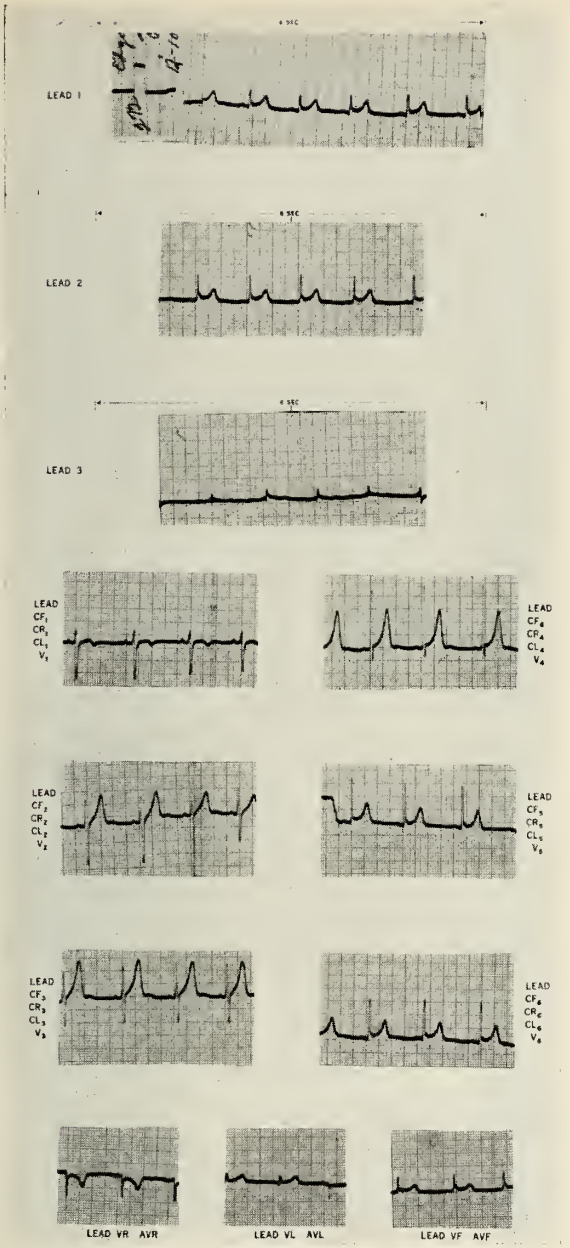


Figure 1

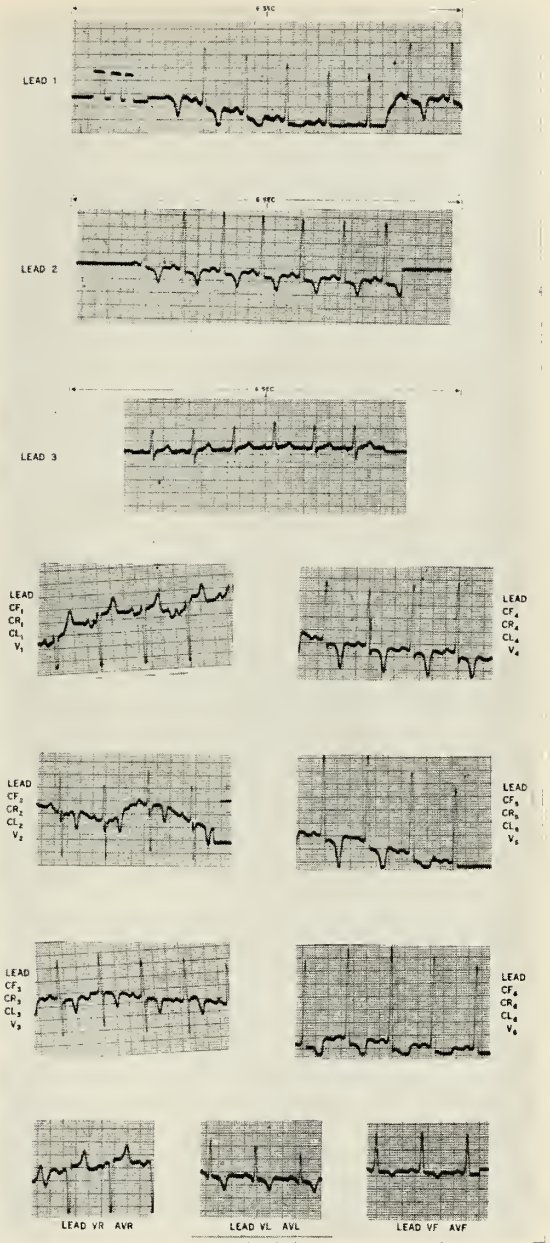


Figure 2

a release and went to see another doctor (A. S. Garlan), who confirmed the above findings.

He continued hard labor. On Nov. 4, 1958, the blood pressure was 145/85. Repeated electrocardiogram was interpreted as further evolution of a fairly recent infarct. He insisted that he felt fine and had no symptoms whatever. A further electrocardiogram was taken on Jan. 12, 1959 which showed accentuation of the T wave inversions. There was a split 2nd sound at the apex with a tendency to gallop; still all symptoms continued to be denied.

On May 11, 1959 patient was again seen in the office.

The electrocardiogram showed no further changes. There was no regression of signs. The individual felt fine and continued working hard.

Case 3. A 35-year-old female, married Negro; never pregnant; always in good health.

The previous week she was being examined for a job requiring heavy physical labor. She was told she had high blood pressure and was advised to see a physician for an examination.

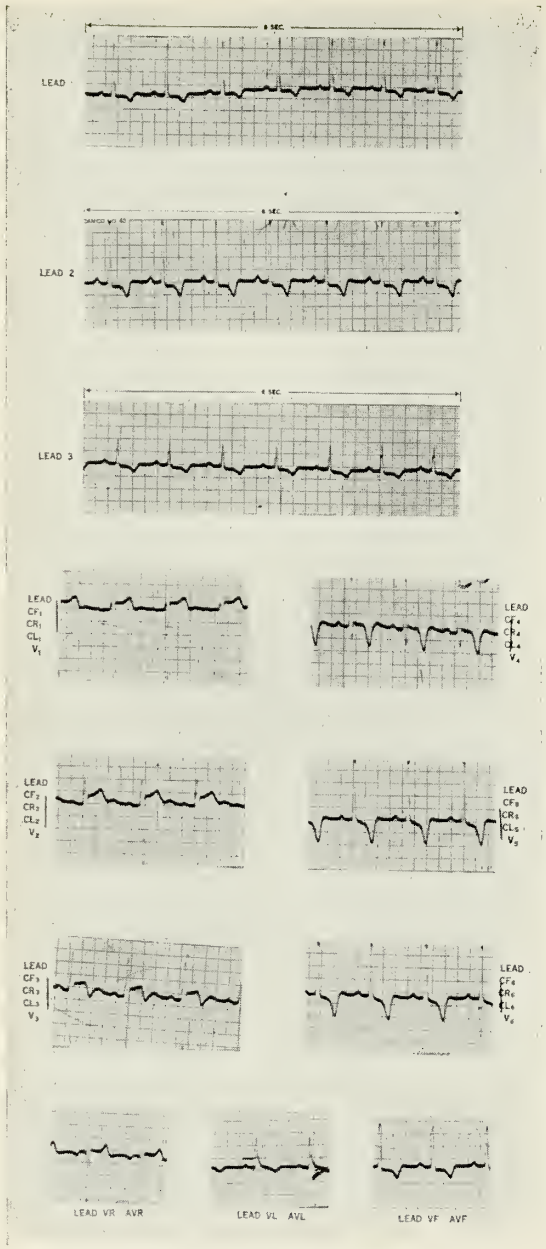


Fig. 3a April 22, 1959

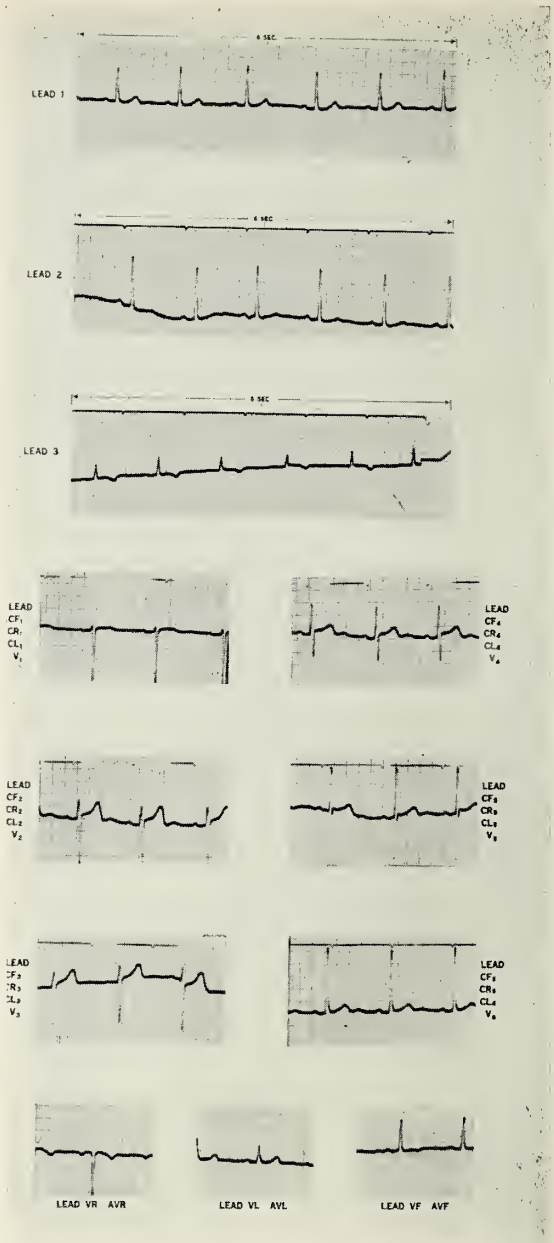


Fig. 3b June 5, 1959

On April 22, 1959 she was examined by one of us (Dr. Birnbaum), who noted a tension of 215/140; no murmurs were heard and the chest x-ray was considered as being normal. An electrocardiogram taken at this time presented a tracing very similar to that shown in our Fig. 2 for Case 2.

The patient was persuaded to enter a hospital for observation. She was put on a Kempner diet and given Serpasil and Hydrodiuril. Within the week her blood pressure came down to normal. Repeated electrocardiograms showed what was diagnosed by ourselves and two consultants as "Anterior Myocardial Infarction . . . recently."

The patient insisted on going home and is doing heavy menial labor as a domestic. She has continued on a modified Kempner diet and is taking 0.25 mg. Serpasil three times daily and Hydrodiuril 50 mg. twice a day. She has continued absolutely asymptomatic. She is very cheerful, bright and an exceptionally alert person.

An EKG taken June 5, 1959 reveals typical evolution of an infarct (Fig. 3, a and b).

Discussion: All 3 cases being presented had

entirely normal thresholds of pain. Ordinary pressure in the supra-orbital notch made them wince; pressure on the styloid process evoked a grimace. They were able to differentiate touch from pin-prick over the entire chest and face. They were of average mentality and appeared to be completely articulate. All the established criteria for silent myocardial infarction appear to have been met.

The detailed review of the literature by Sambhi and Zimmerman[7] implies that truly silent myocardial infarction is an event of extraordinary rarity. However, the fact of our encountering 3 cases within less than 6 months makes it seem more probable that the cases are merely not being recognized. The entity of silent myocardial infarction is not a part of the differential diagnosis and, therefore, is being overlooked. We feel that more cases will be reported after more physicians become aware of the existence of this electrocardiographic diagnosis.

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Hospital Costs Rise

Cost per day in Indiana hospitals increased 5.9% from a $23.13 average in 1957 to $24.49 in 1958. Figures released by Blue Cross-Blue Shield statisticians recently, based on a study of 183,102 hospital admissions, also showed that the length of stay continues to increase, but at a slower pace.

Each year since 1950 this cost has increased nationally from 6 to 8½%, according to an American Hospital Association report.

Cost per day includes the cost of room, meals, nursing and hospital services such as laboratory, x-ray, delivery and operating room, and drugs.

The report points out that the average cost figure is based on all types of admissions in relatively high-cost as well as low-cost areas throughout the state.

Cost per hospital admission was 7.1% higher in 1958 than it was in 1957. The average cost per admission was $189.06 in 1958, and $176.53 in 1957.

Major cost factors included a continued rise in hospital labor costs, and new treatment methods calling for expensive drugs and equipment.

Average length of stay in a hospital increased from 7.6 days in 1957 to 7.7 days in 1958.



The Allergy Clinic at the Methodist Hospital: Our First Year

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GEORGE F. PARKER, M.D.
*JOHN T. HAYNES, M.D.**
*HARVEY MEULBROEK, M.D.**

Indianapolis

IN NOVEMBER, 1957, an allergy clinic for indigent patients was started as a part of the teaching program for interns and residents at the Methodist Hospital, Indianapolis. The enthusiastic acceptance of the program by the house staff, coupled with the better than expected results, was felt to be worth reporting. Several case reports are included to illustrate how simple, persistent, allergic management can change seemingly impossible problems into healthy, grateful patients. The importance of treating only allergic patients with allergic management is also illustrated. The following is a résumé of our experiences to date.

In addition to the clinic, interns and residents are given a series of lectures to cover comprehensively the entire field of allergy from a clinical standpoint. There have also been lectures and laboratory demonstrations for the nursing staff.

Each new patient is seen by one of the house staff. Following a complete history and physical examination the case is reviewed with the attending staff. Routinely a complete blood count, urinalysis, chest x-ray and nasal smears for percentage of eosinophils are done. Any other necessary laboratory work is ordered.

The all-important history is reviewed and additional pertinent questions asked. In this way, the house staff soon learns the importance of a detailed allergic history. They learn to ask whether symptoms are worse indoors or out-of-doors, whether there is any seasonal variation, what room in the house affects the patient most adversely, whether any certain chair causes symptoms, and the effect of smoke, paint, foods, pets, feather pillows, mattress stuffing, infection, cosmetics and weather changes. Although as each resident is rotated through the clinic for a 3-month period, he is given an outline to help him obtain an allergic history, we have felt that a running history is much better than check marks on a questionnaire. It does no good if the patient states he is worse at night and sleeps on a regular type mattress unless the physician knows that this mattress contains such potent allergens as cotton linters, house dust, kapok, cattle hair, horse hair and hog hair. Only in this way can the neophyte learn there is more to allergic management than antihistamines for a stuffy nose, and ephedrine, epinephrine and cortisone for asthma.

It is then decided which tests shall be performed on each patient. We have no established routine. Each patient and his or her problem establishes the routine we follow in that given case. Although an occasional positive reaction gives one a clue in a puzzling case, the better the history the fewer the puzzles.

Treatment can be divided into three categories:

I. AVOIDANCE
II. HYPOSENSITIZATION
III. SYMPOMATIC CARE

I. AVOIDANCE: Probably in no other ill-

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ness is the knowledge of the disease by the patient and his cooperation as important as in the allergic individual. It does no good to treat a patient with an extract of house dust and ragweed if he sleeps with a cat and is sensitive to cat dander. No matter what is done for the asthmatic, if he smokes, the battle is already half lost. The housewife who is dust-sensitive indeed has a problem. Treatment with a dust extract will help but can be compared to a bullet-proof vest. The vest will stop a 38-caliber bullet but not a cannon ball.

Explicit instructions are given each patient as to avoidance of offenders. In private practice, we often visit the homes of patients to check on those who do not do well. This is almost always rewarding. In our clinical patients, this type of follow-through is not done. Yet, it is amazing how well these patients have done, as will be outlined below.

II. HYPOSENSITIZATION: This term and desensitization have often been used interchangeably. Patients are seldom, if ever, desensitized. It is more correct to say they are in balance and thus clinically asymptomatic. Even the well-controlled ragweed patient still has a positive skin test and is likely to have symptoms in a heavy wind or if he drives through the countryside with open car windows. We feel that hyposensitization is a more correct term.

In general, treatment consists of starting with a small dose of extract and increasing the strength at weekly intervals up to an arbitrary maximum which we have placed at 6,000 Protein Nitrogen Units. Many cannot tolerate this dose. Their maximum dose is considered to be the dose above which reactions would develop. It is common practice to go to as much as 4 times the 6,000 Protein Nitrogen Unit dose in those who do not do well. A compilation of our results is given below.

III. SYMPTOMATIC CARE: Symptomatic care has consisted of antihistamines, theophylline preparations, ephedrine, iodides and various ointments. To date, we have no patients who require maintenance steroids. Two of our patients had been on maintenance steroids and are now doing well without them.

STATISTICAL DATA: In the past year, the clinic has seen 58 patients, an average of better than one new patient each week. Of these patients:

1. Thirty-four (34) are active and return to the clinic regularly for hyposensitization.
2. Thirteen (13) are inactive.
3. Six (6) are not allergic individuals.
4. Three (3) cases had contact dermatitis.
5. Two (2) were cases of pityriasis rosea.

The clinic has deliberately been kept small. It is felt that not seeing too many patients allows time for discussion and review. In this way, the clinic is a true teaching tool and the patients are afforded excellent care.

Of the patients seen:

1. Twenty-nine (29) had asthma only.
2. Eleven (11) had allergic rhinitis only.
3. Eight (8) had allergic rhinitis and asthma.
4. Two (2) had atopic dermatitis.
5. Two (2) had urticaria.
6. Four (4) had contact dermatitis.
7. Six (6) patients were non-allergic problems.

Treatment with allergens:

1. Thirty-nine (39) patients were treated with house dust.
2. Twenty-eight (28) patients were treated with ragweed.
3. Twenty-one (21) patients were treated with grasses.
4. Twenty-five (25) patients were treated with molds.
5. Four (4) patients were treated with tree pollens.
6. Seventeen (17) patients were treated with vaccine.
7. Four (4) patients were treated with grain mill dust.
8. One (1) patient was treated with tobacco smoke.
9. Five (5) patients were treated with avoidance and diet only.

CONSTITUTIONAL REACTIONS: We have had many minor constitutional reactions consisting mainly of sneezing and slight cough. We have one patient, a nurse, who develops laryngeal edema from overdose or when the interval between injections is greater than weekly. This has been of mild degree and easily controlled by epinephrine.

One patient developed a severe constitutional reaction from intradermal skin testing and required intravenous hydrocortisone for relief. It has been our policy to apply only 5 or 6 intradermal tests at a time. If the patient's reaction is not severe, then more are done in 30 minutes. If reactions are markedly positive, the patient is asked to return for further testing. In this patient, 30 tests had been applied and this rule had not been followed. A valuable lesson was learned by all concerned in this harrowing experience.

RESULTS OF TREATMENT: All records for the year were reviewed by the attending staff and the house staff. In addition, each patient was given a form to complete stating his or her opinion of improvement or lack of improvement. The two charts below are a compilation of these results:

I

OPINION OF STAFF

% Improvement	Number of Patients
Excellent 100%	12 patients
Good 75-100%	16 patients
Fair 50-75%	3 patients
Poor 0-50%	2 patients

II

OPINION OF PATIENTS

% Improvement	Number of Patients
Excellent 100%	24 patients
Good 75-100%	4 patients
Fair 50-75%	3 patients
Poor 0-50%	2 patients

Case Reports

CASE #1. A 39-year-old colored female was first seen in November of 1957. She gave a history of perennial asthma of 20 years' duration, which was worse in the late fall and during damp weather. She had had no previous therapy other than symptomatic relief. Intradermal skin testing revealed positive reactions to house dust, grain mill dust, feathers, mohair, cottonseed, kapok and many molds. There was a slight positive reaction to ragweed. Treatment was started with an extract of house dust and a mold mixture. The patient was advised as to the avoidance of dust, feathers and other household allergens. Under this regimen, she did exceedingly well and had no asthma until the ragweed season of 1958. Ragweed extract has been added to her treatment and she has had no asthma since the end of the ragweed season.

This case illustrated several points. First, this patient could have been spared 20 years of morbidity if proper allergic management had been instituted at the time of onset. Second, a review of her history revealed that there was an exacerbation of her asthma during the fall of each year. With this pertinent fact in mind, it would have been wiser to retest her with a stronger ragweed extract, and if necessary do sniff testing to ascertain ragweed sensitivity. The importance of a pertinent history and a follow-through is thus demonstrated.

CASE #2. A 30-year-old white male was first seen in October of 1958. He gave a history of perennial asthma of 4 years' duration with exacerbations during the ragweed season, and with upper respiratory infection. He smoked 2 packages of cigarettes daily. Physical examination at that time revealed severe bronchial asthma. Intradermal testing revealed positive reactions to house dust, feathers, mohair, wool, cattle hair, kapok, ragweed, plantain and many molds. He was advised as to the avoidance of dust, feathers, and other household allergens, and told to give up smoking. He was treated with an extract of house dust, bacterial vaccine, plantain, ragweed and a mold mixture. He quit smoking. Under this regimen, except for a mild asthma of several days' duration following an upper respiratory infection, there has been no asthma for over 9 months.

This case illustrates the importance of non-

allergenic factors in the control of allergic disease. In this patient both infections and the irritation from tobacco smoke acted as trigger mechanisms. Since quitting his cigarettes there has been no nonseasonal asthma except as described above with an upper respiratory infection. He has required no symptomatic medication.

CASE #3. A 59-year-old white female was seen in June of 1958 with a dermatitis on both hands with a glove distribution which she had had for 22 years. Her treatment has consisted of a myriad of ointments and dietary restrictions. She had been patch tested in the past with cosmetics and household contactants with negative results. In view of the typical glove distribution, and the history of negative patch tests, it was felt that her dermatitis was iatrogenic in origin. All medication was discontinued with the exception of olive oil locally for lubrication and the wearing of white cotton gloves. Under this regimen her skin cleared completely for the first time in 22 years.

No further discussion on this case is necessary.

CASE #4. A 19-month-old white male child was first seen at the clinic on Jan. 8, 1958. He had a history of wheezing since the first month of life with no cause-and-effect relationship. There were numerous stuffed animals in the house and a pet dog. Both parents suffer from asthma. Scratch testing to common inhalent allergens and common foods were negative with the exception of a 2 plus reaction to milk. The child was placed on a milk-free diet and was asked to return in one month for reevaluation. During the month there was no change in his asthma, but the family reported that he had passed several round worms. He was placed on Piperazine and passed over 50 round worms by actual count. Following his therapy for ascariasis, he had no more asthma. Because of frequent upper respiratory infections he has been placed on a catarrhalis vaccine which seems to have given him good relief.

"All that wheezes is not asthma." Although this patient's parents are both allergic individuals, his positive reaction to milk is probably not significant at this time. It may indicate a future clinical sensitivity. It is felt that his wheezing was due to his infestation.

Summary and Conclusions

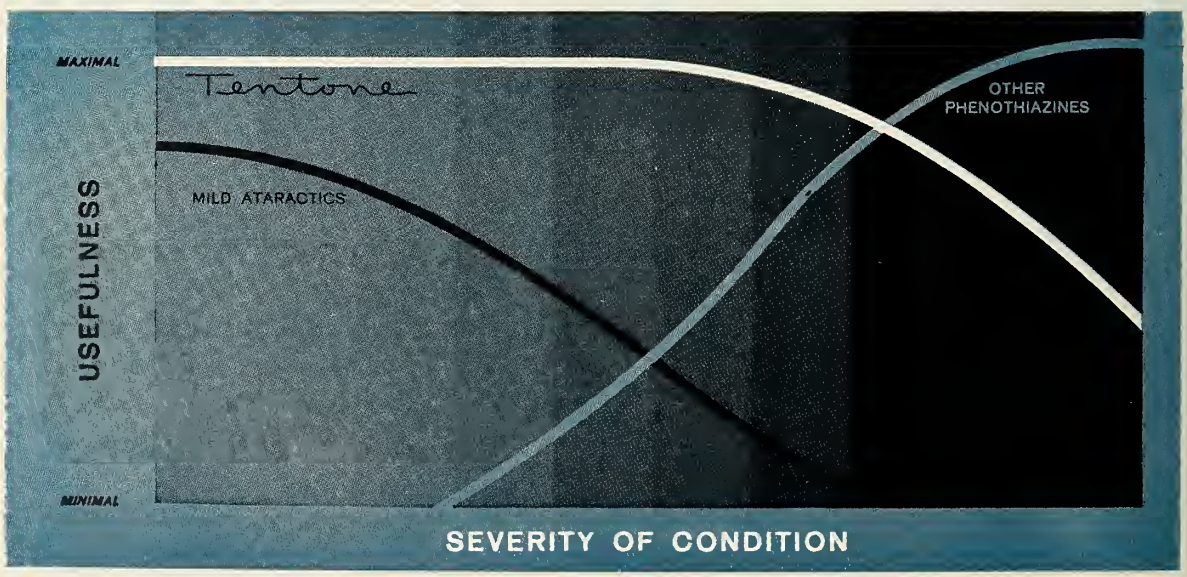
The results of the first year of operation of the allergy clinic at the Methodist Hospital are herein recorded. The improvement obtained by our patients speaks for itself.

From the standpoint of intern-resident training, much has been learned. The clinic has been an invaluable teaching tool. It has demonstrated to interns, residents and nurses what can be accomplished by proper allergic management. They have learned that to treat allergic disease only symptomatically is no different than treating the chronic cough of tuberculosis or lung cancer with codeine and nothing more. A knowledge of what can be accomplished with proper allergic management would do much for the new graduate.

It is also felt that undergraduate medical education in allergic disease is by and large inadequate. Many come with preconceived ideas of a tremendous emotional element in allergic disease. It is so easy to explain away the problems we do not understand on an emotional basis. Of all the patients we have seen, in only one was there a strong emotional component. Here, it was the asthma which presented the emotional problem, not vice versa. One may argue that due to our intense interest in a job well done, we have given the patients a great deal of support. This is indeed true, but is not this a part of all branches of medicine? Although apparently emotional factors may act as one of many trigger mechanisms in one who already has allergic disease, this is by far the exceptional case. We feel that the emotional elements are most often a result rather than a cause of the disease. ◄

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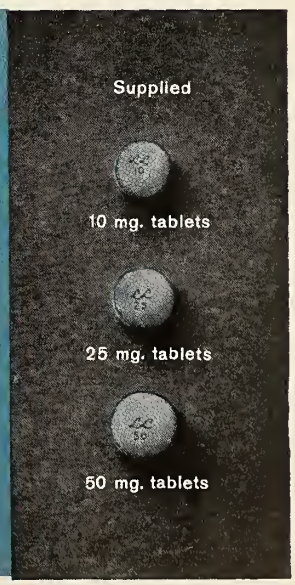
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Lederle



Clinical Evaluation of A New Muscle Relaxant (Chlormethazanone*)

S. EVANS GANZ, M.D.

New York, N. Y.

PHARMACOLOGICAL studies on animals[1-3] and clinical use in patients[4,5] have shown that although chemically different, the action of chlormethazanone is similar to that of meprobamate in relaxing skeletal muscles and relieving symptoms of anxiety and tension states. Although neither the exact mechanism of action nor its site could be determined from the animal studies, the pharmacological profile suggests that chlormethazanone has a spinal cord depressant action similar to that of meprobamate, zoxazolamine and mephenesin. In comparison studies chlormethazanone was more active than meprobamate in these tests of central nervous system activity in various species of animals, such as inhibition of the crossed extensor reflex in spinal cats but no effect on the monosynaptic knee jerk reflex; intensification of the depressant action of both pentobarbital and ethyl alcohol in mice; slowing and spindling of the EEG, and blocking of "EEG arousal" in unanesthetized rabbits. No major peripheral actions were noted in rats after administration of chlormethazanone; and there was no significant effect on either smooth muscle or on the autonomic nervous system. Clinical trials have shown chlormethazanone to be an effective skeletal muscle relaxant and tranquilizing agent.

This study was conducted in a busy office practice and all patients were treated on an ambulatory basis. The patients with clinical symptoms considered to be amenable to chlormethazanone therapy[4-10] were chosen for study. These were grouped into four categories according to diagnosis: torticollis, globus hystericus, bronchial asthma, and apprehensive or tension states as shown in Table 1.

Response was graded as follows: (1) excellent in those whose symptoms were completely relieved, (2) good in those with almost complete relief, (3) fair in those with noticeable but limited relief, and (4) poor in those with minimal or no relief.

Torticollis

A group of 29 patients suffering from torticollis were treated with chlormethazanone. There was spasm of the superficial and deep muscles of the neck, especially the sternocleidomastoid, trapezius and splenius group. The head was rotated to the opposite side as a result of contraction of the muscles. None of the cases herein mentioned was associated with any cervical spine pathology; however, there was probably some degree of psychogenic overlay in all. The main symptom was pain along the course of the sternocleidomastoid muscle. There were 10 patients who were considerably improved within a week of treatment with 100 mg. of chlormethazanone 3 times daily and an additional 10 who obtained very effective relief in one week to 10 days on a dose of 50 or 100 mg. 3 times daily. Fair relief was noted in 5 patients after 2 weeks of treatment with 100 mg. 3 times daily; whereas, there was no demonstrable relief in the other 4 patients. The patients helped by the drug were able to carry the head in the normal position without pain. There were no side effects noted in any of the 29 individuals in this group.

Globus Hystericus

Globus hystericus is a condition frequently associated with a psychoneurotic background.

* TRANCOPAL, brand of chlormethazanone (Win 4692), Winthrop Laboratories.

Table 1

Clinical Response to Chlormethazanone in 219 Patients with Disorders of Varied Etiology

Diagnosis	No. of Pts.	Results				Side Effects		
		Excellent	Good	Fair	Poor	Drowsiness	Nausea	Headache
Torticollis	29	10	10	5	4	0	0	0
Globus hystericus	35	14	18	1	2	5	2	1
Bronchial asthma	55	27	23	0	5	5	7	1
Apprehensive or tension states	100	61	39	0	0	10	6	3
TOTALS	219	112	90	6	11		40	
	100%	51%	41%	3%	5%		18%	

Symptoms are characteristically those of a lump in the throat, and difficulty in swallowing. The patients are apprehensive, and frequently they have a fear of cancer of the throat, although examination reveals no pathology.

Two typical case histories are presented:

A 36-year-old married female, mother of 3 children, complained of a lump in the throat, with difficulty in swallowing and frequent episodes of hoarseness for the preceding year. The patient had had several courses of antibiotic therapy with no relief of symptoms. X-ray of sinuses and nasopharynx revealed no pathology. The basal metabolic rate was within normal limits. Blood count was normal. A smear and culture from the throat were not contributory. Examination of nose and throat revealed no abnormality. Chlormethazanone therapy was initiated with 100 mg. 3 times daily for 3 weeks, at which time the patient reported considerable improvement. There were 2 recurrences of symptoms in the ensuing 3 months, both of which were controlled by 2 days of treatment.

A 46-year-old married male attributed his sore throat, pain and difficulty in swallowing, to the procedure involved in removing a fish bone from his pharynx 6 months previously. Barium esophagram was negative. Smear and sensitivity studies revealed hemolytic staphylococcus with sensitivity to chloramphenicol and tetracycline, but courses of each drug were to no avail. Examination of throat revealed a scarred pharynx due to a previous tonsillectomy, but otherwise it was not remarkable. Treatment with chlormethazanone (300 mg. daily) for one week relieved the patient of his symptoms.

In all, 35 patients with globus hystericus were treated. The dosage was 100 mg. of chlormethazanone 3 times each day, reduced to 50 mg. 3 times daily at the end of 5 days in 8 patients who no longer complained of this condition. The total length of treatment varied from one week to one month. Good to excellent relief was obtained by 32 patients, fair relief by 1, and a poor response in 2. The tranquilizing effect of chlormethazanone was especially significant in this series of patients in whom the source of difficulty was primarily of a psychogenic nature.

Bronchial Asthma

Patients with bronchial asthma, either allergic or postinfectious in origin, were included in this series if they had recurrent paroxysms of dyspnea. All of 15 patients treated with 100 mg. of chlormethazanone 3 times daily for 5 days to 2 weeks stated that they were able to breathe freely and rarely required the use of antiasthmatic drugs since commencing therapy. These patients had been taking Isuprel®-Franol® prior to their use of chlormethazanone. Another 12 patients obtained excellent relief from their bronchial asthma on a dosage schedule of 100 mg. 4 times daily for one month. An additional 15 cases of mild bronchial asthma obtained relief of their asthmatic attacks with the following regimen: 100 mg. of chlormethazanone 3 times daily for the first 2 weeks, then dosage was reduced to 2 times daily for one week and finally 100 mg. a day for one week. These 15 patients received no other drug while taking chlormethazanone. Before starting therapy this group had experienced asthmatic attacks on the average of twice weekly. Of the remainder of this series of 55 patients with bronchial asthma, 8 obtained

considerable relief from therapy and in 5 there was no demonstrable relief.

The reason for the efficacy of this drug in asthmatic patients has not been determined. But its central relaxant effect may decrease the reaction to such secondary factors as emotional distress, excitement or exertion which often precipitate asthmatic attacks in susceptible individuals. Chlormethazanone would also relieve the muscle soreness in the lower chest wall which may result from violent respiratory efforts during an attack of asthma.

Apprehensive States

The fourth category of 100 patients included those suffering from apprehensive or tension states. There were 68 patients in whom apprehension, associated with vague somatic complaints, preceded various operative procedures. The remaining 32 patients were characterized by an anxiety or tension state which was accompanied with a multiplicity of complaints. This entire series was treated with a dosage of 100 mg. 3 times daily for periods varying in length from one to 4 weeks with good to very effective results in all cases in lessening the apprehension, tension and amount of complaining. From the above observations it is apparent that clormethazanone is excellent as a tranquilizer in patients of this type.

The side effects noted in this series of 219 patients were so minor in nature that it was unnecessary to discontinue therapy in any patient. The incidence in descending order of occurrence was drowsiness (20), nausea (15), and headache (5), as shown in Table 1.

Summary and Conclusions

The effect of therapy with chlormethazanone was studied in 219 patients suffering from muscle spasm, globus hystericus, bronchial asthma, and apprehensive or tension states. Good to excellent results were obtained in 202 (92%) individuals on a dosage schedule of 1 to 3 caplets (100 to 300 mg.) daily with only minor side effects occurring from treatment. Chlormethazanone, by relieving the psychogenic symptoms, allows the patient to use his energies in a more productive manner in overcoming his basic problems. Aside from the good results as a skeletal muscle relaxant, our general impression is that Trancopal is a most valuable drug for relieving tension, apprehension and various psychogenic states. Because of the high degree of satisfactory results obtained in this study, it is our belief that Trancopal merits continued and more extensive study in similar and related clinical disorders.

155 East 72nd St.

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The Journal

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VOLUNTARY HEALTH INSURANCE

More people in the United States are covered by voluntary health insurance than ever before and the number is still increasing year by year. All clasifications of people and all types of insurance are on the increase, but surgical and medical costs in hospital, and the people over 65 years of age are showing the greatest gains. Private companies are insuring more people now than do Blue Cross-Blue Shield.

The number of families with at least one insured person has risen from 63% in 1953 to 69% in 1958. There is evidence that this may be raised further, since in 5 of the most densely populated states 85% of the families have some coverage.

Population groups with the lowest coverage include farmers, people with low incomes, those with little education and those in the South. The greatest gains in recent years have been in the middle-income category. Many of those not insured are self-employed. This suggests that increases may be expected with a heightened public education program.

The most significant news is that persons over 65 years in age have increased their health insurance at a phenomenal rate. Almost 40% more such individuals are covered now than was the case 5 years ago. Health insurance coverage is gaining in this group much faster than the group is gaining in numbers.

As is pointed out by the Health Information Foundation when these new figures were released, not everyone has need for health insurance. Members of the armed forces, some of their dependents, those on relief and some of the veterans are cared for by other means. However, the extension of coverage to more and more of the elderly members of the population and

the increased protection of low-income families offers a challenge.

Tabulation of insured persons by age group shows that the bracket between 18 and 24 is not as well protected numerically as the younger groups or as any of the older groups up to 64 years of age. This is, no doubt, due to the fact that the younger members of families do not take out individual policies often enough when they are dropped from the family policy because of age.

A public education program directed to the age groups 18-24 and over 65, to the low income segment of the population and to rural dwellers would do much to increase medical insurance protection.

GOVERNOR'S PROCLAMATION

WHEREAS, A shocking toll in human lives, personal injuries and property damage is sacrificed annually on Indiana streets and highways, and

WHEREAS, About six billion miles of heavy travel during the summer period of vacations and holidays will greatly multiply the occasions of traffic accidents, and

WHEREAS, Under similar conditions during the same period last year, 264 Hoosiers and visitors were killed in spite of progressive engineering, educational and enforcement improvements, and

WHEREAS, Excessive, unwarranted and unwise speed of motorists is the predominant cause of fatalities and severity, and

WHEREAS, Indiana is allied with all of the other several states, the Canadian Provinces, the Commonwealth of Puerto Rico and the District of Columbia in pledging unlimited use of all safety resources in a special summer crusade designed as "SLOW DOWN AND LIVE."

NOW, THEREFORE, I, Harold W. Handley, Governor of the State of Indiana, do hereby proclaim the dangerous season from Memorial Day to Labor Day as a "Slow Down and Live" Period in the State of Indiana, and do strongly appeal to all persons in all communities to drive cautiously and prudently, recognizing that excessive speed is a contributing factor in all traffic mishaps, and, moreover, urge all Hoosiers to observe all traffic laws and rules of courtesy pertaining to motorist and pedestrian safety during this specified high-incident season of motoring hazards.

AMERICAN MEDICAL EDUCATION FOUNDATION

AMEF at the end of April reports that contributions are 26% ahead of last year. Not only is the financial total significantly up, but the number of contributors for 1959 is 70% more than for the same period in 1958.

Letters are now being received from the medical schools acknowledging the latest grants distributed from the foundation. Almost all these letters comment on the high degree of usefulness of the totally unrestricted funds. One of the schools reported that "One of the significant features of Foundation money is the fact that it is unrestricted . . . we can place this support most effectively to strengthen the medical school teaching program at our school."

Another school comments that "money from this source is completely unrestricted and thus may be used in the area of greatest need, and an area that changes from year to year and from school to school."

When AMEF was organized it was realized that the 85 medical schools of the nation, caught in a vise as it were of rising costs and diminishing income, would benefit most from money without strings attached. While the financial difficulties of the schools tend to be similar, they are not the same in every situation and the wisdom of this type of grant is proving itself with the growth of the fund.

Most of the schools are utilizing the money for several purposes. 89% report that all or part of the AMEF grants are being used for salaries; 41% of the schools used a part to purchase equipment. Some have been able to match funds from other grants and thus obtain financial aid which otherwise would have been unavailable.

Physicians who are interested in medical education and its continuation on a high plane without outside controls will be pleased with the following excerpts from deans' letters:

"Without the help of these grants, we would not be able to retain many members of the clinical faculty, and to maintain the standards which we all desire."

"There is no doubt that the availability of the AMEF grant has in several instances enabled us to take care of emergency situations in attracting or retaining key faculty personnel."

"Every major basic science department has benefited from the fund."

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President's Page

As a physician specializing in radiology and because of the increased concern of the public about radiation hazard, I feel it is my duty to devote this message to radiation. All physicians should be informed so that they do not omit necessary examinations for proper diagnosis, nor that they unduly expose their patients either by grossly unnecessary examinations or by examinations done with equipment which has not been properly tested to reduce the exposure to a minimum which will permit an adequate roentgenogram. Radiation effects may be classified into two groups, namely somatic and genetic.

The somatic effect has to do with changes in the tissues receiving the radiation and this effect has only to do with the patient exposed. The somatic effect usually involves either the bone marrow or the soft tissue areas of the body.

The bone marrow changes may produce blood dyscrasia, malignant bone tumors or disturb bone growth. The soft tissue changes may result in thyroid carcinoma in children and skin cancers and cancer of the soft tissue areas which have been exposed to relatively high doses of radiation as given in therapy doses. Nearly all of the malignant changes, including leukemia, have resulted from radiation therapy except where the fetus might have been exposed to radiations from pelvimentry examinations or other diagnostic studies of the pelvic area. There has been no direct proof of radiation being the cause of these malignant changes, but the evidence is of such a high degree of suspicion, one cannot ignore the fact that this is probably true in some, but not all instances. A recent report of a number of children receiving therapy doses of radiation that have been followed over a number of years demonstrated no malignancy developing in any of their patients. A recent report of a three-generation follow-up of children of mothers who received stimulating doses of radiation to the ovaries has revealed no instance of malignant changes in the offspring up to this time. Neither of these two reports, however, prove that radiation changes and malignant degeneration may not occur. It has been reported that radiologists, orthopedists, and urologists and dermatologists have had their length of lives reduced depending upon the radiation doses which had been received over their lifetime. Radiologists receiving the largest doses lived the shortest period of time.

The genetic effect of radiation in humans is more difficult to prove, but it has been demonstrated in lower forms of animal life. The discovery of radiation genetic effects on the fruit fly won a Nobel prize for Doctor Mueller of Indiana University. One can make an educated estimate of the calculable damages to the genes of humans by the work of Doctor Mueller and others on the lower forms of life and by the number and type of congenital defects in humans exposed to various amounts of radiation. Heating of the testicles by wearing of too tight underwear and pants may produce genetic changes and many other environmental factors may produce genetic change. I point this out to try to show that just because a patient or parent received radiation that it is not necessarily the cause of the somatic or genetic change. Radiation is one of the minor causes of congenital defects. The gene that is severely damaged by radiation dies and ends its effect. It is the very slightly damaged gene

that may take many generations to produce changes in offspring that is the most damaging and is the most difficult to predict as to its danger. We must assume that danger to future generations exists and it is our duty to protect mankind. There is a certain amount of calculable risk to health and life in nearly everything we do, particularly in the use of the automobile, but I am sure we will not give up use of our cars. The danger of somatic and genetic effects from judicious use of diagnostic x-ray properly used is negligible. In people up to 30 years of age, somatic and genetic effects are both involved, but after 30 years of age the change in the tissues receiving x-rays is the main concern, for most of the patients have had their children before thirty years of age. In diagnostic x-ray the dose of properly protected and filtered rays is so small that there is practically no danger, especially to people over 30 years of age and in non-pregnant women. However, a doctor should not hesitate to order a properly done pelvimentry examination when needed, for the danger of losing the mother's or baby's life may be much greater than the radiation hazard. The risk of loss of life or prolonged illness may be increased by neglecting to have an x-ray examination and it is true that many people are now living that would have died without x-ray examination. The current excellent status of the health of people is due, in a large part, to x-ray examination over the years. A knowledge of pathology and physiology of medicine has been enhanced immeasurably by and since the discovery of x-ray. In order for us physicians to be above criticism I believe every x-ray unit in the state of Indiana, including those used by dentists, should be checked by a qualified physicist. I hope every doctor and dentist who has such equipment will give serious consideration to this proposal. The I.S.M.A. supported a radiation control bill which passed the last legislature and is now the law. The Vanderburgh County Medical Society has passed a resolution that all x-ray equipment in that county should be monitored by a qualified physicist and all the physicians in the county owning x-ray equipment have had this check done. The dentists have also cooperated in this program. This would be an admirable goal for all of the county societies and their members of the state of Indiana. Vanderbugh County is to be congratulated on this fine achievement.

Kenneth L. Olson M.D.

Acceptance Speech of the Auxiliary President

MRS. J. M. BLACK

Seymour

(Following is the speech given by Mrs. J. M. Black, Seymour, when she accepted the gavel, symbol of the presidency of the Woman's Auxiliary, from outgoing president, Mrs. Earl Bailey.)

Thank you, Mildred, for your advice and help this past year. I speak for the entire membership in thanking you for your able leadership of our Woman's Auxiliary. Now, as I accept this gavel, I realize that "A Task Worth Doing, And Friends Worth Having, Make Life Worth Living." This saying, which I read on one of our church bulletins, seems to help explain why we work so hard for our auxiliary. We are all *so* privileged to have such a wonderful group. What task could be more worth doing than that of helping our busy husbands? Their life of dedication and devotion might be made a bit easier if we all pitch in and do our part.



Sometimes the phone is a bit too insistent, patients are too demanding, our dinners are too cold and then a letter from a grateful and prayerful patient comes and makes us realize that working hard at our task has some meaning. If we can give a little more to A.M.E.F., and help a little more with recruitment, we might help someone else realize this full life. I would like for each county to show the film "Helping Hands for Julie" to their prospective members. What mother wouldn't work a little harder at the task of safety, if she could but realize she might be helping her own child? Civil Defense—prepare yourself for small casualties at home or large disasters in your community.

At this crucial time in medicine and with so many bills affecting us in legislation, we must all keep informed about our elected officials in both the state and the nation. Work during the elections, get acquainted with our senators and representatives, and write and talk to them when necessary. Understand the doctor's plan of insurance. This job is a challenge to us all. Public relations is a vital part of our auxiliary, for if we are well informed, we can help keep medicine as it should be.

Friends Worth Having—how fortunate we are to be able to associate with so many wonderful people with the same problems and ideals. Our *Hoosier Doctor's Wife* is one way for us to chat with each other. Please send in all your news. We learn a lot from all our publications. See that your friends read our *Today's Health.*

I have made many friends through the auxiliary that I shall cherish the rest of my life. For this opportunity, I say thank you from the bottom of my heart. In the coming year, I hope to make more friends—please invite me to your meetings.

If you will help us get more members and urge our present ones to attend our meetings, we can build a stronger, friendlier auxiliary for our doctors. Let's all try to achieve 100% membership in our auxiliary, as our most valuable asset is the individual member.

I know I shall make mistakes. Please tell me and help me. I will do my best. I am very humble as I start this year and count my blessings for my wonderful helpmates. When Joe and I were married, we adopted this as our song, "I'll Get By As Long As I Have You." This I feel again. I know we will have a good year if we will all help each other. Thank you.

PROGRAM

110th Annual ISMA Convention at Murat Temple Indianapolis

October 6, 7, 8 and 9, 1959

(All events on Eastern Standard Time)

Monday, October 5

12 noon Executive Committee meeting, Parlor 1, fourth floor, Columbia Club.

3:00 p.m. Council meeting, Harrison Room, fourth floor, Columbia Club.

Tuesday, October 6

9:00 a.m. Meeting of House of Delegates, Murat Temple.

12 noon Editorial Board luncheon meeting, Directors' Room, Athenaeum.

2:00 p.m. Reference Committee meeting, Basement Dining Room, Murat Temple.

4:00 p.m. Symposium on Blue Shield, Candidates Room, Murat Temple.

6:00 p.m. Buffet supper, smoker and stag party, Dining Room, Murat Temple.

Wednesday, October 7

8:00 to 9:30 a.m. Instructional courses, Murat Temple.

9:30 a.m. *GENERAL MEETING,* Murat Theater.

"Cancer of the Breast,"
GEORGE CRILE, JR., M.D., Cleveland.

"Postoperative X-ray Radiation for Cancer of the Breast,"
JOHN W. BEELER, M.D., Indianapolis.

"The Role of Cobalt Bomb in Cancer of the Breast,"
JAMES C. KATTERJOHN, M.D., Indianapolis.

"Hypophysectomy for Metastatic Carcinoma of the Breast,"
BRONSON S. RAY, M.D., New York.

10:30 a.m. View Exhibits.

11:00 a.m. Panel discussion, led by speakers of the morning session.

12 noon SECTION ON SURGERY luncheon meeting, Kellersaal, Athenaeum.
Speaker: GEORGE CRILE, JR., M.D., Cleveland.
Subject: ————.
Election of Section officers for 1960.

2:00 p.m. *GENERAL MEETING,* Murat Theater.

"Functioning Ovarian Tumors,"
J. DONALD WOODRUFF, M.D., Baltimore.

"Hyperfunctioning Lesions of the Adrenal Glands,"
JAMES T. PRIESTLEY, M.D., Rochester, Minnesota.

"Pituitary Tumors,"
BRONSON S. RAY, M.D., New York.

3:00 p.m. View Exhibits.

3:30 p.m. Panel discussion, led by speakers of the afternoon session.

5:15 p.m. Reception for members of Fifty-Year Club and guests, Parlor A, Indianapolis Athletic Club.

6:15 p.m. President's reception.

7:00 p.m. Annual dinner.

Thursday, October 8

8 to 9:30 a.m. Instructional courses.

9:30 a.m. *GENERAL MEETING,* Murat Theater.

9:30 a.m. *"Ulcerative Colitis,"*
CHARLES W. MAYO, M.D., Rochester, Minnesota.

"The Tired Mother Syndrome,"
LEONARD L. LOVSHIN, M.D., Cleveland.

"Convalescence following Illness and Surgery,"
N. HENRY MOSS, M.D., Philadelphia.

"Modern Treatment of Diabetes,"
GLENN W. IRWIN, M.D., Indianapolis.
"The Steroids,"
ROBERT M. SALESSE, M.D., Rochester, Minnesota.

10:30 a.m. View Exhibits.

11:00 a.m. Panel discussion, led by speakers of the morning session.

12 noon SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE luncheon meeting, ————.
Speaker: RALPH T. HOLMAN, Ph.D., Minneapolis.
Subject: ————.
Election of Section officers for 1960.

12 noon SECTION ON OBSTETRICS AND GYNECOLOGY luncheon meeting, ————, Athenaeum.
Speaker: J. DONALD WOODRUFF, M.D., Baltimore.
Business meeting.
Election of Section officers for 1960.

2:00 p.m. *GENERAL MEETING,* Murat Theater.
"Malignancy of the Rectum and Lower Abdominal Portion of Colon,"
CHARLES W. MAYO, M.D., Rochester, Minnesota.
"The Treatment of Imperforate Anus,"
ARTHUR DEBOER, M.D., Chicago.
"Headache,"
LEONARD L. LOVSHIN, M.D., Cleveland, Ohio.
"The Problems of Emphysema,"
JOHN HICKAM, M.D., Indianapolis.

3:00 p.m. View Exhibits.

3:30 p.m. Panel discussion, led by speakers of the afternoon session.

8:00 p.m. President's night, Murat Theater.

Friday, October 9

9:00 a.m. Final meeting of House of Delegates, Dining Room, basement, Murat Temple.
Meeting of Council and Executive Committee following adjournment of House of Delegates.

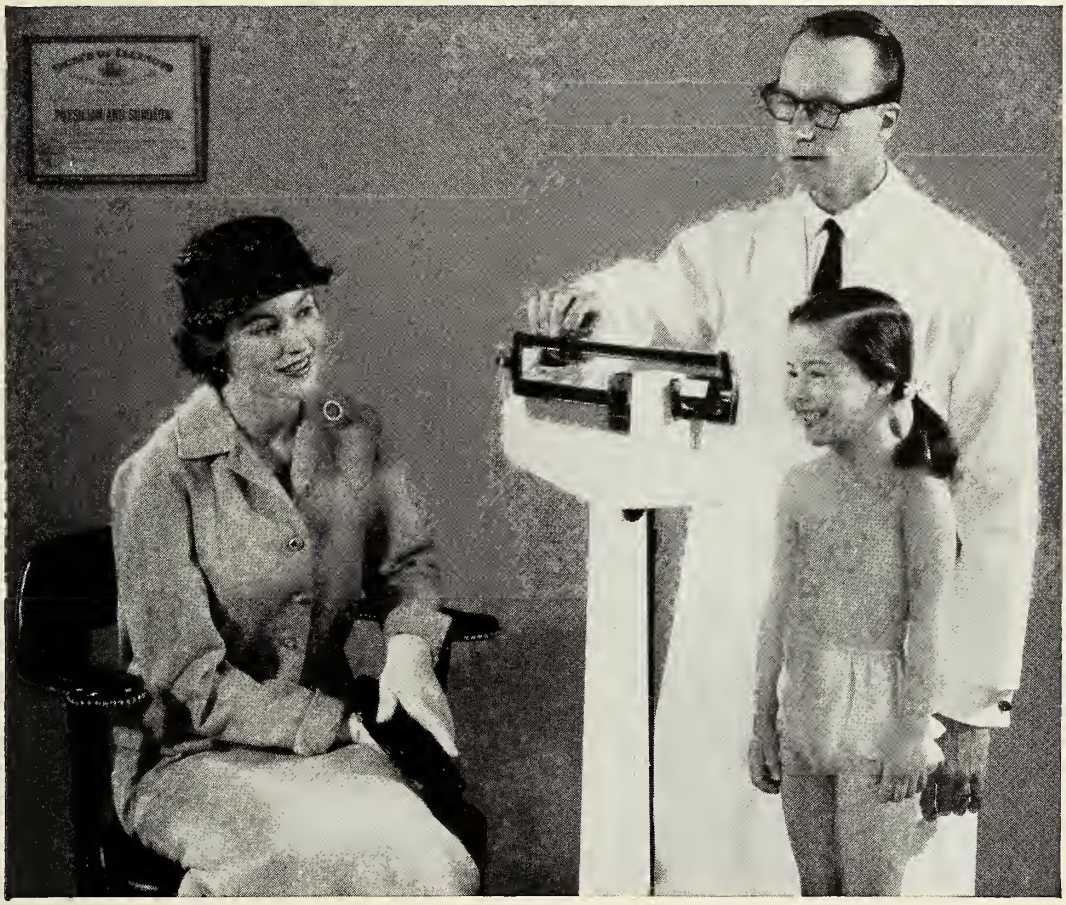
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Annual golf tournament.

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Underweight Children Gain and Retain Weight with Nilevar®

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

What Is the Big Story?

Winners . . . or the Youngsters?

by corki

What would be the most important part of a story about the National Science Fair—1959: winners from Indiana . . . or the yougsters themselves?

This question I asked myself from the time we took off from the Indianapolis runway on an Indiana State Medical Association chartered plane for Hartford, Conn., until the very last award was presented 3 days later.

The kids who won national awards were thrilled, naturally. This had been their goal.

Or had it really been their main goal? Wasn't it more like the remarks made by one winner from another state: "This is wonderful but it isn't what I really was working toward!"

She had already attained a big part of her goal before winning—that of learning and achieving something more lasting, more important than a blue ribbon or $125 worth of equipment.

No, it seems to me there is a far more important story here than who won, where he or she is from, what the exhibit was; a far deeper story, one reaching into the heart of our society.

This story is a headline that should be a banner across every newspaper in the country:

American Teeners are Responsible Citizens!

That headline in itself would be but a small part of the story. These kids are seriously preparing themselves to step into the adult world; but, more than that, the thousands of youngsters who participated in the local science fairs across the nation should each rate his own headline.

If a teenager goes out on the street and commits robbery, murder, destruction, he gets a blaring headline!

If a thousand kids do well, behave, accomplish community improvement, participate in endeavors such as a science fair, there are not a thousand headlines!

So doesn't it stand to reason that newspaper readers—and doesn't this take in just about our whole population—would begin to get the idea that those in the headlines, those so-called "delinquents," are typical of our American youth today?

Thus, we have adults muttering with a cluck, "My, these kids! What will happen to us when they grow up?"

I'll tell you what will happen! Youngsters like the 320 who participated in the 1959 National Science Fair will step in; and, from the looks of them, they'll do better than we're doing if we give them half a chance!

Sitting next to me on the plane over was Christian L. Keuther, 17, of Shortridge high school in Indianapolis. Chris, a winner in the Seventh Central Indiana Regional Science Fair, said that if he had worked 24 hours a day, he guessed he'd have put in a full month on his exhibit. As it was, he dashed home from school each night to work until 2 or 3 a.m. Utilizing weekends, too, he spent a couple of months or better working up his exhibit on "Reproduction of Musical Quality."

I don't pretend to understand electrical engineering or his exhibit. My depth of knowledge stops at whether a hi-fi or stereo set sounds good to me. But this lad has built a few sets of his own.

He's combined his interest in music—he plays in the high school band and with a jazz combo—with his scientific interests and has come up with a good future.

Our one first place winner, Karen Gabbard, 18, of Garfield high school, Terre Haute, worked 1½ years, a total of 600 hours, in her school lab to produce her outstanding exhibit.

I overheard one conversation on the plane that all but shook me up. A young lady, who looked as if she should be giggling at a local soda fountain (by what I might term our national opinion of teenagers), was seriously discussing an operation she had performed on a rat—the removal of the uterus, all the necessary steps, tie-ups, etc., and sewing it back up again. The rat lived, she said, and she was thrilled that this

Continued on page 1155

Six Young Hoosier Scientists Win National Science Fair Awards

Indiana had six winners in the 1959 National Science Fair held May 6-9 at Hartford, Conn. Twenty exhibits were entered in the fair from the Hoosier State.

Earning a first place blue ribbon and $125 "wish" award in the Biological Division was Karen L. Gabbard, 18, of Garfield high school, Terre Haute. Her exhibit was entitled "An Antibiosis Study of Aspergillus Flavus-Oryzae." (See the paper prepared by Miss Gabbard in conjunction with her exhibit reprinted in the *Journal* following this story.)

Miss Gabbard, only winner among the Hoosier girls, also was the only girl to win an Armed Forces award and the first girl to win such an award since they were instituted last year. One of four Army winners, the young lady from Terre Haute received a trip to Walter Reed Institute of Research at Washington, D. C.

David P. Eartly, 17, a senior at Bishop Noll high school, Hammond, was a second place winner with his project, "Methods and Procedures in Electron Microscopy."

Four fourth place winners were: Michael D. McCutcheon, 16, sophomore at New Albany Senior high; David F. Pfendler, 17, senior at West Lafayette high; James A. Tunis, 17, sophomore, Frankfort high; and Stephen M. Sheets, 15, sophomore, Akron high.

National Science Fair, an annual event, is sponsored in cooperation by Science Service and affiliated local science fairs. Local groups, sponsored by newspapers and/or business groups and schools in cooperation with community educators, hold their own fairs and choose winners who go on to regional fairs. Regional winners enter the national judging. Funds are supplied by the local sponsoring groups.

In Indiana, many of the local groups are co-sponsored by county medical societies. The Indiana State Medical Association pays transportation for winners and their teacher-sponsors to attend the national fair.

Next year the National Science Fair will be held in Indianapolis with ISMA a co-sponsor.



KAREN GABBARD of Terre Haute walked off with a blue ribbon in the Biological Division as well as with an Armed Forces Award.

There were 320 exhibits at the Hartford fair representing continental U.S., Alaska, Hawaii, Canada, Puerto Rico, Japan and Army dependent schools in Germany, France and Italy. At least 3 additional foreign countries are expected to enter the 1960 fair with more groups being represented from the U.S.

The agenda consists generally of the youngsters setting up their exhibits (with no help from adults), the judging, educational tours, awards, banquets and two days when exhibits may be viewed by the general public.

Two banquets and a luncheon sparked the Hartford fair. American Medical Association picked up the tab for one banquet and presented awards to outstanding young scientists in the field of medicine.

A luncheon was sponsored by the Armed Forces at the Navy's New London (Conn.) sub-



DAVID EARTLY of Hammond receives his second place ribbon during the huge National Science Fair banquet which was attended by over 900 members of the official fair group. The banquet capped the 3-day fair which had been highlighted by an AMA banquet and a luncheon at the New London Navy submarine base.

marine base when the Navy, Army and Air Force presented special awards.

NSF sponsored the final banquet when official science fair awards were presented.

Tours consisted of local points of special interest to the young scientists such as the sub base, University of Connecticut, Pratt & Whitney Aircraft Division, General Dynamics Corporation, Combustion Engineering Nuclear Division, etc.

Programs for the National Science Fair are handled in most part by a local committee of sponsoring groups and interested citizens and businesses. Science Service sets up criteria with agreement from participating units.

Of the Indiana fourth place winners at Hartford, young Steve Sheets presented an exhibit on "The Effect of Auxins on Plant Tissues"; David Pfendler a project on "Isolation of Hormones in Skunk Cabbage"; James Tunis, "Infra-Red Guidance Design"; and Michael McCutcheon, "Effect of Tobacco Smoke on Hampsters."

Other regional winners from Indiana to attend the National Science Fair at Hartford included: Judy A. Edwards, 17, Columbus senior high; Michael T. Cooper, 17, Central of Evansville; Joseph D. Teaff, 17, St. Romuald high of Hardinsburg, Ky. (representing the Tenth Tri-State Regional fair held at Evansville, Ind.); James A. Delaney, 17, Central Catholic high of Fort Wayne; Thomas R. Stoeckley, 16, North Side of Fort Wayne.

David L. Demske, 17, Saint Joseph of South Bend; Donald E. Cope, William A. Wirt high, Gary; Christian L. Kuether, 17, Shortridge, Indianapolis; David R. Schubert, 15, Thomas Carr Howe high, Indianapolis; William R. Kem, 17, Richmond senior high; Wayne L. Settle, 16, Portland Wayne Township senior high, Portland; Carolyn M. Thomas, 17, Garfield at Terre Haute; John W. Harris, 18, Elston at Michigan City; and Sandra K. Johnson, 15, Liberty Township high, Chesterton. ◄



DR. R. W. LEFLER, assistant professor in physics and education, Purdue, talks to winners (l. to r.) Michael Dennis, James Tunis, Stephen Sheets, David Eartly and David Pfendler prior to take-off for Indiana. Dr. Lefler, for many years, has directed science fair activities in Indiana.

FACTS ABOUT THE NATIONAL SCIENCE FAIR

Over four million people saw more than 450,000 science exhibits made by students and shown at science fairs leading to the National Science Fair in 1958.

The average NSF affiliated fair showed 357 exhibits. The average NSF finalist represented 1,669 exhibitors at the regional and supplementary fairs feeding it. A follow-up study reveals that over 90% of the 14- to 19-year-old finalists actually go on to make science or engineering their career.

The study also reveals that over 10% of the students attaining national honors through their regional or state science fairs already were interested in science before they entered kindergarten.

Home environment was responsible for sparking the first interest for 27% of all of these students. Schools, science clubs and science fairs, encouraged the first interest in 43% of all of the finalists.

The National Science Fair is one of two major annual events conducted by Science Clubs of America, administered by Science Service, the non-profit Institution for the Popularization of Science. The other event is the annual Science Talent Search for the Westinghouse Science Scholarships and Awards. Both are approved by the Committee on National Contests and Activities of the National Association of Secondary-School Principals.

Costs for conducting the regional or state science fairs and the payment of an entry fee to the NSF are covered by the cooperating newspaper and/or the local cooperating groups which also provide for transportation [in the case of Indiana, paid by ISMA], meals and housing of the finalists, accompanying educators, and newsmen. ◄

En Route



A NEWS PHOTOGRAPHER covers the departure of the young scientists and their teacher-sponsors at Weir Cook Airport, Indianapolis.



THROUGH THE PLANE DOOR—the group awaits transportation to their motel after arriving in Hartford, Conn., 4 hours later.



EXCITEMENT OVER, the group prepares to embark for the return trip, looking forward to their first rest in days.

At Breakfast



INDIANA ALWAYS has a big breakfast, sponsored by the Indiana State Medical Association. Here, part of the group partakes of the morning fare.

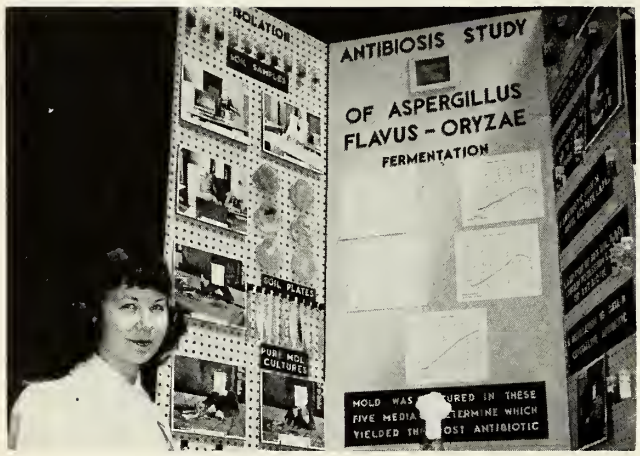


AFTER BREAKFAST the whole group stopped for an informal group shot. All agreed it was a pretty good feed and they were ready for the day's activities.



AT UPPER LEFT table are Dr. Karl Kaufmann (hand on chin), Dr. Harry Pandolfo and Dr. Ralph Eades. Dr. Lefler standing.

—The Winning Exhibits—



FIRST PLACE: Karen Gabbard, 18, Garfield H.S., Terre Haute. Member Science Clubs of America, Y-Teens, GAA biol. science club, yearbook, Jr. Revue. Career: bacteriology.



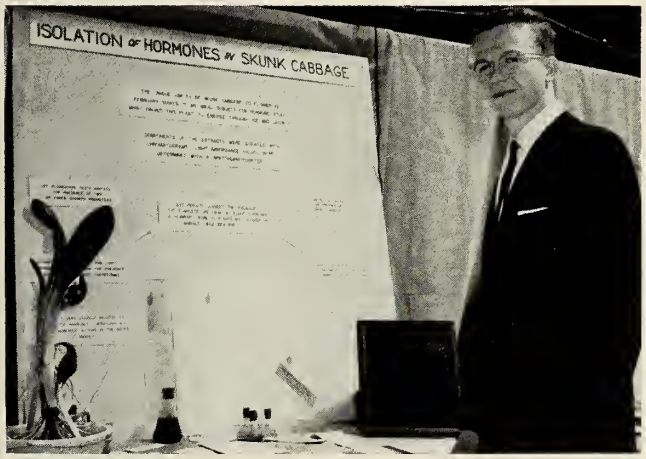
SECOND PLACE: David P. Eartly, 17, Bishop Noll H.S., Hammond. Member SCA, Midwest Society of Electron Microscopists, ham radio club, Astronomy Club. Career: science research.



FOURTH PLACE: Stephen Sheets, 15, Akron H.S. Member Science Club. Participates in electronics, water sports, photography, biology. Career: biology or electronics.



FOURTH PLACE: Michael McCutcheon, 16, New Albany H.S. Member school band, DeMolay. Interested in photography. Career: pathology.



FOURTH PLACE: David F. Pfendler, 17, West Lafayette H.S. Member: football, basketball teams, Jr. class pres., church group pres., science fairs. Career: medical research.



FOURTH PLACE: James Tunis, 17, Frankfort H.S. Member SCA, school clubs, bowling and chess teams, band. Career: engineering.



EXAMINING RIBBONS won by the Hoosier youths is Ralph C. Eades, M.D., Valparaiso, whose interest in the science fairs several years ago was instrumental in active participation by both ISMA and AMA. Dr. Eades follows the fairs every year and aided in getting the fair in Indianapolis next year.



MAJOR GENERAL H. N. Toftoy, commanding general of Aberdeen Proving Grounds, presents the Army award to Indiana's Karen Gabbard at Armed Forces luncheon. Luncheon was held at the U.S. Naval Submarine Base, New London, Conn. (Photo by U.S. Navy)

REPLACING SKUNK CABBAGE. Dave Pfendler woke up early before judging began to find a vital part of his exhibit, a skunk cabbage, had wilted. So he borrowed a shovel, went out along a Hartford creek bank and dug himself a new one! Here he sets it up.



What is the Big Story?

Continued from page 1146

was so. The words sounded much like various disserations I've heard from medical doctors or teachers of anatomy.

The youngster in question was Carolyn M. Thomas, 17, also of Garfield high school, Terre Haute. Her exhibit: "Embryology of Rats."

When I came back from Hartford and was telling some friends about these kids, I had the distinct impression they felt that these were the unusual, were the one-sided, brainy type, the child prodigies. This could not be more wrong!

Chris plays his jazz and is an expert on it. When he wasn't reading a copy of "MAD" on the plane, he was passing his book on American jazz around to others.

Karen, in addition to a number of science awards, holds city tennis awards, has an ISTC scholarship, and pursues a hobby of raising tropical fish.

Carolyn is a member of a dancing group for the school band, takes ballet, swims, etc.

These are but 3 of 20 from Indiana, 3 of 320 at Hartford, 3 of thousands all over the USA. Most of their stories are similar! They really aren't the truly unusual even tho' these particular kids may have been selected as the cream o' the crop.

No, it's the young ruffians who make the headlines for crime that are the *unusual* percentage-wise.

When someone makes a remark about "what are our kids coming to" because they read one blaring headline of teenage crime, remember the thousands of unwritten headlines—think about the thousands, the vast majorty, of youngsters like these science fair kids!

Kids who spent months of work and study to put up highly technical displays, yet who have all the regular interests of teenagers.

Kids who will soon be at the big wheel in our society!

Maybe, just maybe, they'll find a way to help that small percent that take the wrong road. Maybe they'll be smarter than we have been. ◄

Indianapolis in '60

The annual National Science Fair for young scientists between the ages of 14 and 19, inclusive, will be held in Indianapolis May 11-14, 1960.

One of the co-sponsors of the 1960 fair is the Indiana State Medical Association. Dr. Karl Kaufmann, dean of the College of Pharmacy, Butler University, has been named director of this fair.

In subsequent issues of the *Journal,* announcements will be made of plans and schedules for the biggest National Science Fair yet—in Indianapolis—as the program is firmed up.

to the editor:

SENIOR HIGH SCHOOL

West Lafayette, Indiana

May 14, 1959

Dear Sir:

I sincerely hope that my letter is one of many thanking the Indiana Medical Association for the part they have played in promoting scientific interest among high school students.

I was one of the teacher sponsors privileged to travel to Hartford, Connecticut for the National Science Fair. Travel expenses for all Indiana Finalists and teacher sponsors were, as you know, taken care of by the Indiana Medical Association. This gesture is one involving a very farsighted approach to the problem of interesting our young people in science.

At the National Fair, I was amazed at the great cross-section of fields of science represented. I was also very pleased that the students from Indiana competed successfully with students from other States. One first place, one second place and four fourth place winners is an accomplishment worth bragging about.

I do, therefore, wish to commend the Indiana Medical Association for their effort and to thank the members for the privilege of witnessing once again the gathering of some of the most promising future scientists in our country. Backing from organizations such as yours helps insure that individually and collectively we will constantly progress and make the world a better, safer place in which to live.

Sincerely yours,
Kenneth H. Bush

Indianapolis 1, Indiana

May 24, 1959

Indiana State Medical Association
1021 Hume Mansur Building
Indianapolis 4, Indiana

Gentlemen:

I wish to express my sincere appreciation for the honor you accorded me as winner of the 1959 Central Indiana Science Fair.

The trip to Hartford, which you made possible for my sponsor, Mr. William M. Smith, and me, was an experience which I will never forget. To meet so many fine young people with mutual interests was an inspiration. It certainly gave me the enthusiasm to work harder towards next year's Fair.

Respectfully,

David R. Schubert

SECOND CALUMET
REGIONAL SCIENCE FAIR

Purdue University Calumet Center

May 12, 1959

Indiana State Medical Association
1021 Hume Mansur Building
Indianapolis 4, Indiana

Dear Mr. Waggener:

We would like to express our appreciation to the Indiana Medical Association for the major contribution in the form of transportation from Indianapolis to Hartford, Connecticut, round trip, for David Eartly and Donald Cope, participants at the National Science Fair, and their teachers, Sister Scholastica and Joseph Hammerick.

The Calumet Regional Science Fair realizes that this is a worthwhile gesture and we are most fortunate in having such cooperation from the Medical Association. We think the medical society has reason to rejoice in the showing made by the Indiana students at the National Science Fair this year. Much encouragement results when the Medical Society is so active in the Science Fair movement. To each and all the members of this organization, we say thank you for everything in behalf of the Calumet Regional Science Fair.

Sincerely yours,

P. Vincent Flannery
Science Fair Director ◄

An Antibiosis Study of Aspergillus Flavus-Oryzae

*Karen Gabbard**

Garfield High School

Terre Haute

Introduction

FOR SEVERAL years industries have pioneered in the hunt for new antibiotics by screening many thousands of soil samples from all over the world. When microbiologists first discovered that antibiotic producing molds could be found in the soil, it was a fairly easy matter to discover a new antibiotic; presently, so many antibiotics have been found that industries must struggle to discover a new one. This pioneering method will, no doubt, be discarded in time in favor of the organic and biochemical methods.

It became my interest also to hunt for antibiotic producing molds, realizing that the ones I might find would probably only be rediscoveries. A progression through discovery, fermentation and recovery process of an antibiotic enzyme gave me a deeper appreciation of work being done in the drug industry.

Isolation of Antibiotics

Soil samples used in this project were collected from various places around Terre Haute in an effort to get a variety of mold spores. Each soil sample was tested by mixing approximately one teaspoon soil with fifty milliliters of water. This procedure was followed in an effort to form a suspension of the mold spores present in the soil sample. This suspension was streaked out on Sabouraud's Dextrose agar[1] plates in triplicate with an inoculating loop. After an incubation period of 3 days at a temperature of 30°C. mold growths were usually mature enough to present spores, and were isolated into well-defined groups at the third triplicate area of streaking out. By using an inoculating needle and bacteriological procedures, spores were transferred from a mold growth to be isolated to dextrose agar slants. These slants were incubated for 2 days. If slants appeared irregular in growth, the mold spores were streaked out until a pure culture was obtained. The mold aerial hyphae and fruiting bodies were also ex-

*Indiana's first place winner in the Biological Sciences Division at the 1959 National Science Fair held at Hartford, Conn., May 6-9, 1959. Also one of 4 Army Award winners at the same fair. (Paper prepared in conjunction with Miss Gabbard's exhibit.)

Note to reader: **You will find that this explanation of the project is not written in first person singular, but in a technical report form; this does not mean that all work was not done by this student.** ***All work on this project was done by the writer in a high school science laboratory.*** **Time involved—1½ years. Total hours—600.**

[1] Sabouraud's Dextrose agar was used because of the unusually high per cent of sugar (approx. 4%) which induces mold growth and also because of the acid pH which discourages bacterial growth.

amined in order to determine purity of mold cultures.

To detect the slightest antibiotic property of a mold, the spores were transferred from mold slant to agar[2] plates capable of supporting the growth of mold and bacteria. The inoculated plates were incubated for approximately 24 hours until a small growth of mold appeared. Ten % inoculums of Gram-positive and Gram-negative sensitive bacteria were used to test each mold in the manner of spreading the inoculum on the agar surface around the mold growth. Plates were incubated 24 hours at 37° C. Presence of a clear ring around the mold growth gave evidence of an antibiotic enzyme being produced by the mold. Approximately 15 different molds were tested in this manner; two possessed antibiotic properties. The greenish-grey cottony mold[3] was very active against Gram-positive bacteria and only slightly active against Gram-negative bacteria; the other, a yellow-green, many-spored mold[4] was active against Gram-positive and some Gram-negative bacteria. The greenish-grey mold was identified as a *Penicillia* species; the yellow-green mold was identified as *Aspergillus flavus-oryzae*.

Aspergillus flavus-oryzae is a natural mutant between the two closely related species, *Aspergillus flavus* and *Aspergillus oryzae*. The antibiotic enzymes known to be produced by *Aspergillus flavus-oryzae* are n-amyl penicillin and Aspergillic acid. Both are active against Gram-positive and Gram-negative bacteria. N-amyl penicillin (also known as flavicin, flavicidin, gigantic acid, dihydropenicillin F, and dihydropenicillin I) is similar to commercial penicillins, but is toxic; Aspergillic acid is also a toxin. For this reason, these antibiotics are not produced commercially.

Fermentation

Antibiotics are produced by some molds and bacterium either as luxury products or as weapons against other organisms.

When an antibiotic is produced as a luxury product, the organism producing the antibiotic is growing in excellent conditions and is able to change the ingredients of the media into simple foods easily; it, therefore, produces a substance known as an antibiotic which can be used as food later if growing conditions are poor, much the same as animals with pouches eat all they are able and then fill their pouches with food for later use. When the antibiotic-producer is growing in a liquid media, the antibiotic is thrown off into the broth.

The production of an antibiotic as a weapon or protection occurs when a foreign organism interferes with the growth of the antibiotic-producer. In this case, only enough antibiotic is produced to stop growth of the interfering organism; therefore, when an antibiotic-producing organism is grown for purposes of recovering the antibiotic, the organism is usually grown in a liquid media and the antibiotic is produced as a luxury product.

It is necessary to study medias, temperatures and day of peak antibiotic production in order that the greatest amount of antibiotic may be recovered. The mold and spores must be removed from the broth on the day of peak antibiotic production in order that the mold does not start using the antibiotic as food.

A screening of various types of media for fermentation was followed. These were: nutrient media, industrial penicillin media, synthetic media, Bennett's media and Sabouraud's dextrose media. The medias tested varied in the percentage and kinds of sugar and peptone in the ingredients; the pH also varied with each media. The mold was grown at various temperatures—25° C., 30° C., and 37° C. Seed flask growths were characterized by 2-5 mm. diameter light green spiny balls floating in a clear beer. These seed flasks were used as 5% inoculums for fermentation flasks. Samples were taken each day and filtered by Seitz filter. The filtrates were tested to determine the peak of antibiotic production.

The bacteria used to test inhibition were those most commonly used in industry for such work because of their sensitivity and ease of handling: Gram-positive *Sarcina lutea* and Gram-negative *Serratia marcescens*. Filtrates were tesed by

[2] Nutrient agar with a .5% sugar concentration.

[3] Mold later identified as a *Penicillia* sp.

[4] Being unable to identify this mold, at my request the organism was sent to Chas. Pfizer & Co., Inc. plant in Brooklyn, New York, for identification. There it was identified by chromatography methods as *Aspergillus flavus-oryzae*.

dipping sterile filter paper discs (13 mm. in diameter) into the filtrate and placing on the bacteria inoculated surface of nutrient agar plates. These plates were incubated for a period of 24 hours. Some inhibitory substance was produced in all types of media.

Information from these experiments showed that production of the unknown inhibitory substance was best obtained by growing the organism in an industrial penicillin fermentation at a temperature of approximately 37° C. in shake flasks for a period of 5 days. Average peak inhibition obtained from this process was an 18 mm. zone against *Sarcina lutea* and a 17 mm. zone against *Serratia marcescens*. The ingredients of industrial penicillin media are:

Corn steep liquor	40 g.
Lactose	27.8 g.
$NaNO_3$	3.0 g.
KH_2PO_4	.500 g.
$MgSO_4.7\ H_2O$	.250 g.
$ZnSO_4.7\ H_2O$	.020 g.
Glucose	3.00 g.
Water	1 L.

pH 8

The second best results were obtained in production of the inhibitory substance by growing the organism in Sabouraud's Dextrose media for a period of 4 days at a temperature of 30° C. Average peak inhibition obtained from this process was a 17 mm. zone against *Sarcina lutea* and a 16.3 mm. zone against *Serratia marcescens*. The ingredients of Sabouraud's Dextrose media are:

Neopeptone	10 g.
Bacto-dextrose	40 g.
Water	1 L.

pH 5.6

Because of the lack of proper inoculating conditions in the high school laboratory, the most practical procedure was to follow results obtained from experimentations with Sabouraud's Dextrose media. The reason bacterial growth is eliminated in this media is because of the acid pH of 5.6.

Elimination of bacterial growth is necessitated in order that some of toxins produced by the bacteria are not recovered with the antibiotic and also that the bacteria does not use up the peptones necessary for production of the antibiotic.

Recovery

The report received from Pfizer laboratories (refer to footnote number 4) on the identification of the *Aspergillus* mold stated in reference to the mold's antibiotic production, "It was grown in shake flasks of a medium design for penicillin production by *Penicillia* and a sample of the liquid was sent to chromatography. A spot in the region where a small amount of penicillin G would be found on chromatograph paper was observed, so we conclude that the culture produced some of that antibiotic. Various *Aspergilli* are known to produce penicillin." The media in which the mold was sent to the Pfizer plant at Brooklyn, New York, was Sabouraud's Dextrose media.

Since *Aspergillus flavus-oryzae* is known to produce only the antibiotics Aspergillic acid and n-amyl penicillin, it is not possible that the antibiotic being produced was penicillin G, but rather a similar penicillin such as n-amyl penicillin. Because the emperical formulas are very similar, and because little is known about n-amyl penicillin, it would have been a difficult matter to identify the produced antibiotic specifically correct by chromatography. The emperical formula for penicillin G is $C_{16}H_{18}O_4N_2S$, and the emperical formula for n-amyl penicilllin is $C_{14}H_{22}O_4N_2S$. It is, therefore, most likely that n-amyl penicillin is produced when *Aspergillus flavus-oryzae* is grown in a penicillin-type media. Since a type of penicillin is probably produced in Sabouraud's media, the basic principles of penicillin recovery can be applied to the recovery of some of the antibiotic being produced in this liquid media.

Two methods of general penicillin-type recovery were tried in an effort to recover some of the antibiotic being produced by the *Aspergillus* mold. The first method attempted is rather outdated now, and is known as the carbon adsorption process. This process involves the adsorption of the antibiotic on carbon, elution of the antibiotic from the carbon by butyl acetate, addition of sodium bicarbonate in order to obtain a sodium salt of the antibiotic, addition of an organic base such as triethylamine or trimethylamine to precipitate the sodium salt of

the antibiotic, and the distillation off of the water in order that the crystalline antibiotic can be obtained. After several attempts, this process proved rather unsuccessful.

The second method, known as the solvent process, was the most successful and involved the direct recovery of the antibiotic from the beer filtrate. The following is a flow sheet of this process:

1) Added butyl acetate equivalent to 20% by volume of cold media filtrate.

2) Adjusted pH to 2.0 with phosphoric acid. It is necessary to add the amount of phosphoric acid all at once. In order to do this, a small sample of the media filtrate must be tested for the amount of phosphoric acid needed to change the pH to 2.0; phosphoric acid is then added to the larger amount in ratio to the test amount. At pH 2, the penicillins are unstable in water, but are the soluble in the butyl acetate layer.

3) Removed the water layer, or old media layer. This step removes the sugar and peptone so that they will not interfere with the final purity of the antibiotic. Peptone and dextrose are insoluble in butyl acetate.

4) Added 33% solution of potassium pyrophosphate, raising the pH to 8. The antibiotic is insoluble in butyl acetate at this pH, but soluble in water. The purpose of potassium pyrophosphate is twofold—to obtain a potassium salt of the antibiotic and to change the pH.

5) Added butanol, 2 volumes: 1 volume water layer. The antibiotic is insoluble in butanol and will, therefore, crystallize as the water is removed. During distillation, the temperature must not reach 100° C., as penicillins lose activity rapidly at this temperature. The purpose of the butanol is to lower the temperature at which the water distills off; the temperature stays at 92° C. Although liquids are supposed to distill off at their boiling points when mixed with other liquids, this is not always true during first distillation when volumes of close ratio and widely ranging boiling points are mixed. The crystals may be centrifuged or filtered and dried below 100° C.

Properties

Chemical:

The recovered antibiotic reduces potassium permanganate completely, and reduces Fehling solutions to green. A yellow colored solution is produced with hydrogen peroxide and ammonium hydroxide. To prove that these reactions were a result of the recovered antibiotic and not an excess of orthophosphite, di-H, which would have been formed when the potassium pyrophosphate was added in the recovery process, nor potassium pyrophosphate, a recovery process was run with unfermented, sterile Sabouraud's media. The tests run on the white powder recovered (which should have consisted of potassium pyrophosphate and orthophosphite) showed no reduction of potassium permanganate or Fehling solutions. Negative tests are obtained with Xanthoproteic test, $FeCl_3$ test, and $CoCl_2$ test.

The results of the chemical tests on the recovered antibiotic compare exactly with characteristic penicillin tests and exactly opposite the chemical tests for Aspergillic acid. Carboxyls, aldehydes, and monosaccharides reduce Fehling solutions and potassium permanganate; there are no carboxyl groups, aldehydes, or monosaccharides in the molecular structure of Aspergillic acid, but penicillins do have a carboxyl group in their molecular structure which accounts for their oxidation ability. The recovered antibiotic, then, must have either an aldehyde, a carboxyl group, or a monosaccharide in the molecular structure.

Physical:

Crystal form and color: colorless prisms.

Stability: labile to acids and alkalies, and heat. (loses activity rapidly at 100° C.)

Solubility: The recovered antibiotic is insoluble in amyl alcohol, butanol, methanol, isopropyl alcohol, diacetate, ethyl acetate, butyl acetate, amyl acetate, dibutyl ether, glycerin, formaldehyde, turpentine; slightly soluble in water; soluble in water which has been ionized by the addition of small amounts of acid or base.

The physical properties of the recovered anti-

biotic compare with the penicillins but do not compare with the physical properties of Aspergillic acid.

Biological: in vitro. The recovered antibiotic was found to be active against Micrococcus citreus, Staphylococcus pyogenes, var. aureus, Sarcina lutea, Serratia marcescens, Aerobacter aerogenes, Streptococcus faecalis; inactive against Brucella abortus, Brucella bronchiseptica, Escherichia coli, Pasteurella pseudotuberculosis, Pseudomonas aeruginosa, Mycobacterium phlei, yeasts.

None of the chemicals of the recovery process demonstrated any antibacterial effect; therefore, these inhibitions must have been due to the recovered antibiotic.

Turbidometric Assay

Purpose: By adding the same amount of saline solution to equal weights of 2 antibiotics, one of known purity and one of unknown purity, the unknown purity of the antibiotic may be found by comparing the turbidities and acidities of recovered antibiotic to those of penicillin G, i.e., the acidity and turbidity of tube #1 recovered antibiotic; tube #1 penicillin G, tube #2 recovered antibiotic; tube #2 penicillin G, etc. Therefore, by finding tubes of equal acidity and turbidity, the purity of the unknown antibiotic may be found by comparing the number of units oer mg. in all cases, as the amount of antibiotic per tube decreases, the turbidity should increase.

Antibiotics: Added 20 ml. saline solution to 20 mg. recovered antibiotic; added 20 ml. saline solution to 20 mg. penicillin G (2000 units) giving a concentration of 1000 units/ml. penicillin G.

Media: Brain Heart Infusion broth.

Inoculum: Transferred 0.1 ml. of an 18-24 hr. broth culture into a flask containing 30 ml. distilled water and mixed well. Transferred 2.4 ml. of the 1/30 dilution to 80 ml. broth and mixed well.

Tubes: Sat up a series of 12 tubes for each antibiotic and organism used, i.e., 2 antibiotics and 2 organisms = 4 rows of 12 tubes each. To the first tube of each series added 4 ml. broth and 2.5 ml. to all remaining tubes. (1000 units/ml. = 2500 units/2.5 ml. This gave an initial concentration of 200 units /ml. in the first tube.) Mixed well and made serial dilutions by transferring 2.5 ml., using a plugged pipette to the next tube, etc. Finally added 2.5 ml. proper inoculum to all tubes, giving a final concentration of 100 units/ml. in the first tube, 50 in the second, 25 in the third, etc.

Incubated for 18 hrs. and recorded results.

Results: Recorded pH results against *Staphylococcus pyogenes, var. aureus* and *Aerobacter aerogenes* showed that the recovered antibiotic is approximately one-tenth as pure and strong as commercial penicillin G, i.e., 98.25 units/mg. The purest n-amyl penicillin yet recovered was done at Harvard University; the purity was 250 units/mg.

The biological properties of the recovered antibiotic compare with those of penicillins with the exception of the inhibition of *Aerobacter aerogenes,* penicillins do not inhibit *Aerobacter aerogenes* in small concentrations.

Summary

The yellow-green mold isolated from the soil is *Aspergillus flavus-oryzae* which produces two antibiotics—Aspergillic acid and n-amyl penicillin.

Production of the antibiotic is best obtained by growing the mold in a penicillin-type media at a temperature of 30° C.-37° C.

The antibiotic produced in experimented fermentation is n-amyl penicillin; this was proven by chromatography and chemical, physical, and biological properties.

A basic penicillin recovery process may be applied to the recovering of n-amyl penicillin.

Bioassay of the recovered antibiotic in comparison to procaine penicillin G against the organisms, *Staphylococcus pyogenes, var. aureus* and *Aerobacter aerogenes* showed that the recovered antibiotic is approximately 10% as pure and as strong as commercial penicillin G; that is, 98.25 units per mg. recovered material.

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The Human Side of Science

LOUIS M. ORR, M.D.
President
American Medical Association

ON BEHALF of the American Medical Association, please accept my congratulations for the splendid work which has brought you all here as representative young scientists of your communities.

We in the medical profession are keenly interested in the progress of science clubs and fairs. Our governing House of Delegates has urged each state and county medical society to help this worthwhile and constructive program by encouraging the youth of our nation to take a serious interest in the field of science as a career.

Our participation in these National Science Fairs has been a most rewarding experience, and we wish to thank Science Service and the Science Clubs of America for giving us this opportunity as host this evening to honor you and your scientific achievements.

This is the fourth year in which the American Medical Association has participated in the National Science Fair. During this time, we have been greatly impressed with the remarkable scientific accomplishments of young people. And of course, we are pleased with the growing number of you who are exploring the fascinating related fields of medical science.

As I witness the outstanding results of your talents and enthusiasms in your exhibits, I feel that your achievements deserve a generous portion of our interest, enthusiasm and encouragement.

As you know, this evening's banquet is our salute to you and each of you is our honored guest. Four of you, as yet unnamed, will be cited by the AMA for your achievements in the basic medical sciences, and here I wish it were possible to extend individual honors to each and every one of you—because you are *all* winners. But since I cannot, I hope my words may help to keep the dedicated spirit of scientific adventure alive in all of you.

And I hope, of course, that many of you will go on into medical practice, research or teaching. We in the profession realize that other growing sciences make competition keen in attracting qualified students. You may have heard that schools in general are facing the problem of finding top students to fill their enrollments. I can assure you now that there is room for any qualified, capable student in the field of medicine. Our medical schools are expanding under the responsibility of meeting the needs of a rapidly expanding American population, and of providing it with the latest developments in medical research.

To those of you who are seriously planning to continue your career in the various fields of medical science, may I say that your opportunities have never been better, nor your horizons more far-reaching. The practice of medicine has changed dramatically in the last 25 years. It shows every evidence of changing just as dramatically in the next 25. This age of the atom and space is just one area which holds unprecedented promise for the inquiring mind. Change always brings opportunity to those who are alert and ready for it.

For example, authorities in the electrical engineering research field believe that scientific fields will merge. They see a closer relationship between the abstract and the medical, for instance, in the study of the brain. Brain specialists, working with physicists, engineers, chemists and physicians will one day combine their knowledge as a step forward in understanding the brain and how it works.

More than that, in order to work effectively together, these varied scientific fields will develop

Delivered before 10th Annual National Science Fair, May 7, 1959, Hartford, Conn., at the annual AMA banquet.

a common language—an understanding of each other's professional terms—and through this come to recognize the way in which each individual specialty contributes its part to the final understanding of the common problem. We do not have such understanding yet. However, a beginning is being made.

But whether you choose medicine or some other scientific field in which to continue your career, at some point in your future, you will be faced with a universal question which goes hand in hand with whatever discovery or development you may make. That question is: What does my activity mean to mankind?

Without a satisfactory answer to that question, and the *dedication* of spirit to uphold it, all people face the possible menace of an uncontrolled, impersonal science. I think you can agree with me when you think of the evidence you find in your newspapers of world-wide developments in destruction. Of course, we don't want to set up boundaries beyond which science cannot go. At the same time, as a control, we must remember this: The underlying motive of every human activity should be human.

An engineer in one of our nation's biggest companies described a human being this way:

"Man is a complete, self-contained, totally enclosed power plant, available in a variety of sizes, and reproducible in quantity. He is relatively long-lived, has major components in duplicate, and science is making rapid strides toward solving the spare parts problem. He is waterproof, amphibious, operates on a wide variety of fuels; enjoys thermostatically controlled temperature, circulating fluid heat, evaporative cooling; has sealed, lubricated bearings, audio and optional direction and range finders, sound and sight recording, audio and visual communication, and is equipped with an automatic control called a brain." Thus ends his description.

I'm sure the engineer was joking, but his joke has a significant point in what is missing from the description.

He doesn't tell us what makes this robot work.

He doesn't tell us what sets this mechanism apart from such things as man-made moons in the sky, factories with electronic brains, and engines run by atoms.

What does being *human* mean? That is a broad subject, but for our purposes let me put it this way: No one will be able to reduce the value of a sunset, or the stars at dawn, to arithmetic, nor the art of friendship, of statesmanship, or of the soul's expression on canvas or marble or paper. Laughter and love, pain and loneliness, the challenge of accomplishment of living and the depth of insight into beauty and truth . . . these achievements include and surpass the mastery of nature by itself alone.

To put it simply as the poet S. W. Foss did: "Let me live by the side of the road and be a friend to man."

Science is frequently a lonely endeavor, in some cases an isolated endeavor. It is easy for scientists to confine themselves and their thinking to their immediate problems, interests and specialties. It is usual for them to communicate only with each other. If young people like yourselves devote your time to scientific delving exclusively, you will probably hardly notice that you are growing up in a restricted world filled only with the requirements of your interest.

It is on this point of scientific isolation that I want to express a word of caution. Today, we have a tendency to insist from every scientist a dedication so complete that we are in some danger of creating a sort of totalitarian man as single-purposed and as dominating as a totalitarian state.

I believe that dedication is the backbone of achievement, but it should have a broad base. The individual must be prepared not just to work, but to live—at the same time both as a unique person and as a fellow member of the human race. American philosophy places a fundamental value on its regard for the uniqueness and worth of the individual in his own right. The individual is the end of the free society. Without free people, you cannot have a free nation. The possibility of achieving this end depends upon how responsibly individuals use their freedom.

We should not make the mistake of thinking science into a narrow channel. A scientist must be concerned with the environment in which he lives. One of the most frustrating aspects of contemporary life is its tendency to develop compartmental divisions. Business is business, politics is politics, science is science. We have all heard the often repeated fear that our scientific knowledge has far outstripped our human and moral understanding, so that we are in

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danger of destroying ourselves. Without widespread understanding, it could be true.

In a free society, the individual, be he businessman, politician or scientist, plays many roles and shares in making many decisions. Of course, the individual needs to have special knowledge and skills in a vocation or profession, and our society needs highly competent specialists. However, the major roles of the individual are 3: in the home, on the job and in the community. These are the atmospheres in which he lives, in which he makes his presence felt. These are the atmospheres in which he finds his responsibilities and through them his individuality.

In our own field of medicine, we combat a temptation to restrict ourselves to our specialty by entering public life wherever our medical knowledge will aid mankind. Our medical schools recognize this broadened base of dedication. In setting up their curricula, they are adding courses in the humanities. Humanities for the scientist in general aid him in learning the many areas of human effort and aspiration, as well as the authentic aspects of the physical world.

I believe it is important especially for the scientist to know people, to be a part of the people. As each of you grows into your various careers, change will dominate your life. Upheavals and pressures from scientific and technological advances will confront you. But mankind will always remain the basic factor. The physical world was meant to serve man. Certainly this is true of medicine because you are working with man's most valued possessions, his health and his life. It is true also of the engineers who see man's work, his second most valued possession, as a wondrous succession of machine operations. With such automation, man will be either liberated from the routine of mere survival and given the leisurely opportunity to use his endowment of brains for more intellectual pursuits, or he will lose his dignity, if not his freedom, and be left to roam about aimlessly with nothing to do.

You can find the human element in all scientific results. Louis Pasteur recognized this back in 1888 when he said at the dedication of the Pasteur Institute:

"You bring me the deepest joy that can be felt by a man whose invincible belief is that Science and Peace will triumph over Ignorance and War, that nations will unite not to destroy, but to build, and that the future will belong to those who will have done the most for suffering humanity."

Can we as the scientists of tomorrow dedicate our spirits to less?

The human side of science needs freedom in which to realize its greatest triumph. Under the personal freedoms won by people throughout the world, more advancement has been made in the last 200 years than was made in the 5,000 years which preceded.

But today, as young people in a changing world, your idea of freedom may be different from mine. As a member of the older generation, I have seen the American conception of a free people replaced by the concept of a free nation. The clear suggestion here is that freedom is a gift from the national government and not, as oldtimers like myself grew up to believe, a gift from God.

Some of you probably think of security as a synonym for freedom, or will when you get out actively into the world. This is an understandable modern misconception. For example, the 4 freedoms—freedom of speech, of worship, from



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want, from fear—have become for many people a sort of digest version of our Bill of Rights. May I point out that the so-called freedoms from want and fear have no relation to our traditional concept of freedom because they do not come from a self-directed course of action. They depend upon an outside source—the national government—and because of this, they must be considered a form of security, and not true freedom.

I have nothing against security. Security is essential to the full happiness and productivity of which we are capable. But very few of us have really found it. Most of us are still searching. You are on the threshold of looking for yours.

Whoever we are, at whatever age, the majority of us hunt for security in the same three general areas—money, public programs and company benefits such as pension plans, vacation schedules and seniority.

Money is a weak base for security. It does not hold its value over the years. In all the world's history, no currency has ever survived for more than 42 years after being transferred from a physical—based on gold, for instance—to a political base. Your money and mine was changed from gold to congressional paper 25 years ago, and thus far has more than halfway disappeared.

Public programs such as Social Security, unemployment insurance, public housing, while they may have merits of other kinds, represent the great delusion that we can obtain security by voting for it. No political program has ever given more than a passing semblance of security. Programs inevitably change with political expediency.

Lately, company benefits have become more important to job applicants than opportunities for advancement. Employees' interest in what a company will do for them is greater than concern over their capacity to earn the income and financial progress they demand.

We haven't found security in these 3 areas. We haven't found it because we are looking in the wrong places. For you and me, whether we even believe it or not, there is only one place where security can be found. That place is inside ourselves. Here, and here alone, lies the real base for security . . . ideals, not dollars; principles, not pensions; character, not convenience or expediency. Here is the place where each of us is in absolute control. Once we accept this fundamental, it only remains for us as scientists to dedicate ourselves to the job of giving of ourselves for the benefit of those about us.

Eternal law has decreed that what a man keeps for himself he loses, and that which he gives to others becomes his forever. It says that his rewards, his security, his freedom come to him in proportion to the use he makes of his talent and opportunities.

For all of us, scientist, businessman, politician, strength of a free spirit is far more potentially powerful than all the energy in the sun. But especially as scientists, we must nourish that spirit and give it the assurance, the strength, the thirst for human justice that will make science, in wise and good hands, a faithful servant to mankind. This dedication I am proud to place in your young and capable hearts and hands. ◄



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YOU enter Moscow with misgivings. The thousand questions stored in your mind . . . Will they be answered? The night about you . . . Will it be friendly? The silent, big-shouldered driver of the black Zim limousine that is bringing you from the airport up the dark Moscow River into the city. How does he think?

Impressive facades of brightly-lighted buildings loom along the boulevard. You try out your Russian: "New apartments?"

"Da," says the driver.

"Much progress here."

"Da, da, da." You can feel the quick pride that is tongued in that triple yes. You imagine you have already touched the keyword that is moving the Russian people: "Progress."

Two and a half years ago, you pondered the speech made by N. V. Khrushchev at the Soviets' first Communist Party Congress since Stalin's death. Said Khrushchev then: "The principal feature of our effort is the emergence of socialism from the confines of one country and its transformance into a world system. The internal forces of the capitalist economy are working toward its downfall, while the Communist economy is steadily rising toward *its goal of proving itself to the world and transforming itself into a world system through peaceful competition.*"

" . . . Through peaceful competition." A sober challenge and a threat, aimed directly at

* Harold Mansfield, author of *Vision* and *The Challenge* (United Kingdom), is director of public relations of Boeing Airplane Company. He recently visited the Soviet Union as a member of a delegation sponsored by the International Council of Industrial Editors. Before making the trip he learned the Russian language in order to be able better to make a first-hand evaluation of Russia's efforts to surpass America industrially.



RUSSIAN CHILDREN are better dressed than their parents, Harold Mansfield reports. These youngsters, whom Mansfield says could have been photographed in almost any schoolyard in the U. S., are waiting to enter classrooms at Kiev. (Note lace collars, pigtails, sun grins.)

All photographs by Harold Mansfield

the industrial heart-stream of America and the West. Not just defense industry, charged with the task of exceeding Soviet ingenuity in arms, but all industry and business.

Now Khrushchev has been running the show long enough to reveal how he intends carrying out his program. Could he possibly win this race for industrial supremacy, and with it his sweeping political aims? You are here to investigate.

In the days that follow in Moscow, Leningrad, Kiev, Kharkov, between supervised tours and plant visits, you prowl the streets on your own, anxious to meet and talk with workers and citizens. You find them surprisingly friendly. Using your fractured Russian in impromptu conversations, you try to sense the mood and the spirit of the people. You form some impressions.

Russia has a serious look on its face. It is a drab, purposeful, working civilization, in open-collared shirt. Its people are proud and sensitive, self-conscious about their long isolation from the West, hurt by its scorn. They are hungry for the world's esteem, and intend to win it.

"Russians are not barbarians," says a young school teacher, neat in simple skirt and wool sweater. With a slight, quick toss of blond hair and a flick of manicured fingers she adds: " . . . as you can see."

You ask a female guide if a luxurious train between Moscow and Leningrad was not German-built before the war, which it was. She is affronted. "Do you think it's too good to be Russian?"

Somehow you feel that this psychology helps explain the daring push to launch the sputniks, the jutting of astonishing white multi-storied towers, nineteenth-century "monumental" in architecture, out of the otherwise flat, grey Moscow skyline. It helps explain, too, the ornate subway stations under the streets. Marble-columned, sculptured and chandeliered, they appear at once an effort to outdo the splendor of the czars, and an installment on a future-day communist millennium.

Communism exists on the basis of a great hope, a hope kept alive by show of progress, and contrasted sharply with a depressed people's past. The people go along with the objective, little complaining if it is still out of reach. They have set out on an enterprise and intend to prove they can make it go. They have lived with the system long enough now that most take it for granted, much as Americans take theirs for granted.

But the communist "millennium" is a dream. The country is poor. The government knows this and has had to take things in their order, first heavy industry, next trucks and tractors, then busses and subways for public transportation, now apartments. Everywhere you see new apartments being built like mad, thrown up by



"OUR PEOPLE are a free people." This surprising statement was made to Mansfield by a Russian research psychologist. Here, Moscow street scene which Mansfield also compares to U. S. (Yet, doesn't there seem to be a prominence of serious, almost frowning, expressions?)

brigades of mainly unskilled men and women; uninspired, square-walled masonry buildings, each a replica of the last.

By the thousands, the people are moving into these apartments from dingy places on back streets. They still offer only minimum living. You suddenly realize why they looked so dazzlingly bright that first night. No curtains. Frugally furnished, they house often two or three people to the 10- by 16-foot room. But "they're much better than what we had," the occupants tell you.



RUSSIA'S CONSTANT emphasis on output per man-hour is illustrated by Soviet factory poster which declares: "Time is the people's wealth. Watch the working minute." It shows the amount of production accomplished in a single minute by various segments of Russian industry during 1958.

It's the progress that keeps the people going. Press and radio recite it daily. Colored charts in public buildings display it. Progress toward a goal. And always a promise. Tomorrow, refrigerators and automobiles.

You ask a worker, unshaved and in crumpled clothes: "Do you think a man with a five-room house, a car, a television set, electric refrigerator and washing machine is rich?"

"Da," he nods.

"Do you think the average American worker has these things?"

"I don't know."

"He does. Do you think the Russian worker will have them?"

"I don't know. We hope."

You ask another, better dressed, the same question.

"Da," he answers. "We will catch up with America."



"EVERY DAY over the norm," says this poster which depicts a "quota" chart like those posted in factory shops. Column at left shows "plan for the shift," second column the actual productions, and third the percentage of quota achieved. Workers who beat the quota are rewarded by receiving extra pay.

II

In school, in the factory, at the art exhibit, *work* is touted as the basic virtue in Russia. The brass ornament on your hotel room desk consists of three men bent low and pulling a load. The sculptor has made them appear to enjoy it.

Waiting on the street, you talk with a man about jet transports and things. "Are you pleased with Russia's progress in industry and science?" you ask.

"Naturally."

"Why?"

"Because it makes more work."

By the swan pool in Gorky park you ask a keen-looking lad what field he wants to enter when he grows up.

"Science."

"Why? Because of the high pay? Fame?"

He wrinkles his forehead. "Because it is useful," he says.

On the deck of a Sunday afternoon boat up the Moscow River you slide onto the bench beside a man in work clothes, taking a bundle of berry bushes home to plant. He is a skilled mechanic in a nearby factory. You talk with him about his work. "Do you get paid more every year?" you ask.

"Not necessarily. We get paid more when we do more and better work."

"Do you think this is a good system?"

"Da. Good."

A big, brightly-colored factory poster shows a vigorous youth pointing to a minute on the clock. "Watch the working minute!" he cautions. "Time is the people's wealth." A chart shows how much steel, coal, sugar, housing is produced "in our country" per working minute.

"In *our* country, everyone works," the people tell you with pride.

Then they ask about your country. "Is it true there are four million unemployed?"

You explain: "At present the prices on some things have gone rather high and people are not buying as they did. Wages and prices are high. But the state pays those who are out of work."

"How much does a skilled worker make in America?" asks his Russian counterpart, who earns 1,200 rubles a month—or 60 cents an hour, figured at ten rubles to the dollar. (Tourists are given ten rubles to the dollar. Official exchange is four to the dollar, but based on prices, ten to one seems nearer correct.)

"In America he gets $2.50 to $3 per hour; maybe more," you say.

He is thoughtful, possibly incredulous.

You are thoughtful. You begin to see the problem in an unwelcome light.

Khrushchev spoke of the communist economy "proving itself" and "transforming itself into a world economy through peaceful competition." This competition, obviously, is to be in the world



WOMEN DOING manual labor on construction work are a familiar sight in Russia. These women are pick-and-shoveling a water main in Kiev. Factories use more modern methods.

market. On one side is America, with its highly priced man-hour. Up to now it has made good that high cost, by machinery and tooling and mass production. But here you find Russia setting up with deliberate care the same mass-production technique, with low-cost man-hours. You quickly decide America will not relinquish its high pay, because it makes purchasing power. You see a challenge of immense proportions looming before United States industry: How to match a coming giant rival whose ideal is output, not pay.

Before your eyes, you can see the seeds of the great contest being planted. Hotel lobbies and dining rooms are teeming with foreign guests—Asians, Africans, a South American talking business with a Russian host across champagne and caviar. Seeds of peaceful competition.

A strange thought crosses your mind: a future Russia emerging from the iron curtain and America withdrawing behind the dollar curtain, priced out of the market, left trading with itself. "Could it be?" you ask yourself.

You meet a young man from West Africa, jet black, intelligent of speech, a student. He has just visited China, watched the great anti-American rally in Peking. He is touring Russia and western Europe. "I'd like to see America," he says, "but it costs too much."

"A round trip flight from London to New York is down to $450 now, economy fare," you tell him.

"But it's the hotel, the meals, the living costs," he says. "I can't afford it."

America's problem.

You consider an out. Soviet state-owned industry may fail to prove itself; may never be able to produce an equal product for less money. American ingenuity is too much for them. Or is it?

It's time to go into some Soviet plants, talk to the directors, the engineers, the trade unions. See for yourself how they're doing. You set out.

III

The spirit of the Russian industrial worker does not have the airy exhilaration of freedom,

but it has the determination of grim reality: "There's a job to be done and it's up to us to do it."

It is a spirit that has had a frightful past: First the czarist's "Work, you devils, work." Then the revolutionist dictator's "Work with us, or Siberia!" Now the marchwords, "Together, workers, work." It is the song of a new Volga boatman, with the boatmen owning the the boat.

At a machinery plant in Moscow, you enter a dark hallway, emerge to a sawtooth lighted factory area, dirt floored in part but orderly. Unlike the old Volga days, you see no line of men pulling together on a rope, but you quickly learn that collective discipline is the system though each man tends his own machine in modern plant fashion.

You spot a chart on the wall. On it are listed the names of men and women in the shop. After each is a number—the man's "social obligation" in units of work. Squares are filled to show his work performance, with a percentage over his quota.

"How do you reward them for going over the quota?" you ask the manager.

"Extra pay."

"And if they fall behind?" You find there is more to the system. Another chart with the same layout shows the weekly quota, called the "plan," for the shop itself. Chalked in adjoining columns are the shop's actual performance and percentage over plan. The shop's record is compared with other shops. Elsewhere, the record of whole departments is charted, and that of the plant itself, compared with a national plan. It is one huge, systematic, production competition, man against man, shop against shop, department against department, plant against plant. Bonus money is provided for the individuals, shops and departments that make the best record. At the end of the year the plant itself gets a bonus to distribute if it exceeds its plan.

Back to the worker who is not fulfilling his "social obligation," you find that his shop-mates, his department, and his whole plant take an interest in bringing him into line. He is holding up their own chances for a bonus, their own record for exceeding the plan. The star worker, on the other hand, is as popular as the star on a football team. The team doesn't want to lose him.

You marvel that communism has taken free enterprise's strongest drives—competition and incentive—and put them to work on an individual and group basis to an extent never dared by free enterprise.

You speak to a guide about this. "I see you are making great use of competition," you say.

"Nyet," she replies. "We have no competition."

You are baffled. Then you discover there are two different Russian words for competition. The one you have been using—*konkuryentsiya*—means "rivalry," with a capitalist connotation—a bad word in Russia. The one they use—*soryevnovaniye*—means also "emulation." This they approve.

The incentives in this socialist competition are negative as well as positive, you find. You talk with the editor of the plant paper, a heavy woman and every ounce a communist. The paper is employee-run but generally sponsored by the trade union. Enthusiastically, the mother-editor explains the paper's purpose: "To criticize the work of workers and engineers, so they may be ashamed of their work and improve; to criticize the chiefs if they are not fair; to publish production plans and new ideas; to tell about the best workers in the factory so others can emulate them."

Criticism by name in the plant paper, you learn, is only part of the grim process of collective discipline. First step is reprimanding the individual before his friends. A later step, if necessary, is bringing him before a public opinion court. Removal to a lesser job, or "in rare cases," dismissal, may follow.

The head of the union, who is present, explains that the union is as anxious as the management, or "administration" as they call it, to bring forward production. You can see why. The union is closely knit with the Party, which sets the objectives in the first place.

"Is union membership voluntary?" you ask.

"Yes. Voluntary. But ninety-nine and nine-tenths per cent belong."

"Does the union ever strike for higher wages?"

"Strikes are prohibited by law."



HEART OF the Soviet empire is Red Square and massive Kremlin. (Note lack of autos on the exceptionally wide street!)

IV

The director's office in the Moscow plant you are visiting is a plain upstairs room with a desk at one end and a long table. The high window at the end has heavy, dark-blue drapes, edged with tassels. Huge on the side wall is a portrait of V. I. Lenin, looking down half sternly, half benignly, as though saying, "Remember what I taught you, boys, and you'll do fine." A man hurries into the room with an armload of red baize cloth to cover the long table and you know you're in Russia.

The deputy director is in charge in the director's absence. He is thirty-eight, with loose-combed hair, a casual but affirmative manner. He is distinguished from the rest by his necktie.

The plant director, he explains, works under an administration under the district economic council. He takes his plans there for approval, but he has the responsibility for buying his own materials, hiring his people, and negotiating the sale of his products. He is expected to meet the production plan that is established for the year, and to make a profit.

"And what if you don't?"

"We'll probably get moved to another job."

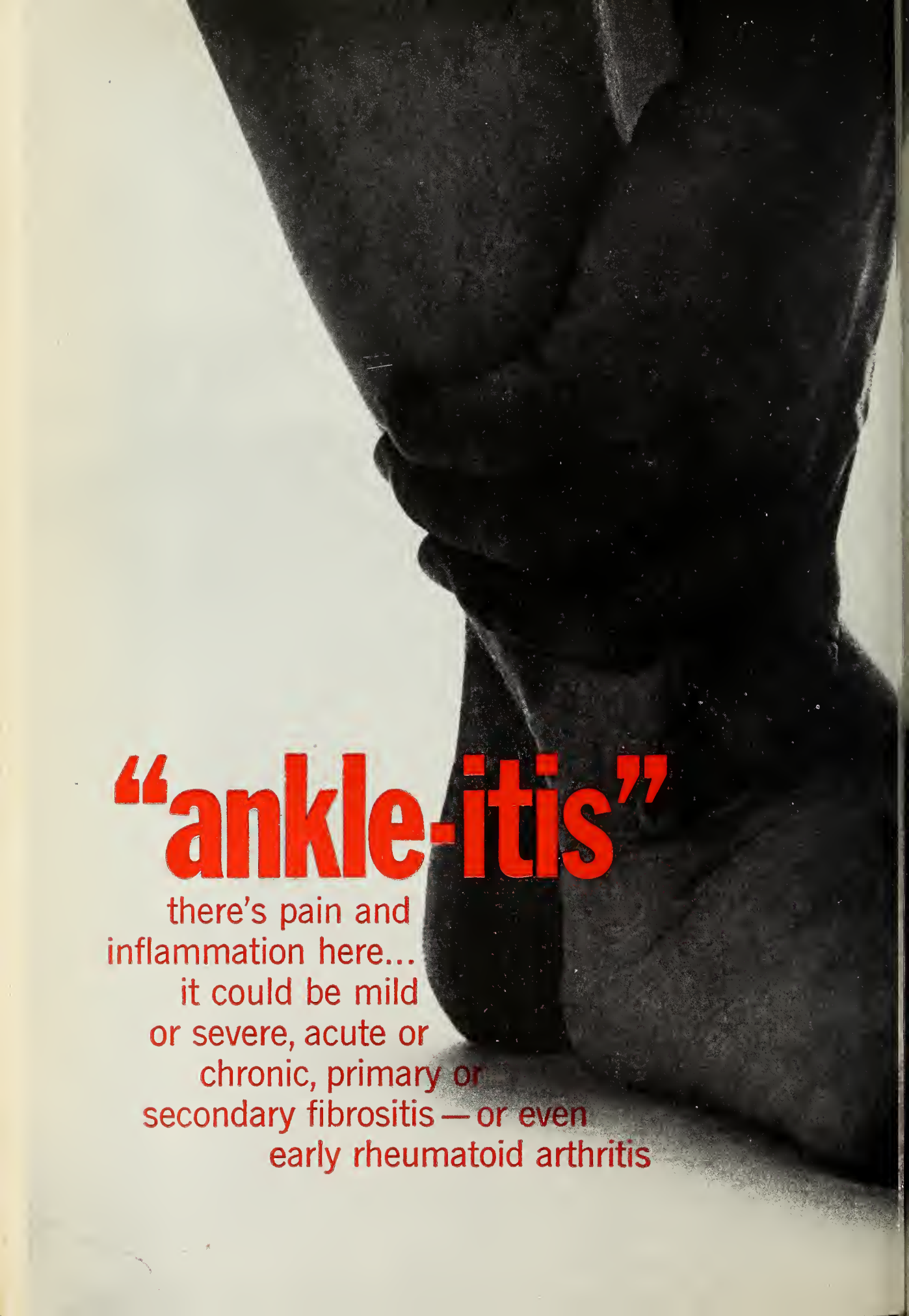
He explains that most of the workers are paid by the piece, rather than by the hour. Their pay ranges from 600 to 1,820 rubles per month. On the average they make 930 rubles per month. This would be $93 at 10 rubles to the dollar.

The deputy director says his own pay is 3,000 rubles, plus bonuses earned for "exceeding the plan."

"How did you get the job?" asks a member of your party. "Marry the boss's daughter?"

He laughs. The government interpreter, loyal communist, takes the opportunity to quip: "Only in your country does that happen." The deputy

Continued on page 1184


"ankle-itis"
there's pain and
inflammation here...
it could be mild
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chronic, primary or
secondary fibrositis — or even
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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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Our Red Rivals

Continued from page 1181

director says he was graduated from an institute, went into the technologists' department, worked up to chief engineer and this.

Employee wages are established in an annual agreement with the trade union. Someone asks the executive, half jokingly, "Do you ever wish you didn't have a union to deal with?"

He doesn't smile. "The unions are helpful," he says.

"But what if the union and management disagree?"

The government interpreter looks around indulgently and explains: "They don't disagree."

Another asks: "What is the basis of wage increases?"

"Productivity. Advancement is on personal ability. General wages go up as productivity goes up."

You find the same system prevails in other plants you visit. "It's the production that pays the wages," they tell you.

You reflect, confusedly, that you have heard management in America make the same case that labor is making in a country where labor wears the hat.

When you wonder, at times, why the workers are not squawking to high heaven about wages, you remember the phrase "social obligation." In their view they are working not just for themselves. They are working together for a goal—to build Russia. "We work half for the present and half for the future," they say. Half to build their own standard of living, half to make the red star the great light of the world. To do this they know they must work to surpass America in all things, but most of all, in industry.

"Do you really think Russia can match America in production?" you ask in Moscow, Kiev, Kharkov, Leningrad.

Says a laboratory assistant: "Da. We are behind you now, but our tempo is greater. That means we will overtake you."

A university professor: "Da. Already we are nearly up to you in output of some things: milk, woolen cloth. We'll reach your standard of living in 10 to 15 years. There is a possibility of doing it faster."

A skilled worker: "It is possible. In ten years we should catch you."

A store manager: "Da, but it will take a long time."

An architecture student: "Ten to fifteen years."

A young factory worker, studying nights to finish his tenth grade: "Da, we'll catch up if you don't interfere." He means if America doesn't interfere by war. Everywhere the people tell you they want peace. But they fear America.

A student of history, candidly: "I don't like communism. I don't like capitalism. I like freedom. But Russian industry is coming up fast. Five years, Russia will produce as much as America."

On a flight between Minsk and Kiev, you sit beside a young jet pilot of the Soviet Air Force, relaxed in a gray leisure jacket made of kapron, the Russian nylon.

"Do you think your scientists will get a rocket to the moon before the United States?" you ask him.

"Sooner," he says, with a polite but confident smile.

"Think Russia will put a man on the moon in ten years?"

"Earlier. Between five and ten years, we will do it." You sense the quiet cockiness of young Russia. You ask the familiar question: "Do you think Russian industry will produce as much as America in five or ten years?"

"More than America," he replies.

You think of the great contrast between Russian living and American. It is inconceivable that they could build up their total economy that fast. "That will be good for the Russian people if they can do it," you say.

But you know, too, that it will also pose a problem for America—in the world market.

V

Opinions differ as to timing, but not one Russian you have talked with believes his country will remain behind America industrially. Most, like the young jet pilot, believe they are already leading in science. In fact, you can recall a good many Americans at home who would grant this, though you believe it to be true only in limited fields. How has the Soviet Union achieved this point of progress? How did it successfully get off a sputnik while others slept? Except for the sputnik, what you have seen in Russia so far has been short on originality. You

wonder if scientists educated under communist dogma can have the imagination to produce new scientific discoveries. You want to learn more about what motivates these men.

Loitering in the main hall of Kiev University, you meet a research psychologist, a man you think should be qualified to discuss this point. "What inspires the Russian scientist?—what makes him try to discover new ideas and put them to use?" you ask him in his cluttered laboratory office next day. "Is it the money he can make, the hope of a Lenin prize and fame, love of his country, or what?"

The man across the desk has intent eyes, a lean face, and needs a shave. You are alone with him, embarking on deep waters with your frail Russian, plus his fragments of English. He leans toward you, interested: "It's all of these," he says, "but these are not all. These are not the main factors." He lays out a finger. "First, our scientists are free."

"Free? How do you mean free?"

"Free to work on things they want. If you have a new idea, you tell your superiors. If they think it is a good idea, they will say, 'Go ahead and work on it.' You are given the equipment and the facilities."

"And if they aren't interested?"

"You have to try again." He continued: "I am free to experiment on what I want. My colleagues are free to work on what they want."

He put two fingers on the table: "Second: the Russian people love the scientist.

"Why?"

"They are servants of the people. They have a high and respected position. Third: Their security is provided. They are secure on account of money."

"You mean they have good material comforts."

"Very good. But this is general: You must understand. Our people are a free people."

"The Russian *people*—free?" It is more than you can swallow, but you are polite and let him continue. He leans closer.

"My mother and father were farmers in the Ukraine," he says. "They can't read or write. I am a scientist. This is what I mean by a free people."

"Free to achieve, to go to a higher position?"

"Da. Also free from exploitation. A Russian is free in his capacity and ability. This freedom is the general factor—the chief factor that inspires our men of science." He adds: "I should have said first of all, we have general education. All are equal in possibilities."

You begin to see how the very things America credits for its great progress, Russia is adapting to its ends. Education and opportunity. You pursue your original question: "But you agreed the desire for money, fame, and love of country were each factors. Which of these three is more important?"

"We are talking openly, freely," he answers. "Love of our country is first. For myself, I do not think about money. For my friends in science, money is not the main thing in their thinking."

You say: "In America, I don't think the scientist is working mainly for money either. He works because he wants to discover new things, get more knowledge, learn new things. Only those who earn the least, work primarily for money."

He nods vigorously. "It is the same in our country. Only those who earn the least."

Continued on page 1188



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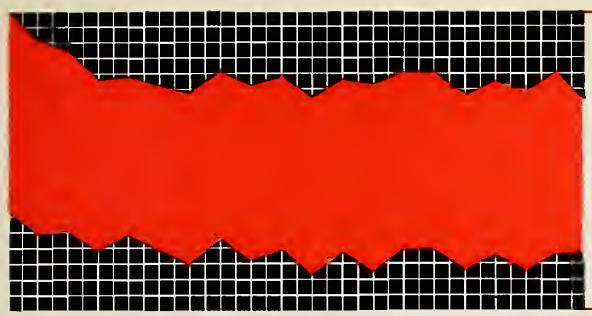
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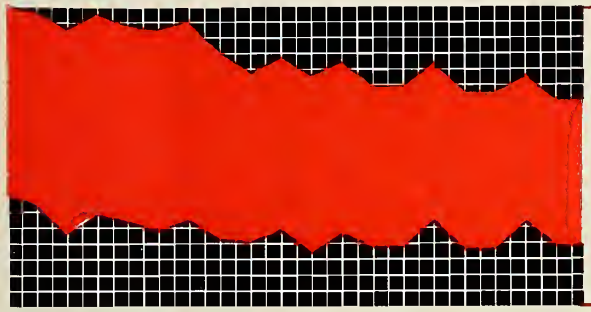
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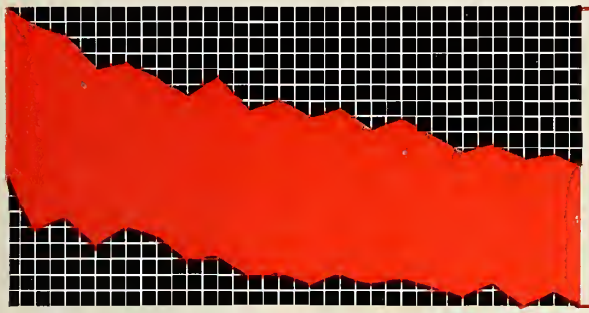
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Our Red Rivals

Continued from page 1185

"What about wages in general. Do the unions ask an increase each year?"

"The government decides," he replies. "If I ask for myself, I may ask too much. It would make prices too high. We do not want inflation." He adds: "One day the ruble will be worth as much as the dollar."

"You think so? When? Ten years? Fifty years?"

"That's hard to say. But it will come."

VI

Up to now, America has been the shining model before the world's eyes. Russia wants to be that model, so people and nations will be attracted to communism. It is easy to see why Russia has set as her main goal to beat America in the economic competition.

The strange contradiction is that it is the nation whose very traditions and manners Russia seeks to warn her people against, which has become the model she seeks to emulate. You think about that. Suddenly it doesn't seem so strange. You remember your puzzling encounter with the two different meanings of "competition" in Russian. The accepted word for it means emulation. It's true, you reflect, in most any competition the contender begins to emulate the successful techniques of the champion. How else can he match him? You know it has been happening for years in design and invention. There is a joke in Russia, that the country's most successful inventor is Comrade Reguspatoff (Reg. U. S. Pat. Off.).

There is other evidence of emulation. The children, better dressed than their parents, the hope of the land, choose English language study four to one over other foreign languages. You ask some of them why.

"Because it will be the most useful to me," one boy tells you. Says another: "Because America is best in technology."

In one of the schools you visit a beginners class in English, composed of fourteen-year-old girls and boys. You mention you have a daughter about their age. Two girls in pigtails step up shyly and brightly curtsy. Carefully one of them articulates: "We wish to correspondence."

The Rusian people like Americans, despite all the propaganda against them. Many tell you they would like to visit your country, but few believe they will ever get the chance.

Managers of enterprises say they want to buy American products. "You have more than you can use. We have shortages of everything," they say. "We should trade with each other."

Russians like American music. University students want to buy American suits and shirts from tourists, "because they have style."

There is even something more subtle that the Russian finds attractive to him in Americans. One guide explains it simply: "They smile."

With more tourists, more trade, is there not hope Russia will also accept new ideas and ideals, you wonder? You ask a devoted communist: "Do you people think Marx's doctrines must apply to all time? Conditions change. Do you re-examine these doctrines in light of new conditions?"

"Yes. We re-examine them."

You are surprised, a little shocked, at the answer. You hadn't expected it. Yet you have seen how these people have adopted practices foreign to the original concept of communism—"from each according to his ability, to each according to his need." Competitive incentives, profit, greater freedom of individual opportunity, private ownership are examples. You meet a family which is buying its own home under a new Moscow plan—borrowing money from the government bank and paying it back over a period of fifteen years. You learn that forty million Soviet citizens have private deposits in savings banks. You become fascinated with a speculation:

Suppose Russia were to achieve her goal of full production: Would she not have to adopt more western business methods just to keep the bustling commerce straight? Would she not have to go still further from Marxist communism, still nearer to Western methods, even though she retained government ownership, as friendly countries do to varying degrees? Instead of the present queues at government shops waiting for a few shirts and shoes, would there not be need for advertising to attract buyers? To stimulate sales, would there not be need for credit buying? Wouldn't bank accounts and checks be necessary to simply handle the money traffic? You want to talk with some bank officials about these things.

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Our Red Rivals

Continued

VII

When you step into a Russian savings bank, an institution rapidly growing in popularity, you think you might be in a small U. S. post office. There is the writing counter against the wall, and across from it two or three attendants' windows. Behind the partition, some women are sorting deposit slips in a shallow wood box. You watch them do their addition on Chinese abacus counting frames, adroitly clicking the beads of the ancient devices that you have also seen used in all the stores.

The manager of the bank, a man in his mid-thirties, unharried, accommodating, invites you to the bank office. You feel that you have been here before, and then remember it is an old farmhouse kitchen you are thinking of, with its square-legged board table in the center. The manager apologizes for a shortage of chairs, and himself sits on the corner of the table. A government interpreter explains the intricacies of soviet banking, the six types of institutions: agricultural, state, communal, industrial, foreign trade, and savings.

You learn there is a crude approach to the use of checks, when one industrial plant writes a note to the bank which keeps its funds, asking that a certain amount of money be transferred to a bank in another city and put in the account of a plant there from which it has purchased some material. You get the manager aside.

"In the future," you say, "Russia hopes to be producing plenty of things for everyone. When that time comes, won't you need things like personal accounts at banks and credit accounts at the stores, and checks to pay for goods and services?" It is a little involved for your Russian. You repeat the question. The official interpreter hears you and comes over. You would rather have talked privately with the banker, but you put the question to the interpreter. She gives it a little laugh of inconsequentiality and turns to another man's question. Later you try it again. Finally as the visit is breaking up you insist you'd like to know the manager's opinion. She asks him. He looks at her, then at you.

"We don't have need for these things now," he says. "When we have communism"—they always speak of communism as something in the future rather than at present—"we will need neither checks nor money."

That ends the discussion. When the wall of dogma appears, communist thought will not attempt to penetrate it. But you can see clearly the contradiction. The trend in Russia is going precisely opposite to the trend planned toward pure communism. You see it further when you visit a large state bank, a more imposing institution with a long row of cashiers clicking the beads of their abacuses, but with modern bookkeeping machines behind, and a mahogany-furnished executive office, suitably adorned with portraits. The manager asks eager questions about banking practices in America.

Business methods—even government business—have only started to make the improvements that Russian science and production have been making in recent years. The distance between the Chinese counting frames at the bank and the electronic computer in the Soviet science laboratory is typical of the glaring inconsistency between the country's forward drive and the cumbersome methods of communism that are dragging it back. Clumsy office methods and procedures, the bureaucratic ladder that must be climbed for policy decisions, delay, dogma and dictation, are heavy fetters on a people's push toward progress.

But Russia is getting wise to these faults. Trade with the outside world will open her eyes, sharpen her practices. To now, America has been reaping a competitive advantage from the backward cumbersomeness of communism itself, the high "overhead" cost of its super-government, the ponderosity of governmental control. Because of this, Americans have often wrongly assumed that Russia could never do what it says. But the streamlining is bound to come. As an example, Russian plant directors say the recent decentralization of industrial ministries has greatly speeded the process of decision.

Meanwhile America has its own trend to "big government." Even now, you reflect, there isn't too much difference between the length of the list of ministries and policy-forming institutes in Moscow and the list of agencies and committees in Washington. Different names. America is not immune to the problems of big government.

VIII

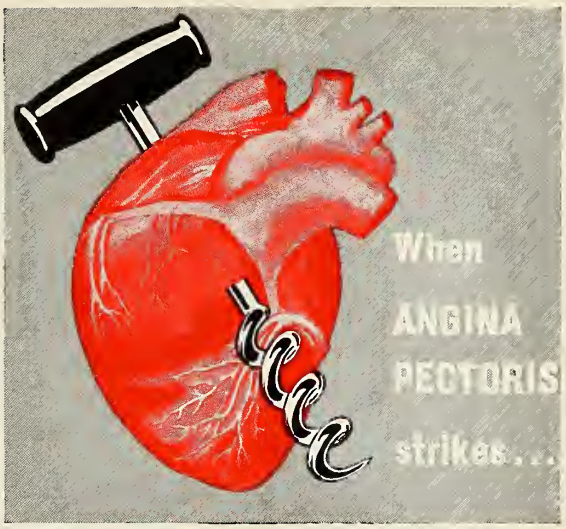
There is ample evidence that Russia is pushing resolutely Khrushchev's program to "prove communism to the world" through peaceful competition.

What of his other contention, borrowed from earlier communist theorists, that meanwhile "the internal forces of capitalism are working toward its downfall"? Can you merely pooh-pooh this brash claim? Viewed from the distance of Soviet Russia, you can see the dangers inherent in America's success. The spoil of success is indulgence. You can't for the life of you see how America can long keep its world leadership in the "peaceful competition" if it indulges the luxury of waste, the luxury of half-hearted effort, the old-style luxury of paying tribute to any group which can exact it through power, the bitterly illusory luxury of inflation. Not when Russia is living and breathing cost control.

Between acts of the opera in Kiev you follow the crowd downstairs to the drawing room where refreshments are being served. You stand in line for a thirty-cent dish of ice cream. You watch with utter fascination the apron-clad girl who is dishing it out. Each dish goes on a little balance like the one at the pharmacist's. She dips up a scoop of ice cream and puts it on the balance. If the balance is high, she adds a trifle, lightning-like because of the waiting crowd. If it is low, with one deft twist of the wrist she flicks off the half teaspoon that will bring it into balance, and returns this to the container for the next serving.

You look about at the happily chattering people. Other than you, no one in the room considers the precise weighing process in the least odd.

This balance, you can't help thinking, is emblematic of Russian effort to make cost and output meet. You have seen it in the whole Russian economy, the fight to build without inflation. You might say it is emblematic, too, of the counter scale of a new, sharp dealer down the street of nations. He is in poor quarters now, but working and saving for the day when he can buy out the rich store on the main intersection. The big store owner with his Cadillac has "had it so good" that he was not much worried about the new competition. But lately he has begun to wonder; ever since the other storekeeper shot a sputnik into the sky and began to attract customers.



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PM **PAUL MANEY**
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Our Red Rivals

Continued

The little ice cream balance, you think further, betokens a balance of power in the world: The forces of communism against the forces of freedom. Two societies basically antagonistic, though simulating each other in surprising, unacknowledged ways. Between them, there is a balancing of military power and of advancement in military weaponry: atomic stalemate. The more frightful the weapon becomes, the deeper the stalemate, because of mutual fear not so much of the other country as of the weapon itself.

You have seen, growing out of the stalemate, Mr. Khrushchev's new plan to sell communism to the world. The pharmacist's balance looms larger, filling the frame of your thought. You see everything that the communist world does and everything that the free world does as adding to one side or the other of the balance. You see everything that either fails to do as subtracting from its side of the balance.



You realize as never before that your country is being weighed in the balance. It has no self-perpetuating heritage of superiority. It must prove itself, year to year. It stands challenged.

Is the system of freedom and equity answering the challenge? To do so, must it not cite for its people a goal of its own—to paraphrase Khrushchev: "the emergence of freedom and equity as a world system"? Must it not sacrifice selfishness and work for its goal, as Russia has taught her people to work for theirs?

You come back to America, land of the free, to find Americans taking riotous advantage of that freedom. You realize as never before that freedom requires self-discipline. Nothing less can match the discipline of a communist regime.

And how is this related to peace?

Because the road to peace is not paved with the unturned stones of idleness, selfishness or complacency.

Because atomic stalemate still leaves the Soviet Union free to gain the balance of world power by the route Mr. Khrushchev has announced.

Because, if communism gains the balance of power by any means, the peace is lost. Then freedom's great struggle will still be ahead.

On the other hand, for America to stay in the peaceful competition will mean that it will have to improve, and that the Soviet system and ideology will have to improve, through competitive emulation. If this happens, the great cause for conflict—the conflict of beliefs—may be removed and replaced by a better understanding, stone by stone.

Industry, labor, all America, have their part to play. Your sense of the unsolved problem shouts within you that Americans must work for their own future.

But not just that.

They must get interested in something besides themselves. In other countries. In the world. In people. Even Russian people. In the two little girls who "wished to correspondence."

The girls are fourteen now. In ten years they will be women. The ten years in which Soviet Russia says it will "catch America." And after that . . .? ◄

Report On Actions of the House of Delegates American Medical Association

108th Annual Meeting, June 8-12, 1959, Atlantic City

Covering a few of many important subjects dealt with by the AMA House. Not a detailed report on all actions taken.

ATLANTIC CITY, June 12—The report of the AMA Commission on Medical Care Plans, relations between medicine and osteopathy, the report of the Committee on Preparation for General Practice and the issue of compulsory Social Security coverage for self-employed physicians were among the major subjects which brought important policy actions by the House of Delegates at the American Medical Association's 108th annual meeting held June 8-12 in Atlantic City.

Another highlight of the meeting was the appearance of President Dwight D. Eisenhower, who addressed an overflow audience of more than 5,000 at the Tuesday night inauguration of Dr. Louis M. Orr of Orlando, Fla., as the 113th president of the AMA. It marked the first time that a President of the United States has addressed an AMA annual or clinical meeting.

Dr. E. Vincent Askey of Los Angeles, speaker of the House of Delegates since 1955, was named president-elect for the coming year. Dr. Askey will succeed Dr. Orr as president at the association's annual meeting in June, 1960, in Miami Beach.

The 1959 Distinguished Service Award of the American Medical Association was voted to Dr. Michael E. De Bakey of Houston, Texas, chairman of the department of surgery at Baylor University College of Medicine, for his outstanding contributions in the field of cardiovascular surgery. Dr. De Bakey received the award at the Tuesday night inaugural ceremony.

Total registration through Thursday, with half a day of the meeting still remaining, had reached 28,225, including 12,921 physicians.

Eisenhower Address

President Eisenhower, speaking at the inaugural ceremony in the ballroom of Convention Hall, warned that inflation posed the greatest danger to the traditional, free enterprise practice of medicine. The cost of inflation, he said, "is not paid in dollars alone but in increasingly stagnated progress, lost opportunities, and eventually, if unchecked, in lost freedoms for the doctor and the patient." Mr. Eisenhower also expressed gratification at learning of AMA leadership in the program to meet the health care needs of the aged.

Commission on Medical Care Plans

The House of Delegates received Part I of the report of the Commission on Medical Care Plans as information only and then acted upon the Commission recommendations item by item. The House adopted 36 of the recommendations without change, but reworded 3 which relate to miscellaneous and unclassified plans. The changed recommendations now read as follows:

B-4. "In an effort to decrease, or at least to prevent an increase, in the over-all cost of health

Continued on page 1196

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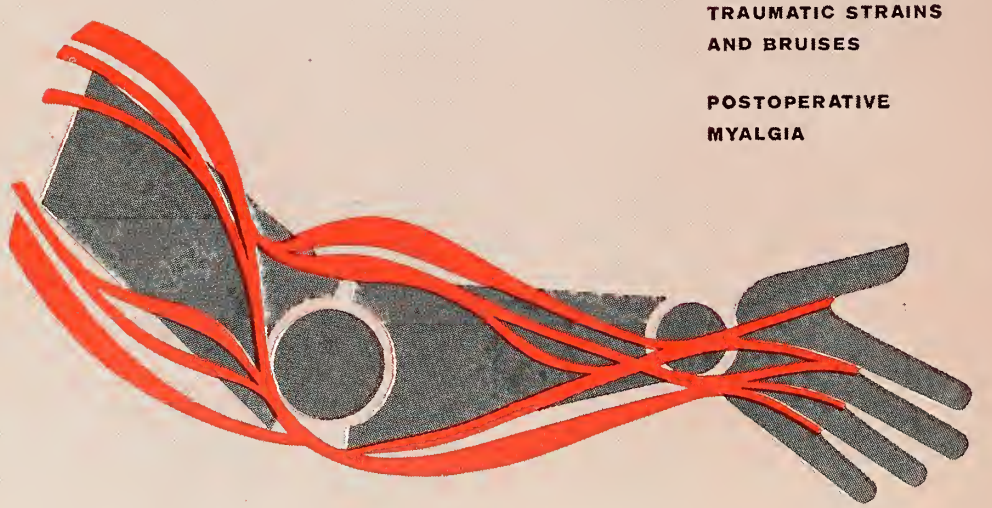
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SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

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AMA Report

Continued from page 1193

care, study should be given to the removal of the requirement of hospital admission as the only condition under which payment of certain benefits will be made."

B-6. "Medical care plans should be encouraged to increase their efforts to provide health education and information concerinng the coverage of their subscribers."

B-16. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses. Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

In connection with free choice of physician, the House also requested the Board of Trustees to transmit to all constituent medical associations the "far-reaching significance" of Recommendation A-7, which says:

"'Free choice of physician' is an important factor in the provision of good medical care. In order that the principle of 'free choice of physician' be maintained and be fully implemented, the medical profession should discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford."

The House also strongly endorsed Recommendation B-11, which declares that "Those who receive medical care benefits as a result of collective bargaining should have the widest possible choice from among medical care plans for the provision of such care."

Many of the Commission recommendations urged increased activity by state and county medical societies and the American Medical Association in such fields as continuing study and liaison, closer attention to legal and legislative factors, and the development of guides for the relationship between the medical profession and the various types of third parties. To carry out 3 of the recommendations involving AMA activities, the House also approved a 7-point program which it requested the Board of Trustees to transmit to the Division of Socio-Economic Activities for immediate attention.

Medicine and Osteopathy

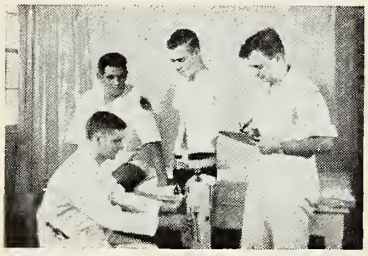
In considering a special report of the Judicial Council on the subject of osteopathy, the House adopted the following policy statement regarding interprofessional relations:

"(A) All voluntary professional associations between doctors of medicine and those who practice a system of healing not based on scientific principles are unethical.

"(B) Enactment of medical practice acts requiring all who practice as physicians and surgeons to meet the same qualifications, take the same examinations and graduate from schools approved by the same agency should be encouraged by the constituent associations.

"(C) It shall not be considered contrary to the Principles of Medical Ethics for doctors of medicine to teach students in an osteopathic college which is in the process of being converted into an approved medical school under the supervision of the AMA Council on Medical Education and Hospitals.

"(D) A liaison committee be appointed by the Board of Trustees of the American Medical



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Association to meet with representatives of the American Osteopathic Association, if mutually agreeable, to consider problems of common concern including inter-professional relationships on a national level."

In another action concerning osteopathy, the House recommended that the American Medical Association representatives on the Joint Commission Accreditation of Hospitals suggest to the Joint Commission that they inspect upon request and consider for accreditation without prejudice those hospitals required by law to admit osteopathic physicians to their staff.

Preparation for General Practice

The House approved and commended the final report of the Committee on Preparation for General Practice, which proposes a new 2-year internship program for medical school graduates planning to become family physicians. To avoid unnecessary confusion, the House deleted only one sentence which read: "Indeed, the committee believes that the one-year internship actually encourages inadequate preparation for general practice." The Committee on Preparation for General Practice included representatives from the AMA Council on Medical Education and Hospitals, the American Academy of General Practice and the Association of American Medical Colleges.

The suggested program would include a basic minimum of 18 months hospital training in the diagnostic, therapeutic, psychiatric, preventive and rehabilitative aspects of medicine and pediatrics in a very broad sense, including care of the newborn. A physician then could elect to spend the remaining 6 months for additional training in other segments of the program. The committee stated, however, that participants who plan to practice obstetrics would be expected to spend at least 4 months of the elective period in obstetrical training.

The report declared that "the graduate program of 2 years in preparation for family practice should be planned and implemented as a unified whole" with a maximum continuity of assignment in specific services. The program also calls for adequate experience in outpatient care and emergency room service.

Continued on page 1200

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Dosage: *One to eight capsules a day in divided doses. Dosages should be established on the basis of individual therapeutic response.*

Precautions: *Drowsiness may occur, and is usually due to the antihistamine effect. Occasionally this may also cause vertigo, pruritus and urticaria. Because of the low dosage, side effects with* ARISTOMIN *have been relatively infrequent and minor in nature. However, since* ARISTOCORT *Triamcinolone is a highly potent glucocorticoid with profound metabolic effect, all precautions and contraindications traditional to corticosteroid therapy should be observed. Discontinuance of therapy must not be sudden after patients have been on steroids for prolonged periods. It must be carried out gradually over a period of as much as several weeks.*

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References: *1. Maurer, M. L.: Clinical Report, cited with permission. 2. Levin, L.: Clinical Report, cited with permission. 3. Gaillard, G. E.: Clinical Report, cited with permission.*

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"I would conclude that ARISTOMIN *is truly a worthwhile aid in treating allergic problems."*[1]

"The results have been uniformly good. The patients have stated that their symptoms were very much relieved. I have not encountered any side reactions except from one patient, who complained of some drowsiness, which I attribute to the antihistamine."[2]

"In general . . . it [ARISTOMIN] *is an excellent product. Over-all, it appears to be more effective than any simple antihistamine we have used. Despite the fact that we employed it in the treatment of a variety of nonselected individuals and problems, we had excellent and good results in 25 of the 39 patients."*[3]

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AMA Report

Continued from page 1197

Social Security

In considering 5 resolutions on the subject of compulsory Social Security coverage for self-employed physicians, the House disapproved of 4 and adopted one reaffirming its opposition to the compulsory inclusion of physicians. In so doing, the delegates expressed concern over the possible effects that a change of policy might have on the association's entire legislative program, particularly with respect to the Forand Bill.

The House also recognized "the apparent growing demand by physicians for economic security" and requested the Board of Trustees to investigate the possibilities of developing group insurance and retirement plans which could be made available to association members. It accepted a reference committee suggestion "that the American Medical Association continue and expand its educational program to inform its members of the economic, social and moral advantages of economic security obtained within the framework of our free enterprise system rather than through the mechanisms of governmental Social Security."

Miscellaneous Actions

In dealing with a wide variety of other subjects, the House also: Urged all physicians to participate more fully in community activities and *socio-economic* matters in their own communities but agreed that no change should be made at this time in Article II of the Constitution, which states association objectives:

Approved in principle the aims and objectives of the President's Council on *Youth Fitness* and the Citizens Advisory Committee on the Fitness of America Youth;

Accepted a Board of Trustees recommendation that the *1962 Annual Meeting* be held in Chicago;

Expressed heartfelt thanks to the Committee on *Amphetamines* and Athletes, which has completed its assignment;

Requested the Board of Trustees to study the problems and possibilities of establishing an AMA-sponsored *medical scholarship* and/or loan program;

Approved the inclusion of *Today's Health* as a benefit of dues-paying membership and urged members to make it available to their patients;

Recommended that state medical societies, where advisable, initiate legislative efforts to eliminate *cancer quackery;*

Received a progress report indicating "phenomenal progress" in the field of health insurance coverage for *the aged* since the Minneapolis meeting last December;

Gave a rising vote of thanks to *Dr. Joseph D. McCarthy,* who finished his term as chairman of the Council on Medical Service;

Reaffirmed its full support of the Educational Council for *Foreign Medical Graduates;*

Endorsed the purposes outlined in the initial report of the *Medical Disciplinary Committee;*

Urged every AMA member to give a substantial gift to the *medical schools* through the American Medical Education Foundation; and

Expressed appreciation for the outstanding *disaster medicine* program presented by the United States Army Medical Service on June 6, 1959, in Atlantic City.



"Isn't it high time we gave away a few of these free samples, doctor?"

Opening Session

At the Monday opening session Dr. Gunnar Gundersen of La Crosse, Wis., retiring AMA president, stressed the personal responsibility of every physician to keep abreast of medical advancements and to deliver "1959 medicine." Dr. Orr, then president-elect, called for concerted effort and medical leadership in 4 areas—the costs of medical care, recruitment of dedicated

medical students, basic research and health care of the aged, Dr. Carl V. Moore, Busch professor of medicine at Washington University, St. Louis, was presented with the eighth Goldberger Award in clinical nutrition. Smith, Kline and French Laboratories of Philadelphia received a special AMA award for its sponsorship of color medical television over the past 10 years.

Inaugural Ceremony

Dr. Orr, in his Tuesday night inaugural address, affirmed his belief in the basic principles of medicine, democracy and faith under which America's physicians live. He pointed out that freedom must continually be fought for by men and women who are willing to stand up and be counted. Dr. Leonard Larson of Bismarck, N. D., AMA Board Chairman, administered the oath of office to Dr. Orr and the latter presented the Distinguished Service Award to Dr. De Bakey. The Fort Dix Band Chorus presented the musical program.

Election of Officers

In addition to Dr. Askey, the new president-elect, the following officers were selected at the Thursday session:

Vice president, Dr. James Stanley Kenney of New York City; speaker of the House of Delegates, Dr. Norman A. Welch of Boston, and vice speaker, Dr. Milford O. Rouse of Dallas, Tex.

Dr. R. B. Robins of Camden, Ark., and Dr. Hugh H. Hussey Jr. of Washington, D. C., were re-elected for 5-year terms on the Board of Trustees. Also elected to the Board, for the first time, was Dr. Percy E. Hopkins of Chicago.

Dr. J. M. Hutcheson of Richmond, Va., was re-elected to the Judicial Council. Re-elected to the Council on Medical Education and Hospitals were Dr. Charles T. Stone Sr. of Galveston, Tex., and Dr. W. Andrew Bunten of Cheyenne, Wyo.

Dr. Willard Wright of Williston, N. D., was elected, and Dr. J. Lafe Ludwig of Los Angeles was re-elected to the Council on Medical Service. Dr. William Hyland of Grand Rapids, Mich., was re-elected to the Council on Constitution and Bylaws.

F. J. L. Blasingame, M.D.
Executive Vice President
American Medical Association

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Congressional Record

An excerpt from the Congressional Record of Proceedings and Debates of the 86th Congress, First Session.

The Medical Education Situation

EXTENSION OF REMARKS
of
HON. CLARK W. THOMPSON
of Texas
In the House of Representatives

Thursday, April 23, 1959

Mr. THOMPSON of Texas. Mr. Speaker, I am interested in the medical education situation in the United States, particularly because the University of Texas Medical School is in Galveston, my hometown. With no little concern I have noted in recent months that the medical profession has been under attack in several areas of the press. As a result, I conferred with Dr. John Truslow, director of the Texas University Medical School, and then prepared seven questions dealing with medical education throughout the country, with a view to ascertaining whether sufficient qualified doctors are being produced to meet the needs of our rapidly growing population. I submitted these questions to Dr. F. J. L. Blasingame, of Wharton, Tex., an old friend and constituent of mine who went to Chicago a year ago to assume the responsibilities as executive vice president of the American Medical Association. I have complete confidence in Dr. Blasingame and his answers to the questions I submitted are very gratifying to me.

I was pleased to learn that since World War II there has been an increase in approved medical schools; that there is a substantial increase in medical students; and that contrary to certain reports, the American Medical Association exercises no control over the number of students admitted to medical schools. There is much other valuable information in Dr. Blasingame's reply and I believe it will do much to eliminate certain misconceptions about the medical profession. Under leave previously granted, I insert my letter to Dr. Blasingame and his reply:

Congress of the United States,
House of Representatives
Washington, D. C., March 9, 1959.

F. J. L. Blasingame, M.D.,
Executive Vice President
American Medical Association,
Chicago, Ill.

DEAR DR. BLASINGAME: My attention has been called to a number of bills introduced in the 86th Congress affecting directly, or indirectly, the medical profession.

As a result, I wish to obtain certain information on the present supply of doctors in the United States and to ascertain as far as possible the prospects for an adequate supply of physicians to meet the needs of our growing population.

So I am calling on you, not only as executive vice president of the American Medical Association, but as my old friend and my loyal constituent, to supply me with the information. On a separate sheet, I am submitting questions that occur to me in this connection. I know you can provide the facts; facts that should be made known to Congress before action is taken to consider legislation affecting the medical profession.

I am writing this after a conference with our mutual friend, Dr. John Truslow, head of the University of Texas medical branch in Galveston, who called on me today.

I will appreciate your answering these ques-

tions and will further appreciate any other information you might give me that is relevant.

I want to say that I think you did a courageous thing in sacrificing your substantial private practice in Wharton to take over the direction of the AMA. I wish you great success.

Dr. Truslow joins me in sending you our best wishes.

Sincerely yours,

CLARK W. THOMPSON.

AMERICAN MEDICAL ASSOCIATION

Chicago, Ill., April 16, 1959.

HON. CLARK W. THOMPSON,
House Office Building,
Washington, D. C.

DEAR CONGRESSMAN THOMPSON: Thank you for your recent letter and your interest in medical education.

It is indeed a pleasure to bring you an up-to-date report on the status of medical education in the United States. As you know, I am proud of the accomplishments of our medical schools and have great faith in their ability to train enough physicians to meet the needs of our growing population.

You asked seven important questions about the medical education picture. Let me answer them one by one.

First, has the number of physicians graduated from approved medical schools kept pace with the growth of the Nation's population? Over the long haul, the increase in medical graduates is much greater proportionately than is the increase in the population. From 1920 to 1958, the percentage of increase in medical graduates from approved schools was 125 per cent, compared with a 64-per cent increase in population. In the past 20 years, the percentage figures are fairly comparable: 32.1-per cent increase for medical graduates; 33.4-per cent increase for population.

The future, I believe, looks bright. Each year, for the past 11 years, the number of students enrolled in approved medical schools has increased. This boost in enrollment amounts to 29.6 per cent (from 22,739 to 29,473).

Your second question was whether medical schools seek to restrict the number of medical students. Two factors make it necessary for a school to establish an arbitrary top enrollment figure: facilities and budgetary funds available to operate the school. Each school faculty determines the number of students who can have a sound education with the faculty personnel and the facilities available to the school.

Medical education is a graduate educational experience following the completion of the regular college course, and because of the subject matter covered requires individual and small group instruction. To turn out well-trained, highly-qualified physicians the school requires a large faculty of skilled educators, plus sufficient teaching and research laboratories, hospital beds and clinical patients. The number of students that can be taught must be necessarily restricted to fit the facilities so that the emphasis can be on quality of the graduate rather than on the quantity of students.

Third, you asked: What is the ratio between applicants to medical schools and those accepted? The answer is 1.97 (15,791 applicants for first year medical school to 8,030 places available). This ratio has remained about the same for the past 5 years.

Incidentally, a common confusion that arises in discussing applicants to student ratio is mistaking applications for people (applicants). Each person applies, on the average, to four medical schools. Thus, for the 1957-58 academic year, the 15,791 applicants filed a total of 60,946 applications.

Next, you asked if it is true that only students with an A college academic record are accepted into medical school. That has never been true. About one-sixth of the entering medical students for the whole country have A college records; about two-thirds have B records and about one-sixth have C records.

Your fifth question was: Is the number of medical schools increasing in the United States? In 1944, there were 77 approved medical schools, including eight 2-year schools from which students had to complete their final 2 years of medical education in any of the 69 4-year schools. In 1958, there were 85 approved medical schools. Eighty-one are 4-year schools; only four 2-year schools.

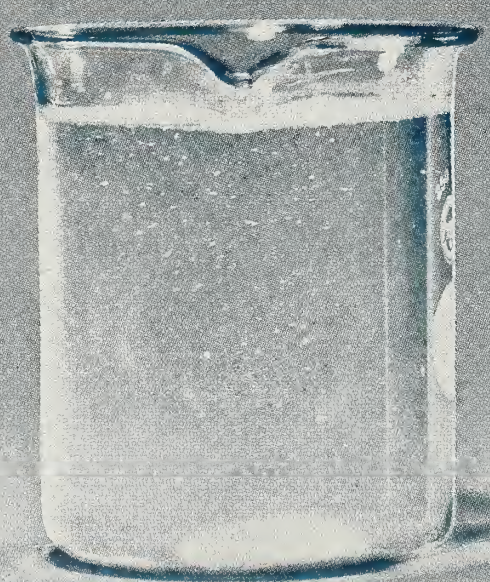
Two other schools are under development. As a step toward still further expansion of

Continued on page 1206

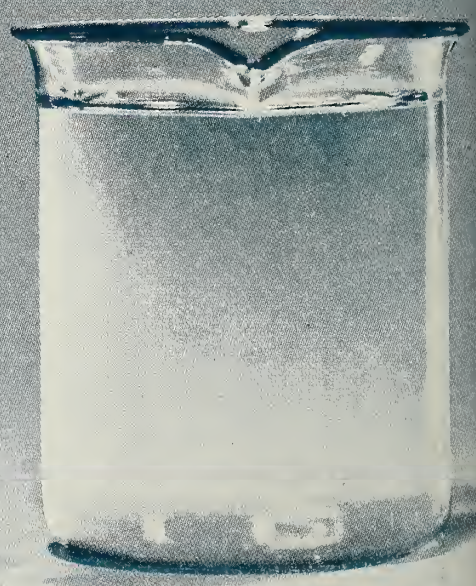
avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.[1-10] Studies performed in conjunction with gastrectomy[4,5] and gastroscopy[2] have shown insoluble aspirin particles firmly adherent to the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.[2-4-5] This is reported to be particularly true in patients with peptic ulcer.[4]

CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage



Regular aspirin crystals 24 hours after being mixed into water.



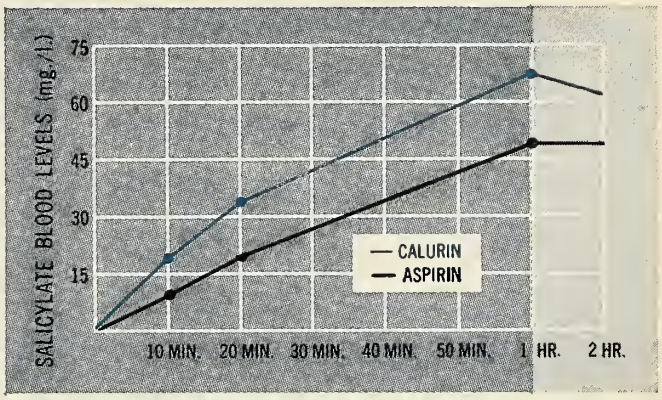
Calurin crystals in solution one minute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



ticle-induced ulceration — section through lesion nd in gastrectomy specimen. An aspirin particle was nd firmly imbedded in this undermined erosion. Such ons may be associated with the relative insolubility aspirin, which remains in particulate form after ersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

1. High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
2. Produces high salicylate blood levels rapidly for prompt analgesic, antipyretic, anti-arthritic effect.
3. Sodium-free — for safer long-term therapy.
4. Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

age: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) cetylsalicylic acid. For relief of pain and fever in adult ents, the usual dose of Calurin is 1 to 3 tablets every 4 rs, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

ERENCES: 1. Waterson, A. P.: Aspirin and gastric haemorrhage, Brit. M. J. 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic rvation of the effect of aspirin and certain other substances on the stomach, Lancet 2:1222, 1938. 3. Editorial Comments: The effect of lsalicylic acid (aspirin) on the gastric mucosa, Canad. M. A. J. 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, Brit. M. J. 2:7, 1955. uir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, Lancet 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, Gastroenterology 16, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, ., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, New Eng. J. M. 258:213, 1958. 9. Cronk, G. A.: ratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, New Eng. J. M. 258:219, 1958. 10. Editorial: Aspirin plain and red, Brit. M. J. 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium lsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, ington, D. C., Sept. 5, 1958.

*TRADEMARK

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

AMA Report

Continued from page 1203

medical school facilities, the American Medical Association last year urged "institutions of higher education where medical education has not been undertaken in the past to give serious consideration to the development of opportunities in the field."

Sixth. Has the American Medical Association anything to do with the number of enrollments in medical schools? Enrollments are strictly determined by each individual medical school. Neither the universities nor their medical schools would permit an intrusion into their academic freedom by a national professional association.

Your final question asked whether I think it is necessary for Federal funds to be provided for medical schools. The medical profession welcomes one-time Federal grants for medical school construction and renovation as well as Federal grants for basic research. The profession has been opposed to continuing Federal aid for operating expenses because of the potentialities therein for Federal control.

I should like to point out that the National Fund for Medical Education, which raises funds from industrial sources, and the American Medical Education Foundation, which raises funds from the medical profession, have made grants in excess of $10 million to medical education over the past 8 years.

I hope this information will aid you in analyzing bills introduced in the 86th Congress which pertain to the training of physicians. As further background, I am sending along a copy of the most recent annual report prepared by our council on medical education and hospitals, which was published in the *Journal* of the American Medical Association, November 15, 1958. It provides additional data that you might find useful.

I am happy that your wrote me after conferring with our mutual friend, Dr. John Truslow. If I can provide any additional information, please make your wishes known.

Sincerely yours,

F. J. L. Blasingame, M.D. ◄

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Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

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"I do hope you don't think I'm just a silly old woman, doctor, but I do like men!"

NEWS NOTES—from State and Nation

Sports Medicine Congress to Meet at Pan-Am Games

A Sports Medicine Congress, one of the most significant conferences of its kind ever scheduled, will be held in conjunction with the 3rd Pan American Games, scheduled for Chicago next Aug. 27-Sept. 7.

The Congress will meet on the Chicago campus of Northwestern University Sept. 1-2, and will feature outstanding experts in the fields of athletic training, care of injuries, diet, cardiovascular effects of sports activity and many other facets of the sports medicine field.

T. R. Van Dellen, M.D., Chicago, medical and health columnist for the *Chicago Tribune,* is general chairman of the Congress.

Paul Dudley White, M.D., world-famed Boston heart specialist who attended President Eisenhower during the latter's illness and convalescence, will be the featured speaker at the first plenary session of the Congress Sept. 1. On Sept. 2, Allen J. Ryan, M.D., attending surgeon and physician specializing in treatment of athletic injuries, Menden, Conn., Hospital, will be the speaker.

All sessions of the Congress will be open to all persons interested in the field of sports medicine. Further information can be obtained from Dr. Van Dellen at Pan American Games, Inc., 310 South Michigan Ave., Chicago 4.

Journal of Occupational Medicine

A new medical journal, *The Journal of Occupational Medicine,* appeared this year for the first time, as the official publication of the Industrial Medical Association.

Editor is Adolph G. Kammer, M.D., University of Pittsburgh. The new journal will encourage publication of original articles of clinical significance, and will also conduct a special department for abstracting the current literature on subjects of interest in industrial medicine.

Chinese Air Force Honors Local Man

Col. James M. Davis, son of Mrs. James P. Davis, 5550 E. Washington St., Indianapolis, was recently honored by the Chinese National Air Force with the award of their flight surgeon wings.

The award was made in Taipei, Taiwan (Formosa) by Lt. Gen. HSU, Huan-shen, deputy commander in chief, Chinese Air Force.

Colonel Davis is presently assigned as director, Professional Services for Pacific Air Forces located at Hickam Air Force Base, Hawaii.

While assigned to the Far East Air Forces in Japan prior to coming to Hawaii, he worked closely with the Chinese Air Force on planning, training and staffing of their medical facilities. "The improvement of flight surgical activities with remarkable achievement" was cited in the award.

Colonel Davis is an alumnus of Indiana University at Bloomington and Johns Hopkins University, Baltimore.

He is married to the former Elizabeth R. Buddy of St. Louis. The couple reside with their 3 children at Hickam AFB.

I.U. Receives Hearing Grant

The Deafness Research Foundation recently announced initial grants of $13,240.00 from Foundation funds for basic research in hearing and deafness.

The Foundation, established less than a year ago, is the only national voluntary health organization, founded and governed by laymen, devoted primarily to fundamental research in the causes, prevention and cure of deafness.

A grant of $4,400.00 was made to the Hearing and Communication Laboratory, Indiana University, Bloomington, to support research on the fundamental relationships between the amount of noise exposure and the amount of permanent hearing loss, with particular reference to industrial and military personnel.

Urology Essay Awards Announced

The American Urological Association is offering an annual award of $1000 for essays on the result of some clinical or laboratory research in urology.

First prize is worth $500, second for $400 and third $200.

Competition is limited to urologists who have been graduated not more than 10 years and to hospital interns and residents doing research work in urology.

First prize essay will appear on the program of the forthcoming meeting of the American Urological Association to be held May 16-19, 1960, at the Palmer House, Chicago.

For full particulars write the executive secretary, William P. Didusch, 1120 North Charles St., Baltimore, Md. Essays must be received by Mr. Didusch before Dec. 1, 1959.

Candidly Speaking



IT WASN'T ALL WORK at the Woman's Auxiliary 15th House of Delegates session in April. Here George Lull, M.D., AMEF director, enjoys the company of Mrs. Ethyl Gastineau, newly elected president of the AMA Auxiliary; Mrs. Mary Black, new ISMA Auxiliary president; and Mrs. Mildred Bailey, immediate past president, ISMA Auxiliary.



"YAAAA . . . your father's moustache!" Well, anyhow, it LOOKS like that is what Jim Waggener, ISMA executive secretary, is saying! The four gentlemen above evidently were enjoying the big banquet held by the Woman's Auxiliary. They are (l to r): Dr. Lull; George D. Buckner, M.D., immediate past president, Allen County Medical Society; Mr. Waggener and Kenneth L. Olson, M.D., ISMA president.

Parliamentary Info Offered

Information on parliamentary procedure has been made avalable to medical society members, according to a notice from George F. Schmitt, M.D., Miami.

Two informative sheets, one entitled "The Medical Meeting" and the other "Chart of Parliamentary Procedures," recently were made available to officers of county medical societies throughout the U.S. Because the response was so good, they are now being offered to those who are not officers.

These sheets were published by Dr. Schmitt, a registered parliamentarian. Those interested should write him, enclosing a stamped, self-addressed, long envelope for free copies. Address is: 30 S.E. 8th St., Miami 32.

Goiter Conference Accepts Abstracts

The Fourth International Goiter Conference will be held on the Royal College of Surgeons, London, England, July 5-9, 1960. Abstracts of American papers to be considered for presentation should be sent to J. E. Rall, M.D., National Institute of Arthritis and Metabolic Diseases, National Institutes of Health, Bethesda 14, Maryland.

Abstracts from all other countries are to be sent to Dr. Selwyn Taylor, 3 Roedean Crescent, Roehampton, London, S.W. 3, England.

All American abstracts must be received by Dr. Rall by Dec. 1, 1959. They should not exceed 400 words and should be submitted in quintuplicate.

Presentation of papers will be limited to 15 minutes, and a copy of the final paper must be sent to the London secretary 2 weeks prior to the meeting.

The Journal of the Indiana State Medical Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year

1959-1960

$100.00 First Prize

75.00 Second Prize

50.00 Third Prize

Watch subsequent issues of the Journal for detailed information

General Heaton Appointed Army Surgeon General

Maj. Gen. Leonard D. Heaton, Army Medical Corps, has been confirmed by the Senate to be the Surgeon General of the Army, effective June 1, 1959. General Heaton, who has been commanding general of Walter Reed Army Medical Center since April 1, 1953, succeeds Maj. Gen. Silas B. Hays, who is scheduled to retire from active duty.

General Heaton, who performed surgery on President Eisenhower and Secretary Dulles, was born in Parkersburg, W. Va., and received his M.D. degree from the University of Louisville, Ky., in 1926. He was appointed a first lieutenant in the Medical Corps Reserve and assigned to active duty July 17, 1926. He received his Regular commission as a first lieutenant in the Medical Corps Aug. 3, 1927.

There were 24,830 pedestrians injured crossing intersections *with* the signal in their favor during 1958 in the United States.



All-leather soles—firm, yet *flexible.*

Sturdy uppers of kitten-soft elk—red, tan, white. Features that soundly, gently support little feet just learning to scoot and scamper.

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Van Meter Prize Award Offered Again for 1960

The American Goiter Association again offers the Van Meter Prize Award of $300.00 to the essayist submitting the best manuscript of original and unpublished work concerning "Goiter—especially its basic cause." The studies so submitted may relate to any aspect of the thyroid gland in all of its functions in health and disease.

This award will be made at the Fourth International Goiter Conference in London, England, July 5-9, 1960, where a place on the program will be reserved for the winning essayist if he can attend the meeting. For 1960, recipient of the award will receive consideration for an award of a travel honorarium.

Competing essays may cover either clinical or research investigations, should not exceed 3,000 words in length and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to the secretary, Dr. John C. McClintock, 149½ Washington Avenue, Albany 10, N.Y., not later than Jan. 1, 1960.

Gamma Globulin for Indigent Patients

The Indiana State Board of Health will receive a limited supply of gamma globulin from the American National Red Cross. Due to limitations of the supply, the material will be reserved for indigent, chronically debilitated children exposed to measles and for intimate family contacts of cases of infectious hepatitis.

Physicians having indigent patients who qualify either because of measles or infectious hepatitis may obtain gamma globulin directly from the Indiana State Board of Health by correspondence or telephone call.

Any requests for large quantities of gamma globulin to be used for clinical research programs or individual clinical cases such as agammaglobulinemia should be sent directly to: Sam T. Gibson, M.D., Senior Medical Officer, American National Red Cross, National Headquarters, Washington 6, D. C.

Cars that did not have the right-of-way injured 608,400 and killed 3,890 persons on U. S. highways in 1958.

all physicians are invited to attend...

In recognition of the responsibility of the pharmaceutical industry to aid postgraduate medical education, Lederle originated its Symposium Program eight years ago. Initiated with a meeting sponsored by the Knoxville Academy of Medicine and continued with other medical organizations, the program presents up-to-date information of clinical significance to physicians throughout the United States and Canada. Through Symposia, over 50,000 physicians have had the opportunity to hear and question specialists in every field and, with their wives, participate in the activities of a Symposium day.

You and your wife may wish to attend one of the Symposia below.

JEKYLL ISLAND, GEORGIA—Thursday, August 27, 1959
The Jekyll Club

BATON ROUGE, LOUISIANA—Friday, Sept. 18, 1959
The Capitol House Hotel

BEAUMONT, TEXAS—Saturday, September 19, 1959
The Hotel Beaumont

KANSAS CITY, KANSAS—Friday, September 25, 1959
Battenfeld Memorial Auditorium

INDIANAPOLIS, INDIANA—Wednesday, Sept. 30, 1959
The Sheraton-Lincoln Hotel

OKLAHOMA CITY, OKLAHOMA—Friday, October 2, 1959
The Skirvin Hotel

BIRMINGHAM, ALABAMA—Sunday, October 11, 1959
The Dinkler-Tutwiler Hotel

TACOMA, WASHINGTON—Wednesday, October 14, 1959
The Hotel Winthrop

TRAVERSE CITY, MICHIGAN—Friday, October 23, 1959
The Park Place Hotel

LUBBOCK, TEXAS—Saturday, October 31, 1959
The Lubbock Country Club

ST. CHARLES, ILLINOIS—Wednesday, November 4, 1959
The St. Charles Country Club

DALLAS, TEXAS—Friday, November 6, 1959
The Hilton Hotel

WICHITA, KANSAS—Saturday, November 7, 1959
The Hotel Broadview

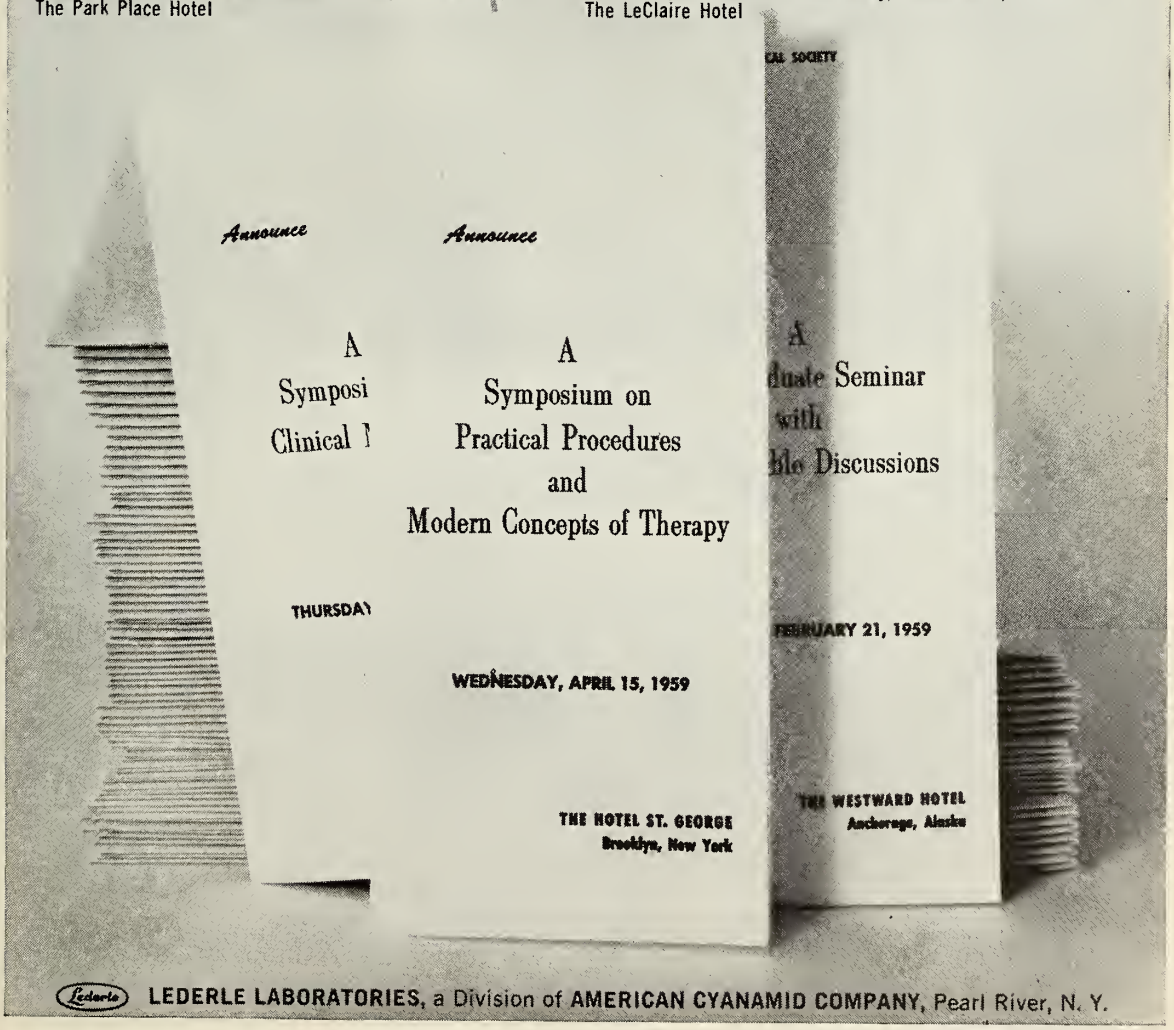
SCHENECTADY, NEW YORK—Thursday, November 12, 1959
The Mohawk Golf Club

CORPUS CHRISTI, TEXAS—Friday, November 13, 1959
The Robert Driscoll Hotel

RIVERSIDE, CALIFORNIA—Sunday, November 15, 1959
The Mission Inn

SANTA BARBARA, CALIFORNIA—Wednesday, Nov. 18, 1959
The Santa Barbara Biltmore

MOLINE, ILLINOIS—Wednesday, December 2, 1959
The LeClaire Hotel



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Add 1

Memories of a San Francisco Vacation; Life, Which Variety Is Spice Of!

by corki

Dateline—a mountain hideaway somewhere in California—June 14 . . . A lesson in vacation planning . . . don't go where you know lots of people if you want to get away from it all.

It becomes a mad, dizzy round of people, parties and rich food. The people are wonderful, the food good and San Francisco as beautiful as ever.

Even was lucky to catch a period of warm, clear weather—no fog yet. The Pacific and sky meet in an azure blending so bright it hurts winter-deadened eyes. The white buildings of San Francisco stand in relief against the clear, deep blue of San Francisco Bay. Every corner offers a new breathtaking view.

Old friends are warm and friendly and wonderful. But before 2 days, a tight schedule of activities to astound a princess was set up and someone forgot to turn off the liquor tap. Wonderful, wonderful people. But tired, tired, tired!



"I mentioned thot we needed new blood in our orgonizotion, so find out who the wise guy was thot left a bottle of plosmo on my desk!"

One friend took pity and offered this lovely, lonely cabin in the mountains for a weekend of *real* rest. No schedules. No parties. No water taps even! Just the quiet of mountain birds and animals and the restive rustling of wind through tops of tall, tall pines.

I could reach up and touch a star it seems, they are so bright and so close. They appear to twinkle amongst those bristly pine tree arms.

Relaxing. Quiet. Night sounds . . . the only remembrance of modern metropolitan madness is the occasional whirr of an auto passing on a distant highway. So quiet the cars sound close.

Makes one wonder if modern, high-speed living is worth it all. Surely those pioneers who entered this virgin land were not in need of tranquilizers and barbiturates.

Or . . . oh . . . pump system just went out. No water and no old-time convenience available to compensate! Time out to fix it.

On second thought, maybe modern life does present its better points.

So on with the high-speed living and the tranquilizers . . . along with modern conveniences!

A week later . . .

Back at the office and knee deep in stacks of work . . . papers, papers, papers. Can't make heads or tails of the accumulated conglomeration.

It was a nice vacation. Should be more of them. Even if the work stacks up and one must go at double speed to catch up eventually, it was worth it to get away and visit with old friends who were so wonderful . . . see my lovely cool, grey city by the bay (as it is called by San Francisco columnist Herb Caen) . . . see the hills, the mountains, the bay . . . see a play, visit the zoo, root for



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Neo-Synephrine® HCl, 0.5%
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the Giants (and what a ball game!) (let's vote for having major league baseball in Indiana!), sample all sorts of weird, wonderful, delectable foods (any remedy for "ailments" caused by over-rich foods???).

Yes, always on the go and sick-tired upon return home. But still worth it to change paces. Hurrah for vacations! Have you tried one lately, doctor?

Tid-bits to remember about San Francisco. Koala bears from Australia nibbling on eucalyptus leaves at the zoo (supposed to be the first allowed to leave Australia because that's the only food they'll eat—it's abundant in the Bay Area).

Big League

Big league ballgames . . . Willy Mays running for a long fly although hampered by a bruised leg . . . one old gal, dressed to the proverbial hilt, putting on makeup at a crucial moment in the ballgame, sun shining in her mirror, reflecting into faces of those fans really interested in outcome of games . . . several little boys brought from out of town by their teacher —and teacher wondering why they came to game and never sat down to watch it . . . Giants winning to keep their second place league standing (beat Milwaukee later to move in front, then lost and fell behind again).

Chinatown

Chinatown and the singsong of Cantonese, the weird but fascinating whine of Chinese music, the gala colors, the tourists mostly indiscriminate in their souvenir buying, the delicious, rich food featuring sweet and sour sauces, vegetables not cooked to death, meats with such unusual seasonings.

The Wharf

Fisherman's Wharf and the Balclutha (an old sailing ship open to the public), creaking fishing smacks and lobster pots, and so many places to eat.

The Buena Vista (or BV to those in the know I'm told) with its Irish coffee as brought to this city by S. F. columnist Stanton Delaplanes . . . looking like a neighborhood bar and grill, but featuring rare drinks, where everyone who is anyone is supposed to go at least once.

View of the Golden Gate from the Presidio (Army post), ships passing under the Golden Gate Bridge, some seeming to be swallowed by the ocean as they steam toward the horizon, others bringing goods and people from far-off lands.

The Cliff House, always a must for Sunday brunch, featuring a gin drink from New Orleans.

Theater

The theater and seeing "Once More, With Feeling" with Fernando Lamas (and, oh, what a handsome man!) and Marjorie Lord at the Alcazar.

And food . . . the Chinese as mentioned, Japanese food in "Japanese Town," German sauerbraten in the Marina, Russian borscht, raviolis in Richmond district, and American steaks over charcoal in the mountains. Enuf's enuf!

Cocktail parties and old friends.

Sunbathing and playing with a friend's pet monkey called "Squeeky."

Discussing Hal Gilliam's latest books with the author and his wife Ann (who collaborated with him on one and is about to present him with a little Gilliam, too).

So many things to remember. To savor. To look forward to again on another vacation, another year!

But for now, back to the stack of papers! This is life, which variety is the spice of!



"Outside of proving that your suit is of an inferior weave . . . what else have you found out today, doctor?"

Lighter Vein—

A salesclerk went to the manager with a problem. "How," he asked, "can I stop women customers from complaining about our prices, and talking about the low prices in the good old days?"

"Very easily," replied the manager. "Act surprised and tell them you didn't think they were old enough to remember them."—*Escort.*

Nothing makes a weathered picket fence look more quaint and attractive than being the fellow who will have to paint it.—Vesta M. Kelly, *Quote.*



"I told you not to flinch, sir, when I gave you this shot!"



"Well, if I took it out of medical terms and explained your ailment in plain English, it would be such a simple thing that you'd refuse to pay my bill."



"We enjoyed your lecture tremendously, doctor. Who would have ever guessed that the kidneys and intestines could be such fun!"

A young mother paying a visit to her doctor, made no attempt to restrain her 5-year-old son who was ransacking an adjoining treatment room. But finally an extra-loud clatter of bottles did prompt her to say, "I hope, doctor, you don't mind Billy being in your examining room."

"No," said the doctor calmly. "He'll be quiet in a moment when he gets to the poisons."—*Scarboro Missions.*

Deaths . . .

E. H. Clauser, M.D.

E. H. Clauser, M.D., 69, died May 31 in Ball Memorial Hospital. Dr. Clauser had been a Muncie physician and surgeon for the past 43 years.

He graduated from Indiana University School of Medicine in 1915. Served as chairman of the Indiana hospital licensing committee and was formerly president of the Muncie Academy of Medicine. He was a World War I veteran and had been chairman of the Executive Committee of the Indiana State Medical Association.

Baruch M. Edlavitch, M.D.

Baruch M. Edlavitch, 74, a practicing physician in Fort Wayne since 1912, died in Parkview Memorial Hospital May 18.

A veteran of World War I, Dr. Edlavitch was the first medical man to be called to service from Allen County.

He was a member of B'Nai B'rith and the Temple Brotherhood, a graduate of the Johns Hopkins University, receiving both his Bachelor of Arts and M.D. degrees there.

Dr. Edlavitch was a charter member of the American Diabetics Association, the Fort Wayne, Indiana, and American Medical Associations.

John C. Glackman, M.D.

Dr. John C. Glackman, age 78, of Culver, former chairman of the Indiana Board of Health, died May 21 at St. Joseph Hospital in Kokomo.

A retired army colonel, he was a veteran of two wars, a member of his local, State and American Medical Associations, and the American Legion.

Charles B. Matthews, M.D.

Charles B. Matthews, 86, of Hammond, died May 30 at his home.

He received his degree from Kentucky School of Medicine in 1894 and completed 50 years of medical practice in 1954. Discharged from the U. S. Army with the rank of major.

A member of the First United Presbyterian Church, 50-year member of the Masonic Lodge, McKinley Lodge 712, F. & A. M., and Royal Arch Masons 90.

He was also a member of the AMA, ISMA and Lake Co. Medical Society.

Harry E. Murphy, M.D.

Harry E. Murphy, M.D., 64, Franklin physician, died May 8 in St. Mary's Hospital at Rochester, Minn. after a long illness.

He graduated from I. U. in 1916, where he later received his doctor of medicine degree. Interned in Roosevelt Hospital at New York City and later served in the U. S. Navy.

Johnson County health officer since March, 1953, Dr. Murphy was a member of the Johnson County Medical Society, ISMA and AMA, and the Indiana and American Academies of General Practice.

County Societies

Henry

Dr. R. A. Weitemier spoke on "Pediatric Electrolyte Balance" before 14 members of the Henry County Medical Society. The meeting was held at the Henry County Hospital, May 21.

Marshall

Eight members and 2 guests were present at the May 6 noon meeting of the Marshall County Medical Society meeting.

Dr. James D. Kubley was elected delegate and Dr. Louring W. Vore, alternate.

Tippecanoe

"The History of the Development of Hospital Expansion Program in Lafayette" was the title of the speech given by Mr. Brunge at the April 14 meeting of the Tippecanoe County Medical Society. Fifty-four members were present to vote on the adoption of the 9th District Constitution.



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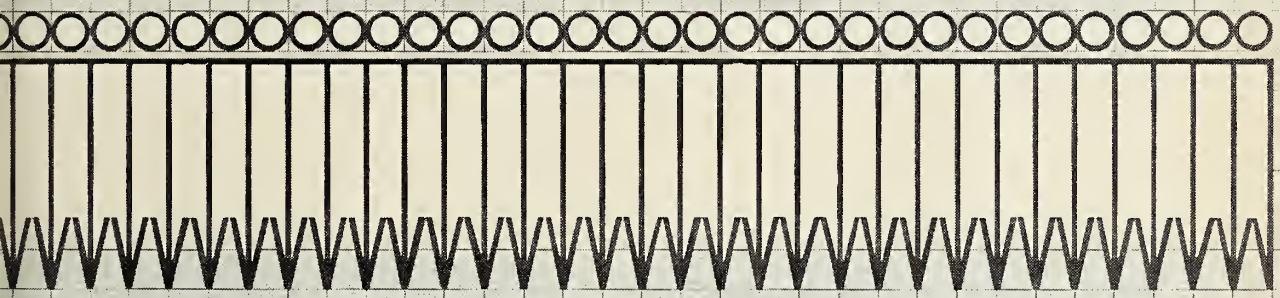
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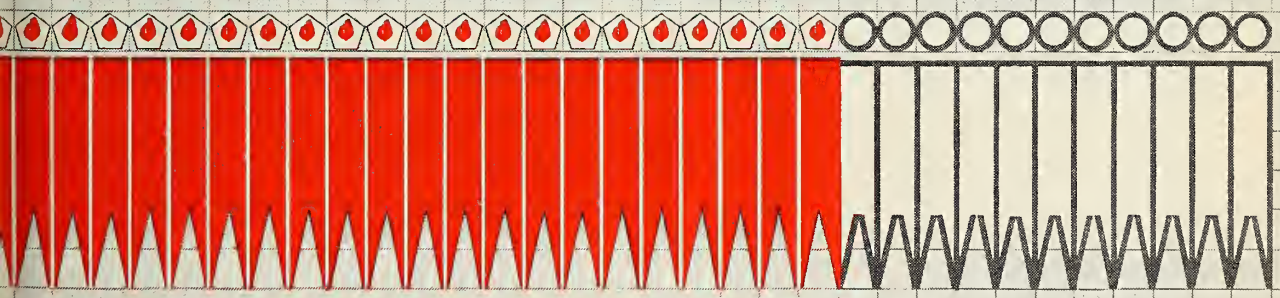
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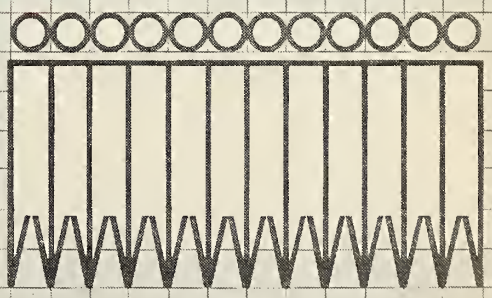
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1. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
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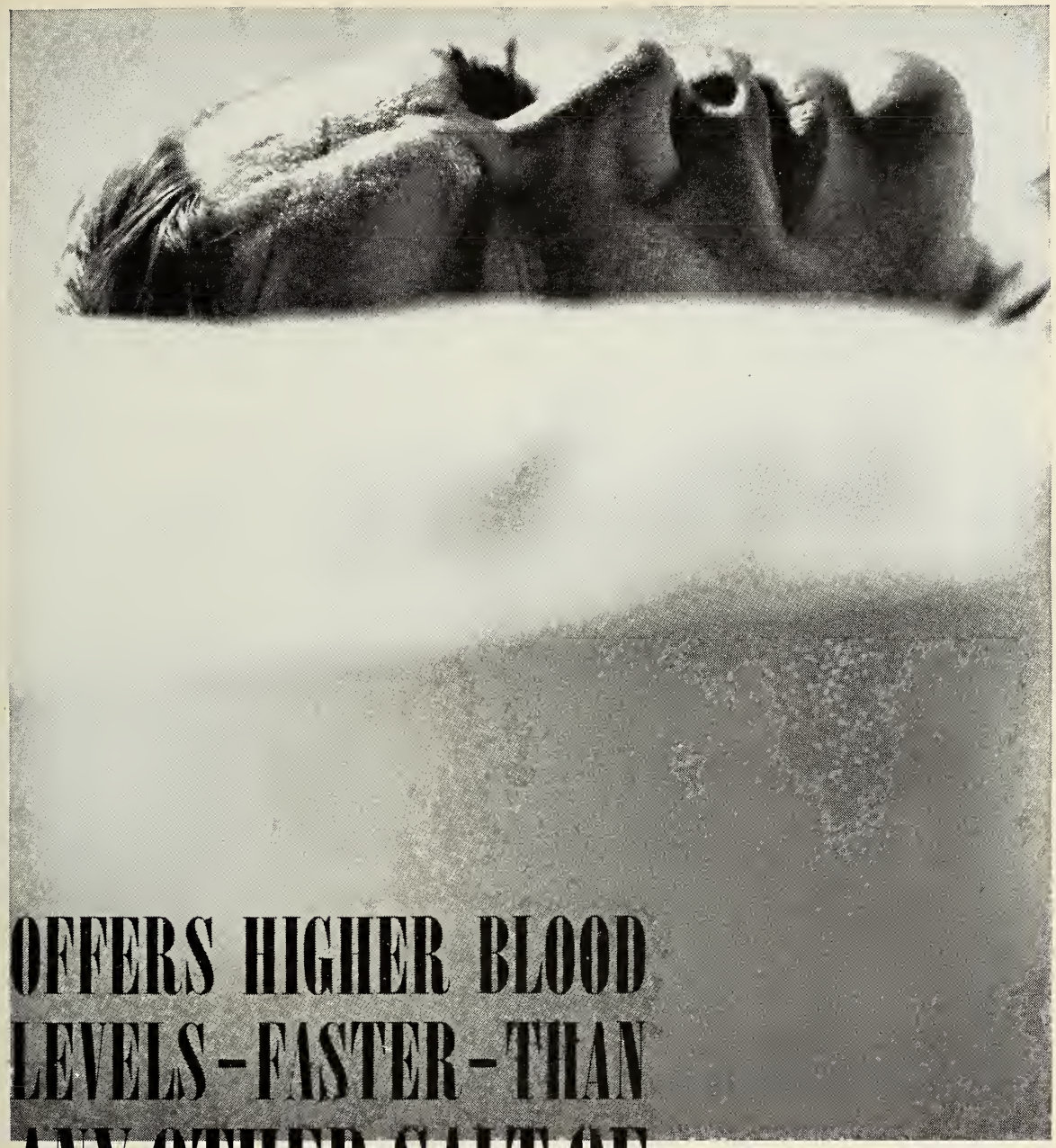
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2.	Herbert O. Chattin, M.D., Vincennes	J. S. Brown, M.D., Carlisle	1960
3.	P. T. Hodgin, M.D., Orleans	(to be appointed)	Fench Lick, 1960
4.	Robert M. Reid, M.D., Columbus	David L. Adler, M.D., Columbus	Columbus, May 11, 1960
5.	Gilbert Rhea, M.D., Greencastle	James B. Johnson, M.D., Greencastle	Greencastle, 1960
6.	Kenneth G. Hill, M.D., Newcastle	John A. Davis, M.D., Flat Rock	Shelbyville, May 11, 1960
7.	Leon Gray, M.D., Martinsville	Herbert L. Egbert, M.D., Indianapolis	Fall, 1959
8.	Richard C. Swan, M.D., Anderson	M. P. Benoit, M.D., Anderson	Anderson, June 8, 1960
9.	Harry E. Klepinger, M.D., Lafayette	Forrest J. Babb, M.D., Stockwell	Lafayette, May 18, 1960
10.	Martin O'Neill, M.D., Valparaiso	John R. Frank, M.D., Valparaiso	1960
11.	Eugene Cook, M.D., North Manchester	C. L. Wise, M.D., Camden	Monticello, Sept. 16, 1959
12.	Harold F. Zwick, M.D., Decatur	Stephen C. Michaelis, M.D., Fort Wayne	1960
13.	Richard W. Holdeman, M.D., South Bend	James M. Wilson, M.D., South Bend	South Bend, Nov. 18, 1959



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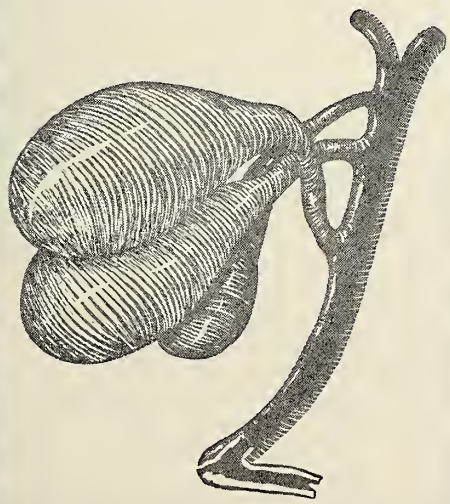
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(1) Beckman, H.: Drugs: Their Nature, Action and Use, Philadelphia, W. B. Saunders Company, 1958, p. 425.
(2) Biliary Tract Diseases, M. Times *85*:1081, 1957.

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This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and airmailed to THE JOURNAL on the ninth of each month preceding month of issue.

THE MONTH IN WASHINGTON

Washington, D. C. -- President Eisenhower's power of veto has been a powerful weapon in his fight against big spending program of the Democrats.

His outstanding use of the power so far in this session of Congress was the veto of the Democratic, catch-all $1,375,000,000 housing bill. Mr. Eisenhower said the measure was extravagant and inflationary. He warned that the fight against inflation could not be won "if we add one spending program to another without thought of how they are going to be paid for and invite deficits in times of general prosperity."

The housing bill included three provisions of interest to the medical profession. One provision, endorsed by the American Medical Association, would have authorized Federal Housing Administration guarantees of loans for construction of prorietary nursing homes. The second provision would have authorized direct federal loans for housing for interns and nurses. The third would have authorized both such loans and guarantees for housing for elderly persons.

Mr. Eisenhower objected to direct loans for housing for the aged. But he directed his main attack against the legislation's public housing and urban renewal provisions.

The President also vetoed a wheat price support bill which, he charged, "would probably increase.....the cost of the present excessively expensive wheat program."

The threat of a veto also caused the Democrats to retreat and cut back their airport construction legislation.

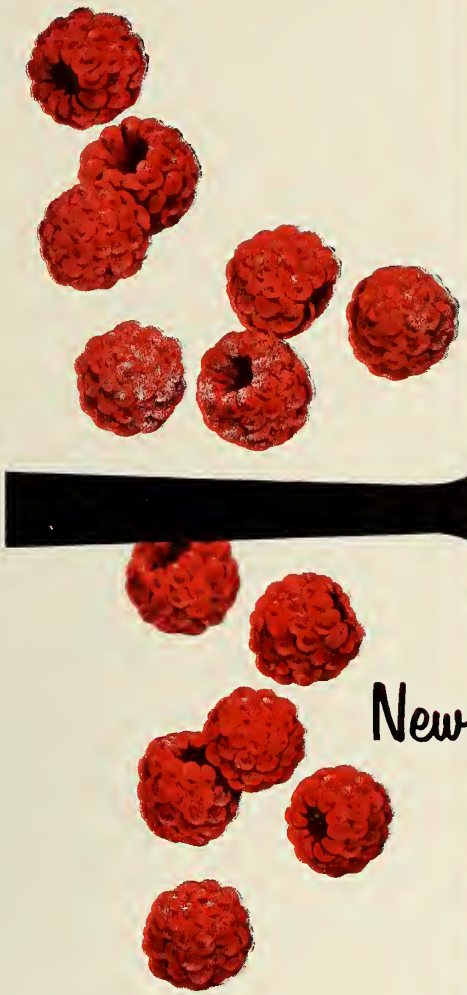
These actions improved prospects for a balanced, or near-balanced, budget in the current fiscal year. Another factor working for a balanced budget is the economic upsurge which means more federal revenue than originally estimated.

But Congress voted more for medical research than the President wanted. However, all of it may not be spent because the President has the authority to hold back part of it.

The Senate voted $481 million and the House, $344 million, for the National Institutes of Health--as against $294 million requested by Mr. Eisenhower. It was mandatory that a House-Senate Conference Committee, in working out a compromise between the House and Senate figures, approve a larger amount than the President requested.

The House Ways and Means Committee held hearings on the controversial Forand bill which would finance medical and hospital care of the aged through the social security system. Witnesses for the medical profession vigorously opposed the legislation. Dr. Leonard Larson, chairman of the AMA Board of Trustees, and Dr. Frederick C. Swartz, chairman of the AMA Committee on Aging, presented the AMA's views.

Representatives of various state medical societies either testified or presented statements in opposition to the legislation which would be



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financed through higher social security taxes and which would cost about $2 billion a year.

On another legisaltive front, AMA witnesses--Dr. George M. Fister, a member of the AMA Board of Trustees and chairman of the AMA Council on Legislative Activities, and Dr. Vincent W. Archer, a member of the AMA House of Delegates and the AMA Committee on Federal Medical Services--testified before the Senate Finance Committee in support of a House-approved bill (Keogh-Simpson) that would provide tax deferrals for self-employed persons who invest in qualified pension or retirement plans.

Dr. Fister testified that high taxes and inflated living costs make it "difficult for the self-employed person to set aside adequate funds for retirement without a tax deferment similar to that available for corporate employees."

Experts from 17 nations gave favorable reports on use of live polio virus vaccine at a week's conference sponsored by the World Health Organization and the Pan American Health Organization.

However, the 61 experts conceded in a statement summarizing the conference discussions that problems remain in use of the vaccine which is given orally. Their main concern was with "the very difficult problems in the development control and evaluation of the safety and effectiveness" of the live vaccine. They also recognized that "the use of a product that spreads beyond those originally vaccinated represents a radical departure from present practices in human preventive medicine."

An advisory committee of the U. S. Public Health Service recommended a fourth shot of Salk polio vaccine as routine for children and adults under 40 years of age. The report also said that Salk vaccine shots could be beneficial for persons over 40 but was "less urgent" because they had polio less frequently than younger people.

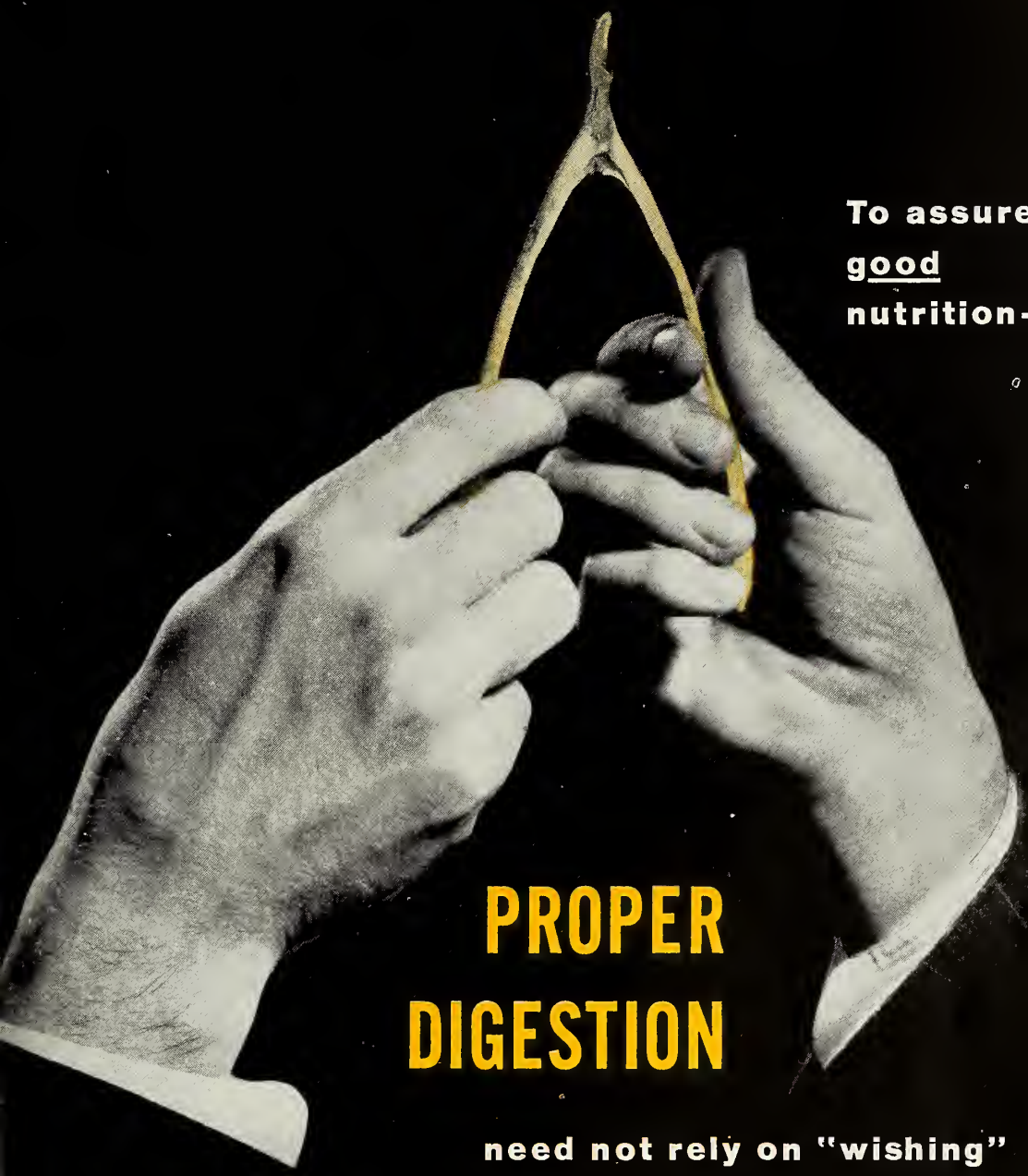
Surgeon General Leroy E. Burney of the Public Health Service also issued an urgent warning that tragic polio outbreaks might occur this year if communities didn't push polio vaccination campaigns.

* * * * * *

The Medical Society of the District of Columbia adopted a relative value scale of fees expressed in units rather than dollars. The basic unit of 1.0 is a routine office visit. The other relative values for medical services are multiples of the basic unit. For example:--an appendectomy, 30 units; allergy skin tests, 2.0 units per 10 tests with a maximum of 15 units for multiple tests; anesthesia, first half-hour or any fraction thereof, 4.0 units.

It is not mandatory that the District Medical Society members charge fees conforming to the relative value scale. It was designed to show the relative value of a physician's services, particularly for health insurance purposes.

The AMA House of Delegates unanimously approved last year the study of relative value scales by state medical societies.



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The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Health Inspections

Perhaps there will be a great to-do over the 5-to-4 decision of the Supreme Court upholding a Baltimore ordinance on sanitary inspection of dwellings. Aaron D. Frank, a householder, was arrested and fined for refusing to allow a Baltimore health inspector to enter a tumble-down dwelling to see whether it harbored the rats which were menacing the health of the neighborhood. The case went to the Supreme Court on the question whether the inspector, without a formal warrant, had the right to enter a man's property against his will.

The cry has already been raised by the minority of the court that this is an opening wedge for the invasion of every citizen's privacy by the police and the bureaucrats. We don't believe it. Baltimore's ordinance has been in effect in substantially its present form for 150 years without leading to the feared result. Dr. Bundesen, head of Chicago's health services, says the city's health inspectors have been operating without warrants for 50 years; thus here, too, and in scores of other cities the sanitary inspectors have not served as an opening wedge for anything except sanitary inspection.

The court in its majority opinion was careful to say that the inspectors do not arrest anybody and do not wake anybody in the middle of the night to drag him off to jail. The inspectors work in the day time. They do not walk off with private papers or other private property; if they did they could be severely punished for thievery. They do not break down doors. There is no record of their having abused the citizens or inspired any other public official to do so.

The 4th amendment [and, by inference, the 14th] forbid "unreasonable searches." We can't see anything inherently unreasonable about authorizing city health inspectors to go about their business of safeguarding the health of the community with no more hindrances than confront the gas company's meter readers.

Chicago Tribune
May 5

But—Don't Stop Your Salk Shots!

"Live vaccine, which may ultimately be a strong weapon against polio, is still experimental. The Public Health Service is following its development closely, and we are also conducting our own studies.

"In the meantime, I urge you not to wait. Until the live vaccine has been proven—and that may be a long time in the future—I strongly recommend that you get your Salk shots, which are of proven value, now."

—DR. LEROY E. BURNEY
Surgeon General of the U.S.
—*This Week Mag.*
June 28

Live Polio Vaccine?

It was good to read in *The Tribune* on Friday that the city-council health department finds the health of Howard County excellent.

No communicable diseases are on the department's records as of this date. Not one case of polio has been reported in the county this year, and only one was reported last year.

That is a far cry from the period several years ago when the incidence of polio here was one of the highest in Indiana. The miracle of the Salk vaccine is the reason, of course.

Now the polio season is approaching again, and health authorities urge that further protection be given children by inoculation with the vaccine. Interestingly enough, tomorrow's children could well obtain their immunity from polio from candy or a milk shake rather than undergo today's occasionally painful and almost always frightening method of inoculation in the quivering arm or buttock. At least three live-virus vaccines which may be taken orally have been developed in this country, and one or more



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of them could replace the killed-virus Salk vaccine.

One, the product of the research of Dr. Albert Sabin of the University of Cincinnati, has been extensively used in Russia, where it has been fed to 3½ million persons. Dr. Sabin told a World Health Organization meeting, June 22, that his vaccine, unlike the Salk vaccine, "may ultimately" break the "chain of transmission" of polio germs.

A Russian doctor who conducted field trials in 1957 told the same group, June 24, that the Sabin vaccine immunized not only the children who received it by mouth but also those in close contact with them. This could not have happened, he said, with the Salk killed-virus vaccine.

The U. S. Public Health Service will make the eventual decision on commercial production in this country of any live-virus polio vaccine. The recommendation of the National Foundation, which has supported the work of Dr. Sabin since 1940—as well as the research of Dr. Jonas Salk—would count heavily with the government agency.

It is claimed for the live-virus vaccine administered orally that it is much cheaper to produce than the Salk vaccine. Dr. A. M. M. Payne of the World Health staff in Geneva on June 22 estimated that live-virus vaccines could be given in mass immunization by mouth at one-tenth the cost of Salk vaccine.

Moreover, the Salk vaccine requires three inoculations over a period of months. To maintain immunity, the individual must be revaccinated every two or three years. Longer immunity—perhaps even life-long immunity—is claimed for the one dose live-virus vaccine.

Are the federal authorities dragging their feet on approval of a live-virus vaccine? Not even the advocates of oral immunization would make such a charge. For one thing, some doctors have long been afraid of a mutation or reversion of the attenuated live viruses back to their former deadly strength. The World Health Conference in June was told that live vaccine viruses can still damage the spinal nerves of monkeys when injected directly. What significance this has for human beings remains in doubt. Only recently have full safety reports on the live viruses reached the Division of Biologics Standards at the National Institutes of Health, the Public Health Service section which is responsible for setting safety and quality standards for all U. S. vaccines.

Meantime, Surgeon Gen. Leroy Burney is urging block-by-block polio vaccination campaigns, using, of course, the Salk vaccine. Nationally, paralytic polio cases are running about double the rate of a year ago. Dr. Burney on June 26 warned of "tragic outbreaks" of polio if communities continue to delay in pushing major drives to reach the unvaccinated.

—Kokomo Tribune
July 3

Britain's Doctors Talk Strike

The British Medical Association has drafted plans under which 97% of British physicians enlisted under the socialized health service to care for patients would refuse to perform for the government service until their pay is raised. Patients would have to foot the bills now paid by the government. They could seek reimbursement later from the government if the demands of the physicians were satisfied.

The doctors contend that when they were inveigled into socialized medicine more than a decade ago, they were promised that the state would maintain the pre-war living scale of 1939. No pay increase has been forthcoming from the government since 1951 and the lag in compensation, compared with 1939 levels, now exceeds 25%.

The impasse in Britain provides another commentary on the something-for-nothing schemes of socialists. Charges for treatment and medicine assessed against patients and met under social security allotments cover only 20% of the costs of British socialized medicine. The remainder comes out of general tax revenue. Even so, to foster the illusion that Britons are getting something "free," it is necessary for the government to short-change the practitioners.

This experience is especially illuminating at a time when the New Deal welfare staters in Washington have plans on the fire to ease the nation by degrees into socialized medicine. The preliminary step, embodied in the bill offered by Rep. Forand of Rhode Island, is to extend "free" medical and hospital care to those collecting social security benefits.

As a method of further ballooning federal spending, wiping out the independence of a val-



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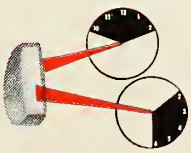
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References: 1. Sheldon, J. M.: Postgrad. Med. **14**:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy **19**:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.E.N.T. Monthly **37**:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. **112**:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. **5**:1183 (Sept.) 1958.

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Continued

ued professional group, extending dependency among the people, and promoting deficits and inflation, no better scheme could be devised. And the worst effect would be one that is not reflected on the cost sheet. It would be in the deterioration of professional standards, competence and interest in the patient.

—*Chicago Tribune*
June 4

Death in Ice Boxes

It still goes on.

Children still suffocate in abandoned refrigerators. A 10-year-old Muncie boy was found dead in such a situation last Saturday, several hours after police started a search for him.

It was only by accident that the lad's body was discovered. His younger brother found him when he went out to throw some garbage into the refrigerator.

It would be helpful if everyone in this community—and other towns and cities—would look around his or her neighborhood on the chance that abandoned ice boxes may be lying around some yard or lot.

If one is found and its door has not been removed, it is a potential death trap. A good neighbor will suggest to the owner of an abandoned box that he remove the door, or if the owner cannot be located, the presence of the box should be reported to the police department.

—*Kokomo Tribune*
June 4

Radiation Effects on Human Beings

In the last few years the publicity about radioactive fallout has been coupled with statements that the dosage resulting from the testing of atomic weapons was small by comparison to the dose received in using x-rays for medical diagnostic purposes. This caused some people to become afraid of medical x-rays and many refused to have x-ray examinations.

Medical experts believe that only one side of this story has been adequately told to the public. Writing in the *Journal of the American Medical Assn.,* Drs. J. E. Miller and G. E. Swindell state that "it would be the rare person who might receive enough radiation to cause even the slightest demonstrable body harm" from medical examinations.

Mutations resulting from radiation are not different, say Drs. Miller and Swindell, from those which have been occurring naturally in the human race for centuries. In their words, this naturally occurring rate of mututation is called "normal" for the human species.

The two doctors point out in their article some of the benefits of medical radiation. For example, until roentgenology (x-ray) was developed, the opportunity for curative surgery was limited, and the development of much surgery in the future awaits better diagnosis, whether by x-rays or other methods. The progress of heart surgery to its present status could not have occurred without the aid of the x-ray examination.

Radiologists are not careless men. Indeed they lean on the side of caution, and physicians in general are concerned with keeping the medical dose of radiation as low as possible. Drs. Miller and Swindell say that x-rays used in medical diagnosis "are not harmful; they are beneficial. . . Any practitioner who uses radiation with conservative judgment and skill should not be made to feel uneasy about its use. The potentiality of causing damage to future generations should not prevent the real benefit to be obtained by the use of radiation in the present generation."

And in the same issue of *The Journal,* Drs. George Cooper Jr. and Kenneth Williams declared that "in careful hands, radiation is less dangerous than many other hazards accepted daily without question—anesthesia, transfusion, automobile driving, etc."

Medical experts, then, are not denying that radiation used in medical treatment may be dangerous if used in excess or if used unadvisedly. But they say that its hazards have been greatly exaggerated in the public mind and that the public need not fear it.

—*Kokomo Tribune*
June 24

A Slight Swing?

The pendulum may be starting a return swing in American colleges where teacher training once swept out to an extreme attitude which emphasized how to teach, rather than what to teach.

The latest indication is an announcement from

Continued on page 1254

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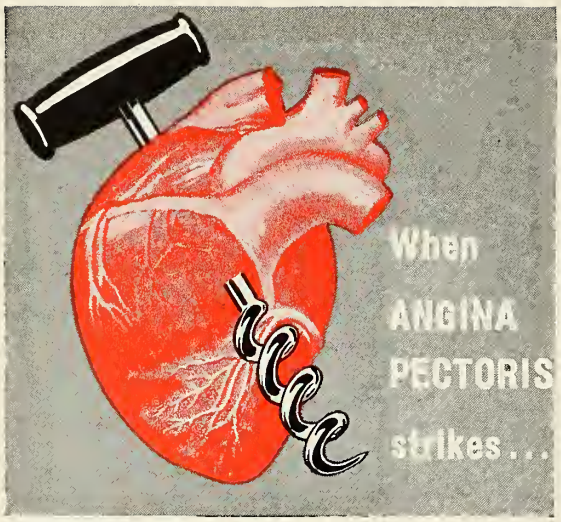
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Niphylline is safe, and well tolerated . . . exerts strengthening effect on heart muscles, and acts synergistically, remarkably reducing severity and frequency of cardiac attacks.

Indications: Relief and control of angina pectoris, cardiovascular symptoms, asthenia, coronary spasm with myocardial pain, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Dosage: One or two tablets, 3 or 4 times daily, or as directed by physician.

Supplied: Bottles of 100 and 1000 tablets.

PM **PAUL MANEY**
LABORATORIES, INC.
Cedar Rapids, Iowa

Fourth Estate

Continued from page 1250

the Ford Foundation which says there has been a "breakthrough" in the program of teacher education. Among objectives of this effort is the extension of general or liberal education of teachers. Three other goals have to do with the methods of teaching.

The foundation says it hopes that a series of grants made for this "breakthrough" program will "help improve teacher education throughout the country." It notes the money will be spent in several different kinds of colleges.

There was a time when an extension of liberal education for teachers probably would not have been ranked as an objective in this kind of program. It has only been at the insistence of those outside the education system that even this gradual change has taken place.

Nor does the list of colleges to receive the grant show that any major change is to be made immediately in this field. Of 10 included by the foundation, only three emphasize the training of teachers who learn first what to teach, and later how to teach. They are Johns Hopkins University, and the Universities of North Carolina and South Carolina. Seven others place greater emphasis on "internship" and demonstrations of methods and teaching devices.

College professors at a conference last week gave limited approval to increasing the stress on subject matter to prospective teachers, as well as showing how children should be taught. Casting an eye at the "internship" system of teacher-training, one speaker noted that colleges "don't make writers spend a couple of semesters in a garret before they go on their own." Educationists don't like this kind of talk, but they cannot refute its general common sense.

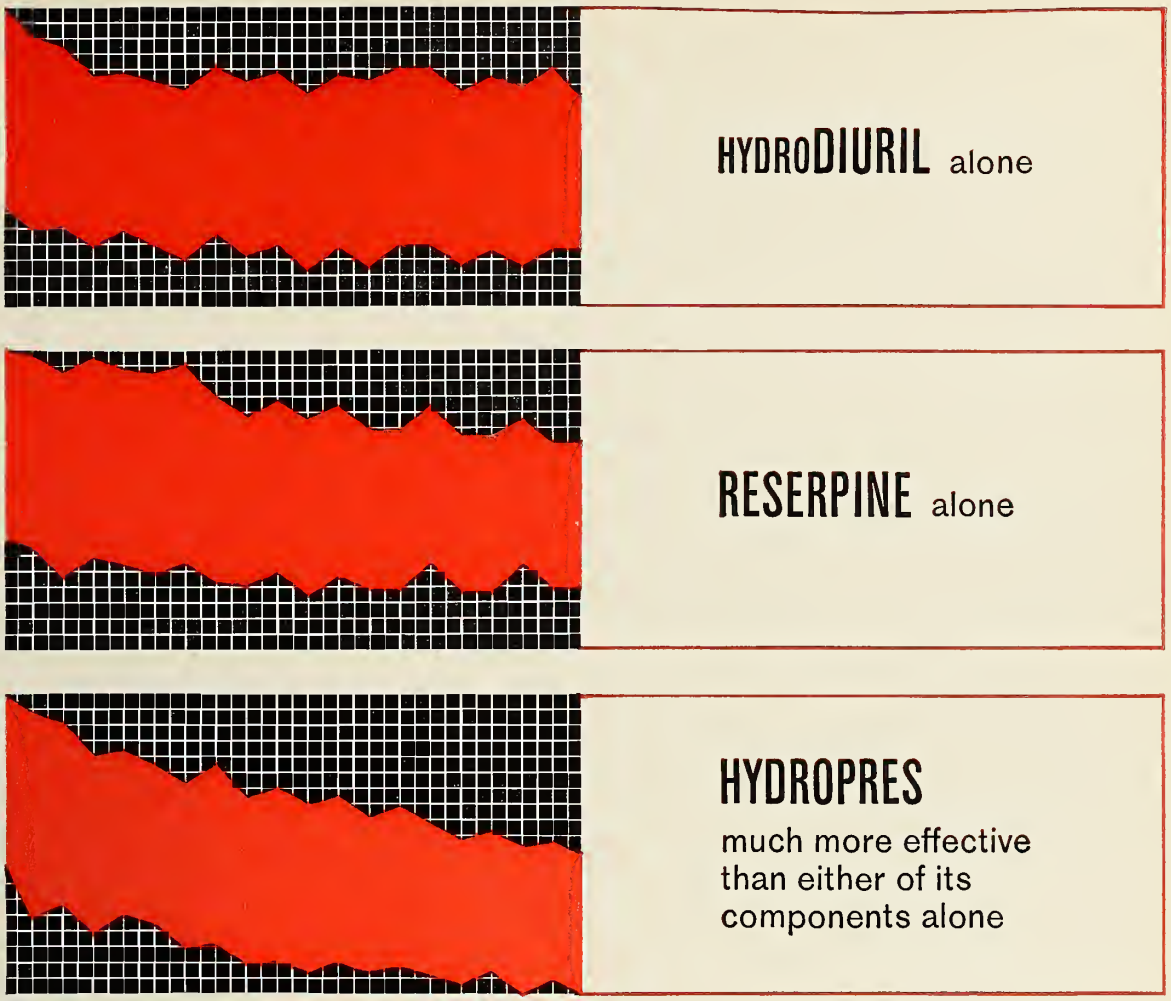
Those who want the nation to have better teachers, students and schools—and the ingredients of an educational system come in that order —will continue to press for better-*educated* rather than better-trained schoolteachers.

—*Indianapolis Star*
June 5

Pedestrian Fatalities

Most motorists know they must give the right of way to pedestrians, yet more than half of the people killed in urban traffic accidents are pedestrians. This sobering fact was pointed out

Continued on page 1258



- Effective by itself in a majority of patients. Provides smooth, more trouble-free management of hypertension.
- Since HYDRODIURIL and reserpine potentiate each other, the required dosage of each is lower when given together as HYDROPRES than when either is given alone.
- HYDROPRES provides the needed and valuable tranquilizing effect of reserpine. Lower dosage may reduce such side effects of reserpine as excessive sedation and depression.
- Arrest or reversal of organic changes of hypertension may occur.
- Headache, dizziness, palpitations and tachycardia are usually promptly relieved. Anginal pain may be reduced in incidence and severity.
- With HYDROPRES, dietary salt may be liberalized.
- Convenient, controlled dosage.

HYDROPRES-25

25 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one to four times a day.

HYDROPRES-50

50 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one or two times a day.

If the patient is receiving ganglion blocking drugs or hydralazine, their dosage must be cut in half when HYDROPRES is added.

MSD **MERCK SHARP & DOHME,** DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

*HYDRODIURIL AND HYDROPRES ARE TRADEMARKS OF MERCK & CO., INC.

Fourth Estate

Continued from page 1254

last week at the Indiana Editors and Publishers Traffic Safety Seminar in Indianapolis.

In behalf of motorists, it should be noted that they generally are careful to respect the rights of pedestrians, especially at street intersections. The pedestrian has an obligation and a responsibility, too. His position is a poor one if he deliberately dares a driver to hit him, for example. And in many cases where pedestrians cut across streets in the middle of a block, where there are no authorized middle-of-the-block walks, they step out in front of motorists with no warning.

In such instances, the pedestrian is partly responsible for any injury to himself. The best way for the motorist to avoid complete blame for hitting and injuring a pedestrian is to observe the lawful driving speeds in a residential area. This speed is 30 miles an hour.

Burton Marsh, director of the taffic engineering and safety department of the American Automobile Assn., who addressed the seminar, agreed that while more attention should be paid to the pedestrian, marked progress has been made in this phase of traffic safety. Pedestrian fatalities have been reduced one-half since 1937, compared with a 21% reduction in all other traffic fatalities, he said.

The *Kokomo Tribune* was one of the sponsors of the seminar, and this newspaper joined others in Indiana in acknowledging with appreciation the statement by George Stewart, executive vice-president of the National Safety Council, that without the support of traffic safety programs by Hoosier newspapers the state's traffic accident toll would be 50% greater.

The press works constantly at the cause of street and highway safety and is glad to be a part in that effort. But newspapers and all others who keep up this fight dare not rest on their oars. Emphasis and re-emphasis on the causes of accidents and on the rules of the road are a "must" in this age of speed and growing numbers of automobiles.

—*Kokomo Tribune*
June 17

Noble Experiment

Another insurance company has decided to take the plunge and put a premium on traffic safety. It will reward safe drivers with lower rates. Drivers with poor records will get higher rates.

Nebraska is the first of four Midwest states to start the experiment for this particular underwriter. If it works out, it will be applied to the country as a whole and may well be accepted by all insurance companies.

We all have a good reason to pull for the Cornhuskers to come through—not only for the selfish sake of our own pocketbooks, but for the impetus to safe motoring that ought to result.

Motorist or not, we would all benefit.

—*Kokomo Tribune*
June 26

A friend of ours, just back from England, reports that among the emergency telephone numbers on a list in the newly-decorated guard room at St. James' Palace are those for Buckingham Palace, Scotland Yard, the War Office and a firm of television repairmen.—*Quote.*

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Each timed-release tablet provides:

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(phenylpropanolamine HCl.....25 mg.
pheniramine maleate 12.5 mg.
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Dormethan (brand of dextromethorphan HBr) 30 mg.
Terpin hydrate 180 mg.
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topical "Meti" steroid relief in a pocket-size dispenser that patients can carry with them

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for poison ivy dermatitis, summer exacerbations of skin allergies

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50 Gm. container—16.6 mg. prednisolone.
150 Gm. container—50 mg. prednisolone.

METI-DERM with Neomycin Aerosol—
50 Gm. container—16.6 prednisolone and 16.6 mg. neomycin sulfate.
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5-185

X-Ray Equipment Check:

Statement from Vanderburgh County Medical Society

The Vanderburgh County Medical Society announces that a voluntary safety survey of all x-ray equipment in the offices of its members has been completed. We are the first county medical society in the United States to undertake such a survey as a society project.

This voluntary effort is a part of our program to provide the best possible medical care for the people of this community and to maintain the high rating our profession received in the Fantus Survey Report. Medical care here was rated above average by the Fantus Factory Locating Service of Chicago in a recent community appraisal of Evansville's potential for industrial growth. We were gratified to learn from the inspection that the x-ray equipment in the offices of our members is generally in good condition. All corrections recommended were of a minor nature and have been made. In almost every instance corrections recommended were found to be of a type which would affect the quality of the x-ray picture rather than the safety of the operating personnel and the patient. Much of the equipment needed no correction.

Thirty-five pieces of x-ray equipment were inspected by two certified radiation physicists engaged for the survey.

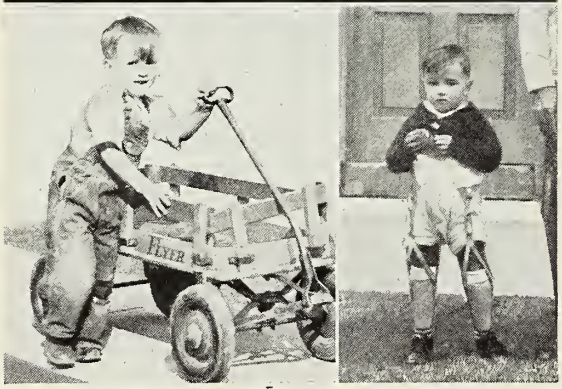
The check was undertaken as a medical society project because attention of the public has been directed to radiation hazards, causing much undue alarm over the use of x-rays in medical application. The specially qualified radiation physicists, one from Chicago and the other from Indianapolis, were called in to check the equipment of physicians so they might be assured that their procedures are adequate, satisfactory, and provide the greatest amount of protection from radiation for their patients, their x-ray personnel and themselves.

Thirteen states have laws requiring the registration of x-ray equipment. The medical society's voluntary survey went much further than the legal requirements of these states by actually having the equipment inspected. Indiana has no registration law.

In general, the medical profession has been aware of the possible hazards of radiation for many years before the present wave of public concern, and has been working steadily and gradually to eliminate them, particularly in medical use of x-ray.

Public concern over radiation hazards has caused a number of states to consider the possibility of some type of legislation affecting radiation. The medical society would like to serve warning that undue fear and alarm might result in laws of such a restrictive nature that they could seriously handicap the proper use of radiation in medical diagnosis and treatment. This could do a great disservice to the people of America, and over the years cause greater harm than good. ◄

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Hanger Prosthetic Appliances have brightened the present and the future for many amputees. For example, Weaver Nolt says: "My son, Lloyd, was a pathetic figure in a big hospital bed after his legs were amputated because of an accident. Today it's a big and wonderful world again as he gets along so wonderfully on his Hanger Legs. He walks without any help, and runs and pushes his wagon all over the farm. That other day is just a hazy memory, and we are so pleased things are so different than we expected.

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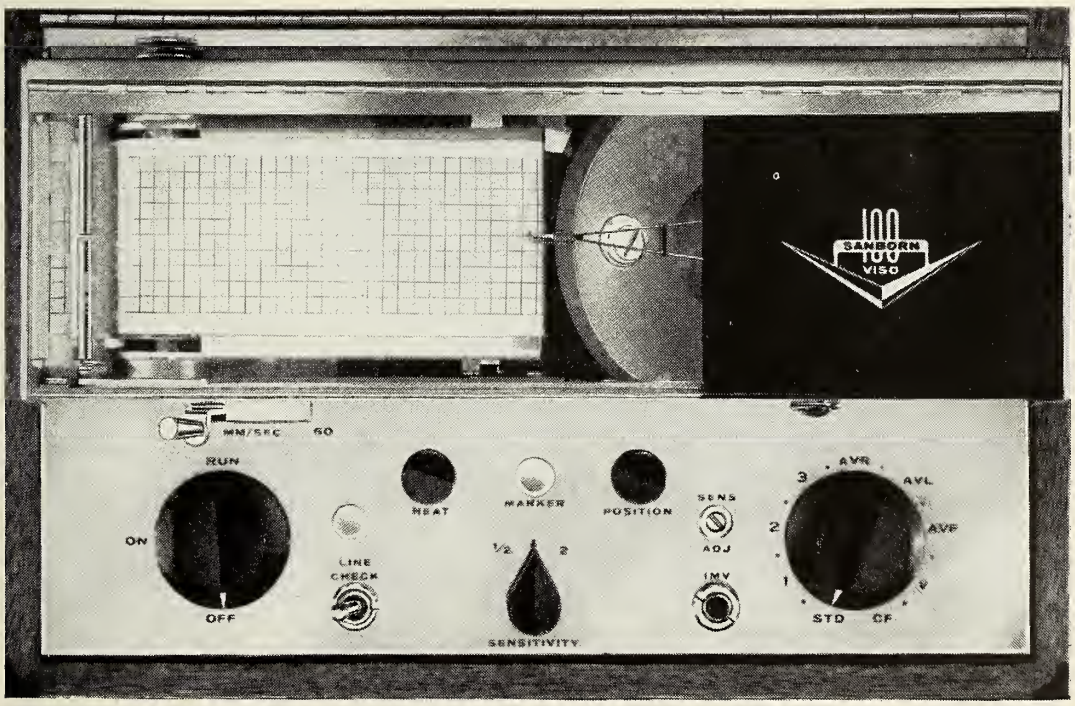
One dad to another: I'm no model father. All I'm trying to do is behave so that when people tell my son that he reminds them of me, he'll stick out his chest instead of his tongue."—*Manchester Oak Leaves.*



The new Sanborn 100 Viso electrocardiograph: two speeds . . . 25 or 50 mm/sec . . . clearly defined, permanent traces on 6cm charts . . . normal, ½, or 2-times recording sensitivity . . . two additional inputs for recording other phenomena, plus outlet for connecting monitoring oscilloscope . . . 15 transistors saving space, weight, and power . . . and the mobility of 29 pounds, complete . . . make this

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Prescription For Safety:

Treat the Mind Behind the Wheel

A review of "what motorists really think about traffic safety," published by the Pure Oil Company and the ATA Foundation, Inc., on the basis of a study conducted by Opinion Research Corporation.

MODERN mass communications, admirably dedicated to traffic safety, must handle drivers with kid gloves these days for maximum effectiveness.

American drivers are a sensitive group . . . studies show that 90% are above average, in their own opinion, and are easily insulted by the suggestion that they don't drive safely. They want to be good drivers and have a genuine desire to keep up with modern highway progress.



But woe is the man who seeks to reach them by a "drive safely" type of slogan! That's for the ordinary guy—the fellow you run into in traffic jams.

Mr. Above-average Driver scorns law-breaking; yet, due to his feeling of superiority, thinks he should be warned and not fined for offenses. Drunken driving and speeding most easily upset him—but at the same time, he's the fellow who is "completely" under control at the wheel and sees nothing wrong with scooting along at just a few miles over the limit.

Police force popularity polls are more encouraging than those for traffic court judges, but neither group could take a sweepstakes. . . . Most of the skepticism about the effects of cracking down on drivers with stronger laws is due to doubt about proper enforcement.

Happy motoring through safe driving also leaves a bad taste in the adult's mouth. Most oldsters, it is found, don't enjoy being behind the wheel. At the same time, however, teenagers do, and are good targets for this approach. The teen driving population is a problem in itself, merely because they are most dangerous, in the adult way of thinking. Yet the younger generation is more enthusiastic about driver education and even feels a need for more comprehensive programs!

PRESCRIPTION: Ironically, safety promoters can take a hint from habitual violators—



"AND JUST WHAT MAKES YOU THINK I'VE HAD TOO MUCH TO DRINK ALREADY?"

a group that realizes the need for psychological help. Drivers today are still vulnerable to suggestions and ideals—but not to being told. They are in need of a better image of law enforcement personnel, of realizing that life-long injury—not death—is often the result of careless driving. Teens, too, can be reached . . . careless drivers are "squares" . . . who wants to have that reputation?

The average driver is almost non-existent in our society these days—and the most effective mass media campaigns will be geared to this concept. Superiority complexes are capable of being pampered—in safety's best interests.

In 1958, more than 49% of the traffic injuries resulted from weekend accidents.

Abstracts:

THE PLASMA PROTEINS

Paul G. Weil, M.D., Ph.D., Director, Transfusion Service and Assistant Physician, Victoria Hospital; Lecturer in Medicine, McGill University; Consultant in Medicine, Queen Mary Veterans and Grace Dart Hospitals; Consultant in Transfusion, Queen Elizabeth and Royal Edward Laurentian Hospitals. 122 pp. Price $3.50. J. B. Lippincott Company, Philadelphia, Montreal.

This interesting book of only 122 pages discusses alterations in the blood proteins in a great variety of disease states. Most of the work appears to be based on electrophoretic methods of protein separation. That accurate methods for electrophoretic study of blood proteins are not generally available to most physicians does not detract from the interesting material in this volume.

Although the author is director, Transfusion Service, Royal Victoria Hospital in Montreal, many interested in blood banking in this country would take some exception to the introductory paragraph in Chapter 4 entitled "Plasma Protein Substitutes" where mention is made of the danger of homologous serum jaundice after storage at room temperature for six months. Clinical pathologists may criticize the interpretation which the author places on the commonly used cephalin-cholesterol and thymol turbidity flocculation tests in the diagnosis of liver disease (Chapter 10). On page 39, there is a misprint where 5 mg. per 100 ml. is printed, and 5 gm. per ml. is intended.

The volume is recommended as informative and makes easy reading.

Jene R. Bennett, M.D.
South Bend

THE SEDIMENTATION RATE OF HUMAN ERYTHROCYTES

Frank Wright, M.D., F.A.C.P., F.A.S. 43 pp. Price $2.50. Vantage Press, New York.

This confusing book is an exposition of the author's concepts of the sedimentation rate as ". . . an accurate measure of energy at work." From this point the book often becomes incomprehensible. "As an alarm reaction, the sedimentation rate alerts the population the world over

for a HAPPY HOLIDAY



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. . . where American history comes to life; a vast collection of Americana from time of early settlers to present day and historic homes, shops, stores, etc., from all parts of America.

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Abstracts:

Continued

concerning fallouts." "This I find of great value in checking high-powered executives who are flirting with disaster." "Once a crisis of this sort is avoided and understood, the fear of a sudden holiday—wrecking demise or stroke paralyzing speech and locomotion can be circumvented." "By means of the sedimentation rate I can measure the energy poured down upon individuals from far-ranging distant bomb blasts in its effect upon the dynamic activities of individual human cells."

The book is not recommended.

Jene R. Bennett, M.D.
South Bend

SURGICAL PATHOLOGY

Lauren V. Ackerman, M.D. in collaboration with Harvey R. Butcher, Jr., M.D. 1079 pp. Price $15.00. C. V. Mosby Co., St. Louis.

A text, not designed for light reading, presents in its 26 chapters a lucid story about the surgical pathology encountered in all the various areas of the body. It permits the surgeon to review the pathology of any given area and to answer the question so aptly put by the author, "What does the future hold for this patient?" While perhaps more important to the surgeon, it's comprehensive nature makes it applicable to all physicians in their quest for that end result.

Better patient care—The text has 1114 illustrations and with ample references appended to each chapter. No segment of medicine escapes the implications of pathology, hence it is a volume worthy of consideration by physicians in any field.

W. L. Portteus, M.D.
Franklin

CORRELATIVE NEUROANATOMY AND FUNCTIONAL NEUROLOGY

Joseph G. Chusid, M.D. and Joseph J. McDonald, M.D. 337 pp. Lange Medical Publications, Los Altos, Calif.

A volume intended for the beginner in Neurology and the General Practitioner. Knowledge of its contents covering anatomy, physiology and clinical features makes it ideal for a quick reference. Its many superb illustrations doubles its value in explaining neurological problems to patients as well as orienting physicians in the realm of fundamental neuro-anatomy.

The appendix—covering neurologic signs and syndromes and neurologic examinations—will certainly elevate the average physician to the unusual.

W. L. Portteus, M.D.
Franklin

Radio Russia says that America is a hysterical topsyturvy country where people eat upside-down cake, doors go around in circles and everybody has an inside outhouse.—*Santa Fe Mag.*, Santa Fe Railway.



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IN 735 PATIENTS, BLOOD PRESSURE FELL AN AVERAGE OF 30.7 mm. Hg:

- more than half of these patients suffered from **moderate to severe hypertension**
- more than half of the cases involved hypertension of at least 6 years' standing, with **many histories of up to 20 years' duration**

THE SIDE-EFFECTS PROBLEM WAS MINIMIZED IN MOST PATIENTS:

Chart shows gratifyingly low incidence of side effects in 233 patients given Singoserp with no other antihypertensive medication

Side Effect	Number	Per Cent
Lethargy	7	2.9
Headache	6	2.5
Gastrointestinal upset	3	1.2
Vertigo	2	0.8
Nasal congestion	1	0.4

DOSAGE: Initially, 1 to 2 tablets (1 to 2 mg.) daily.
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Samples available on request. Write to CIBA, Box 277, Summit, N.J.

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for the anxious hypertensive with or without tachycardia

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For Your Information:

American Cancer Society Opposes Little Red Door—United Fund Alliance

The legal action of the American Cancer Society against the Little Red Door (The Marion County Cancer Society, Inc.) and the indirect involvement of the United Fund of Greater Indianapolis, Inc., together with the resulting publicity, have prompted me to write this letter of explanation, so that you as one of the leaders of our community will know the position of the officers of our United Fund in this matter.

At the outset I would like you to know that we who are associated with the development of the policies of the United Fund of Greater Indianapolis, Inc., do not now nor have we ever taken exception to the objectives of the American Cancer Society in the field of medical research and education. In support of this statement I point to the fact that our United Fund has made annual allocations to the Marion County Cancer Society, Inc., for several years, with the full realization that the local agency has been supporting the program of the national agency. We have been informed that this support has actually exceeded the quotas established for Marion County by the American Cancer Society. We are perfectly willing to continue raising funds locally for this purpose.

The United Fund of Greater Indianapolis, Inc., was organized because the majority of the residents of this community preferred being solicited once a year for their combined charitable giving and because a need existed for an organization through which such federated giving could be made.

The Little Red Door was one of the several agencies, previously associated with the Community Chest, which was included in the United Fund of Greater Indianapolis, which now solicits financial support for 71 separate community services.

Some months ago the American Cancer Society ordered all of its affiliate units throughout the country to withdraw from participation in United Fund or Community Chest fund drives by January, 1960. After considerable thought, the board of directors of the Little Red Door voted to continue its association with the United Fund of Greater Indianapolis, despite the orders to the contrary from the national organization.

This action was taken because the officers and directors of Little Red Door believed that in not resuming a separate fund drive they were complying with the wishes of a majority of the giving public and that they were better able to interpret local thinking in this matter than is the American Cancer Society which is headquartered in New York City.

Because of this action by the officers and directors of the Little Red Door, the American Cancer Society has instructed its Indiana Division to establish a second cancer society in Marion County. In addition, legal action has been taken, in the name of the Indiana Cancer Society, Inc., against the Little Red Door (Marion County Cancer Society, Inc.).

In this legal action the Indiana Cancer Society is asking the Court to order the Little Red Door to pay over and deliver to the Indiana Cancer Society, ". . . all equipment, supplies, money and other property held by it on March 1, 1959. . . ."

The complaint also asks, among other things, that the Court direct Little Red Door to pay the Indiana Cancer Society, Inc., the sum of $14,343.26, plus interest, which it contends is due the state and national agencies from contributions received by Little Red Door in the fiscal year 1959, and further asks that the Court order Little Red Door to pay to the state society 60% of any contributions attributable to the year 1959, to which Little Red Door was entitled prior to March 1, 1959.

The Indiana Cancer Society, Inc., through its attorneys, has also made a demand to the United Fund that it surrender any assets held in the name of the Marion County Cancer Society, Inc. This demand was given proper consideration

A memorandum to the business leaders of Indianapolis and Marion County from C. Harvey Bradley, president of the United Fund of Greater Indianapolis, Inc.



VESPRIN made the difference

SQUIBB TRIFLUPROMAZINE HYOROCHLORIDE

in anxiety and tension states / psychomotor agitation / phobic reactions / obsessive reactions / senile agitation / agitated depression / emotional stress associated with a wide variety of physical conditions

In the patient with anxiety and tension symptoms — Vesprin calms him down without slowing him up... and does not interfere with his working capacity. Vesprin permits tranquilization *without* oversedation, lethargy, apathy or loss of mental clarity.[4]

And Vesprin exhibits an improved therapeutic ratio — enhanced efficacy with a low incidence of side effects; no reported hypotension, extrapyramidal symptoms, blood dyscrasia or jaundice in patients treated for anxiety and tension.[1,2,3]

dosage: for "round-the-clock" control — 10 mg. to 25 mg., b.i.d.; for "once-a-day" use — 25 mg. once a day, appropriately scheduled, for therapy or prevention. **supply:** Oral Tablets, 10, 25 and 50 mg., press-coated, bottles of 50 and 500; Emulsion (Vesprin Base) — 30 cc. dropper bottles and 120 cc. bottles (10 mg./cc.). **references:** 1. Stone, H.H.: Monographs on Therapy *3*:1 (May) 1958. 2. Reeves, J.E. Postgrad. Med. *24*:687 (Dec.) 1958. 3. Burstein, F.: Clinical Research Notes *2*:3, 1959. 4. Kris, E.: Clinical Research Notes *2*:1, 1959. 'VESPRIN® is a Squibb Trademark

Vesprin—the tranquilizer that fills a need in every major area of medical practice

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Cancer Society Opposes

Continued

by the Executive Committee of the United Fund and denied since it did not originate from the agency for whom we conducted a fund drive.

The court trial of the issues in this matter has been set for October 6, 1959. In the interim the Court has entered an order limiting Little Red Door to the use of 40% of the monies which have been allocated for its use by United Fund.

The officers of United Fund of Greater Indianapolis, Inc., deplore that the American Cancer Society, whose national program of medical research and education we admire, have determined to abandon their affiliation with Little Red Door, have created a new county organization in competition with Little Red Door, have instituted legal proceedings obviously intended to strip Little Red Door of its funds, records and properties and have elected to conduct a separate fund drive in Marion County in complete defiance of the "one fund" solicitation which we believe is desired by the majority of the residents of this community.

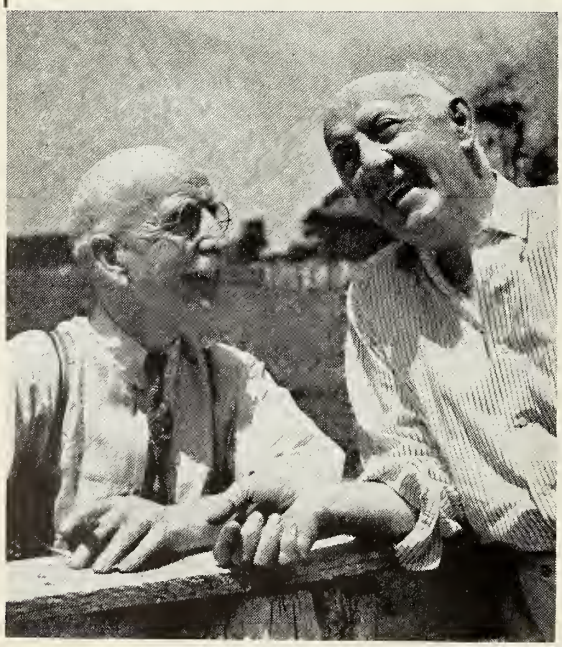
It is my sincere hope that this letter has clearly set out the issues in this matter and the attitude of the officers of the United Fund. If you agree with our position in this matter you can do a great service to United Fund by explaining the situation to your friends and associates.



"Those tranquilizers have been making me so happy lately that I just wondered if you had a pill that would depress me!"

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IN TINNITUS—When cerebral function and oxygen supply can be improved, visual and auditory improvement is often noticeable.

SUPPLIED: Tablets—bottles of 100.
Elixir—pint bottles.

Composition: Each tablet and each 5 cc. elixir contains 100 mg. Pentylenetetrazol, and 50 mg. Nicotinic Acid.

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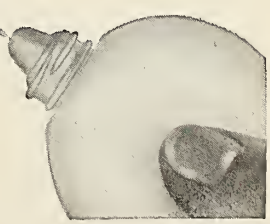
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Hoosiers Attending AMA Meeting, Atlantic City, Listed in Bulletins

MORE THAN 120 Hoosier physicians traveled to Atlantic City in June for the American Medical Association annual meeting. Following are the lists of registrations as they appeared in the AMA daily Bulletins:

I.S.M.A. DELEGATES: Drs. Gordon B. Wilder, Anderson, and Wendell C. Stover, Boonville.

SECTION DELEGATES: Dr. Lester D. Bibler, Indianapolis, section on general practice; and Dr. Lall G. Montgomery, Muncie, section on pathology.

PHYSICIANS

Drs. Charles H. Ade, Lafayette; Mary Keller Ade, Lafayette; Charles R. Alvey, Muncie; Robert L. Armington, Anderson; Earl W. Bailey, Logansport; Willoughby M. Barton, Centerville; Milton B. Bergal, Gary; Lester D. Bibler, Indianapolis; Joe M. Black, Seymour; Norman R. Booher, Indianapolis; Abraham A. Brauer, Gary; Robert E. Bryan, Kendallville; and Carl A. Bunde, Indianapolis.

Drs. Harold F. Burdette, Indianapolis; John R. Cassady, South Bend; William B. Challman, Mt. Vernon; Stanley M. Chernish, Indianapolis; Clarence G. Clarkson, Liberty; Frederick J. Colosey, South Bend; Raymond L. Conklin, South Bend; Franklin S. Crockett, West Lafayette; R. Louis Curry, Indianapolis; Dorothy Darling, Gary; William L. DeRenne, Newport; Joseph E. Dudding, Hope; Baruch M. Edlavitch, Fort Wayne; Gustaf W. Erickson, South Bend; Henry R. Eshelman, Montery; and Arthur N. Ferguson, Fort Wayne.

Drs. Henry Fisher, Marion; Thomas C. Fleming, Evansville; Clementine Frankowski, Whiting; Robert D. Fry, Indianapolis; Euclid T. Gaddy, Indianapolis; Willam H. Garner, New Albany; Francis H. Gootee, Loogootee; James H. Gosman, Indianapolis; George F. Green, South Bend; Harold R. Griffith, Fort Wayne; Edgar A. Hawk, Evansville; Norman L. Heminway, Elkhart; and Robert N. Henderson, Brookston.

Drs. Herman S. Hepner, Bloomington; Don C. Hines, Indianapolis; Arthur A. Hobbs, Evansville; Marian Hochhalter, Logansport; Anson G. Hurley, Muncie; Eli S. Jones, Hammond; Robert Kammen, Indianapolis; William R. Kirtley, Indianapolis; Eugene C. Klatte, Indianapolis; Harry E. Klepinger, Lafayette; Kenneth G. Kohlstaedt, Indianapolis; Edward H. Kruse, Fort Wayne; Paul T. Lamey, Anderson; Francis L. Land, Fort Wayne; Clarence Laubscher, Evansville; and Russell W. Lavengood, Marion.

Drs. Glen Ward Lee, Richmond; Robert J. Lewis, Lawrence; Frank L. Lyman, Evansville; Otis R. Lynch, Marengo; Gordon Marquis, South Bend; W. Burleigh Matthew, Indianapolis; Wilbur C. McCormick, Brazil; Fletcher W. McDowell, Muncie; Dennis S. Megenhardt, Indianapolis; Richard G. Mehne, Brazil; Robert D. Meiser, Huntington; and Earl W. Mericle, Indianapolis.

Drs. Stephen C. Michaelis, Fort Wayne; Hugh A. Miller, Elkhart; Alfred M. Mintz, Hammond; Lall G. Montgomery, Muncie; Cleon A. Nafe, Indianapolis; Leonard L. Nesbit, Anderson; Henry G. Nester, Indianapolis; Richard T. Nolin, Indianapolis; Myron H. Nourse, Indianapolis; Harold C. Ochsner, Indianapolis; Kenneth L. Olson, South Bend; Thomas R. Owens, Muncie; Guy A. Owsley, Hartford City; William A. Paff, Elkhart; Harry Pandolfo, Indianapolis; and Donald J. Parrot, Fort Wayne.

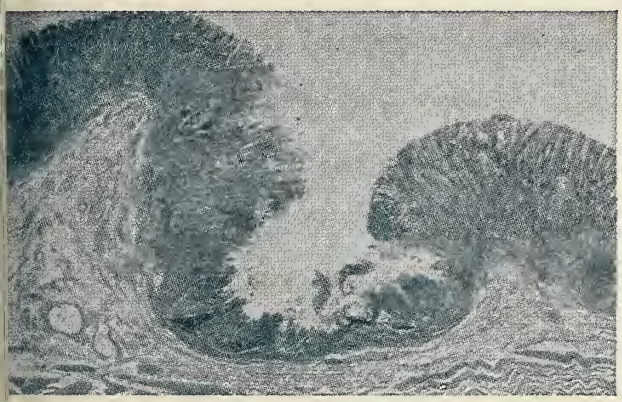
Drs. Franklin B. Peck, Sr., Indianapolis; Arvine G. Popplewell, Indianapolis; Walter L. Portteus, Franklin; Thomas A. Rafalski, Indianapolis; Raymond M. Rice, Indianapolis; Anthony S. Ridolfo, Indianapolis; Edward L. Rigley, South Bend; Evered E. Rogers, Auburn; Bernard D. Rosenak, Indianapolis; Bernard B. Rosenblatt, Evansville; Theo. F. Schlaegel, Jr., Indianapolis; V. Brown Scott, Shelbyville; Roscoe L. Sensenich, South Bend; and John C. Shattuck, Brazil.

Drs. Harris B. Shumaker, Jr., Indianapolis;

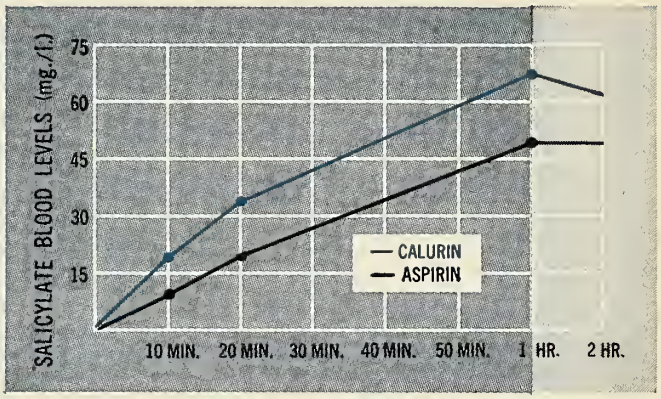
Continued on page 1278

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A Winning Letter:

In My Opinion

Frank Oski, M.D.

(The following is the first prize letter in a contest staged by "The New Physician," publication of the Student AMA, and printed in the June, 1959, issue. First prize of $500 was presented Dr. Frank Oski, University of Pennsylvania Hospital, Philadelphia, at the 1959 SAMA Convention.)

The public and press continually clamor about the rising costs of medical care, yet no mention is made of the rising standard of this care.

I feel certain a patient could receive the same treatment today that he received 20 years ago for the same price after adjustment was made for the increase in the cost of living. But if a patient were to receive this same care today as he once had he would no doubt feel inadequately studied and treated.

The higher cost of hospitalization today is largely a result of the wider range of diagnostic tools available to the physician, a broader pharmacologic armamentarium, and newer and improved surgical tools and technics.

No one expects to pay the same price for a television set that they once paid for a radio or expects the cost of a new refrigerator with all its conveniences to be the same as the old ice box. Therefore, it is not understandable why the public should expect to receive all the advantages of modern medicine for the prices that they used to pay. ◄

Hoosiers at AMA

Continued from page 1274

A. Wilson Smith, Greencastle; William D. Snively, Jr., Evansville; Morris C. Snyder, Richmond; George E. Stauffer, Mooreland; Wendell C. Stover, Boonville; James H. Stygall, Indianapolis; John M. Sullivan, Terre Haute; Stephen N. Tager, Evansville; George V. Teter, Indianapolis; William R. Tindall, Shelbyville; James F. Treon, Aurora; John H. Warvel, Indianapolis; Harry D. Webb, Anderson; and John R. Weber, Fort Wayne.

Drs. Morris D. Wertenberger, Richmond; Merle E. Witlock, Mishawaka; Robert D. Williams, Markleville; Donald E. Wood, Indianapolis; Henry L. Worley, New Albany; and Paul S. Yocum, Gary. ◄

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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Volume 52 — August 1959 — Number 8

Aortic Regurgitation

Multiple Eponyms, Physical Signs and Etiologies

A. D. DENNISON, JR., M.D.*

Indianapolis

IN THESE days of gadgets, gimmicks and graphs in cardiology, anyone who cries out for the renaissance of the bedside physician may be like "the voice of one crying in the wilderness." It is not too profane to submit that we may some day have an American Board of I. B. M. Cardiology. We wrestle not against principalities but against the powers of the chart room, the increasing demands of the record room, the subtle nuances of the laboratory reports and the easy contributions of the radiologic laboratory. The magnificent contributions of the pharmaceutical industry in this country have made us therapeutic giants, but by contrast we may have become diagnostic dwarfs. We will catheterize anything from the bladder to the left ventricle, but when it comes to the "laying on of hands" so successful in the world of the spirit, so well accepted by the patients, and so productive to the physicians, we are woefully remiss.

How often patients have complained that the physician has made a hospital visit, stood at the end of the bed, perused the chart, charged 5 dollars, but has never listened to their heart with a stethoscope. The public has great faith in the value of a physical examination. It is a constant battle to find time for the patient, but even small victories will undoubtedly bring a smile to the sleeping faces of Auenbrugger who extolled percussion, Laennec who promulgated auscultation and Skoda who clarified and popularized both. Thus the *raison d'etre* for this presentation.

Aortic regurgitation might well be and has been called the "pulsating disease." Those of you who have combated obstipation ad constipation by reading the handy sized publication *Modern Medicine* in the popular American reading room will recall the flood of publications on pulseless disease or Takayasu's disease. Aortic

* Associate in Medicine, Indiana University Medical School. Presented at Michigan Academy of General Practice—Fall Postgraduate Clinic November 12, 1958.

regurgitation is the direct antithesis of pulseless disease. In aortic insufficiency most everything pulsates, and many of the great names of historical medicine have become attached to the various signs of aortic insufficiency because they described an area which pulsated. For, in this free valvular leakage, we find that the spleen may pulsate, the liver may pulsate, the uvula may pulsate, the head may jerk, the ear lobes may pulsate, the carotids may pulsate, the retinal vessels may pulsate, the temporal arteries may pulsate, even the cervix may pulsate. Indeed, it is the pulsating disease and this pulsation is related to the widened pulse pressure.

Eponyms

Because of these somewhat dramatic features, perhaps easily observable signs, aortic regurgitation abounds with more eponyms than almost any area in cardiology. Here we note Muller's Sign[1] in which pulsation of the uvula may be observed as well as a systolic flushing and diastolic paling of the tonsils and soft palate, which occurs concurrently with the heart beat. Here a famous French poet contributed to medical lore, for de Mussett's Sign was named after Louis Charles Alfred de Mussett,[1a] a French poet who succumbed to syphilitic aortic insufficiency and whose physician, Dr. Delpeuch, noted the jerking movements of his patient's head synchronous with each heart beat. Here, the ill mannered, ill tempered, unhappy Traube left his name for posterity with Traube's Pistol Shot Sound heard over the femoral artery, and Traube's Double Tone also detected with the stethoscope over this same area.[1b] This is to be distinguished from Duroziez's double systolic and diastolic murmur heard over the femoral artery when light pressure is made with the stethoscope.

Well known to all of us is the Water Hammer or Collapsing Pulse described by the Irish clinician, Sir Dominic Corrigan, Quincke's Sign of capillary pulsation which consists of alternate flushing and blanching of the finger nails, the blanching occurring during diastole. And finally, the United States' contribution to the physical diagnosis of this valvular defect, the Austin Flint Murmur. This is the murmur of relative mitral stenosis heard at the apex in aortic insufficiency. It is significant that Flint strongly disapproved of the custom of associating any physical sign with the name of the discoverer and thought that such a policy could only lead to obscurity and confusion. Hill and Rowlands[2] noted a disproportionately higher systolic blood pressure in the femoral artery as compared to the brachial artery. Instead of the normal difference amounting to 10 to 20 mm. of mercury between the arm and the leg, in aortic insufficiency this difference may be 60 to 100 mm. Finally, the various pulsating signs may include Landolfi's Sign[1] of the Pulsating Pupil, Gerhardt's[3] and Sailer's Sign[4] of the pulsating previously diseased spleen and Rosenbach's[5] description of pulsation of the liver.

We have hoped to make a young aspirant in the field of obstetrics and gynecology quite famous by placing his name in the historical stream of eponyms. Dr. Richard Shelley, our outgoing resident in obstetrics and gynecology, was surprised and perplexed to note a vigorously pulsating cervix as he peered at this organ through the open speculum. He summoned the resident in medicine for consultation, demonstrated the pulsating cervix, and after the astute resident in medicine had listened to the precordium and noted free aortic insufficiency, it became quite apparent that the vigorous pulsation was isochronous with the heart beat. Such comments may not bring fame and fortune to this young man, but the ensuing jocularity has made the game of medicine more fun.

AORTIC REGURGITATION

MULTIPLE EPONYMS

1. MULLER'S SIGN—pulsating uvula.
2. CORRIGAN'S PULSE — water hammer collapsing pulse.
3. de MUSSET'S SIGN—jerking movements of head synchronous with heart beat.
4. DUROZIEZ'S MURMUR—double femoral murmur.
5. AUSTIN FLINT MURMUR — relative mitral stenosis.
6. QUINCKE'S SIGN—capillary pulsation.
7. LANDOLFI'S SIGN—pupil may contract in systole and dilate in diastole.
8. TRAUBE'S PISTOL SHOT SOUND
9. HILL'S SIGN—disproportionate femoral systolic hypertension.
10. SAILER'S SIGN—pulsating spleen.
11. SHELLEY'S SIGN—?????

AORTIC REGURGITATION

VARIOUS ETIOLOGIC FACTORS

I. RHEUMATIC
II. SYPHILITIC
III. RHEUMATOID SPONDYLITIS
IV. TRAUMA
V. DISSECTING ANEURYSM OF THE AORTA
VI. BACTERIAL ENDOCARDITIS
VII. FUNCTIONAL (HYPERTENSION)
VIII. ARTERIOSCLEROSIS
IX. VENTRICULAR SEPTAL DEFECT WITH AORTIC REGURGITATION
X. ANOMALOUS CUSPS
XI. COARCTATION OF THE AORTA
XII. MARFAN'S SYNDROME (ARACHNODACTYLY)

Physical Signs

The murmur of aortic insufficiency is usually high pitched, blowing, diastolic in timing, decrescendo in character, best heard along the left sternal border, and unless extremely intense, may be missed in the recumbent position.[6] It is an interesting commentary on medical practice that many patients are seen only in the consultation room, sitting in a chair by the doctor's desk, where they frequently have their blood pressure recorded and are given, especially women, a decollete examination. This means that a V-shaped area over the upper sternal region is all that is available for examination. Men are much more willing to strip to the waist, even for the casual repeat office examination. If patients are only examined in this upright position one may ignore one of the most important murmurs in cardiac auscultation, the murmur of mitral stenosis. One might pick up the subtle murmur of early aortic insufficiency, but more needs to be done than this. The patient should be sitting up, leaning forward and in expiratory apnea. Since the murmur is high pitched, the Bowles flat chest piece is essential, especially when the murmur is faint. In mitral stenosis the murmur is low pitched, best heard with the Bell type of stethoscope, with the patient recumbent or partially over on his or her left side.

It was my privilege to study medicine at Cornell University Medical School in New York City under Dr. Eugene DeBois. He knew that many of us used the subway a great deal for transportation, as our medical school did not then have its present luxurious student dormitory. He urged us to develop our powers of observation and without being rude or vulgar to sit in the subway car and pick out the various clinical features we could see in the surrounding passengers. There are some unusual visual clinical features associated with severe aortic insufficiency.[7] These patients generally wear loose fitting collars to minimize the sensation of the pounding carotids. They are uncomfortably aware that others are staring at these prominent pulsations in the neck. Because of this, women avoid jewelry about the neck such as beads, and may wear blouses or dresses with higher necklines. A number of men shun bow ties, the movement of which might attract attention to their pulsating neck. This is again due to the rocking, pulsating carotid vessels. Patients with severe aortic insufficiency of varying etiology have a prediliction to sudden death, excessive sweating, heat intolerance, cervical (carotid artery) pain, abdominal (aortic) pain, angina pectoris, pounding sensation and splash sounds. The angina is inclined to last longer, to be nocturnal, and to respond less satisfactorily to nitroglycerine. The severity of the sweating tends to parallel the clinical course of congestive failure. The neck pain, in all probability, results from the excessive stretching of the carotid sheath. The same conclusion applies to the abdominal pain which is presumed to be due to constant stretching of the wall or sheath of the abdominal aorta. The splash sounds result from the pulsation of the enlarged left ventricle or aorta against a partially filled stomach.

Rheumatic and Luetic

Heretofore when detecting the left parasternal border diastolic murmur indicating aortic regurgitation, we have usually come to the conclusion that it must be rheumatic or perhaps, less likely, syphilitic in origin. It is statistically true that rheumatic aortic valvular disease represents the highest incidence of patients to be encountered. Certainly if the patient is under 35, has a history of rheumatic fever, associated aortic stenosis or mitral valve involvment, the diagnosis is quite tenable. The challenge in medicine is in finding the valvular defect and then arriving at an accurate conclusion as to its etiologic nature. We need to apply deductive reasoning based on broad

medical knowledge to the interpretation of the diastolic murmur indicating aortic insufficiency.

If there is a history of syphilis, a positive serology, radiologic evidence of an associated aneurysm or calcification in the ascending aorta in an individual under the age of 50, then luetic aortic insufficiency is a reasonable conclusion.

With Rheumatoid Arthritis

But, all that leaks is not rheumatic or syphilitic. In recent years, aortic regurgitation has been found in association with rheumatoid arthritis.[8, 9, 10] Certain clinical features of this entity make it wise for us to re-examine carefully the precordium of our patients with rheumatoid arthritis. The clinical data indicates that the presence of ankylosing spondylitis is most significant. Much more evidence is marshalled if the individual is a male and there is uveitis and psoriasis also present. Post-mortem studies on such cases have indicated that the aortic valves were insufficient, thickened and shortened with fibrosis at the base but without commissural irregularity or oblituration.[11] Some of these cases have undergone cardiac surgery.

Traumatic Causation

Of medical-legal significance is traumatic rupture of the aortic valve with ensuing free aortic regurgitation.[12] In these days of congested highways, high speeds, and steering wheel chest injuries, it behooves us to realize the significance of a history of trauma, history of tearing pain in the chest, a new diastolic murmur, rapidly developing and relentlessly advancing heart failure. Bean and Schmidt[13] have described the disappearing diastolic pressure as a diagnostic sign of rupture of the aortic valve. A sudden fall or complete disappearance of the diastolic blood pressure is extremely informative in this situation. It is known that traumatic rupture from a non-penetrating injury can occur in the normal valve,[14] or more easily, in the diseased valve.[15] It is also well documented that spontaneous rupture can occur on the normal or diseased valve.[16] Again, the male is more vulnerable.

We must not forget that dissecting aneurysm of the aorta, or more preferably called dissecting hematoma of the aorta, is becoming more common, is happening to younger and younger patients, and may not be associated with severe pain or a short course. The dissection may be retrograde, disrupt the aortic valve and cause acute aortic insufficiency.[17] The features of this diagnostic possibility would, therefore, encompass a middle-aged male, with hypertension, without previous aortic insufficiency, who may or may not have excruciating chest pain, develops the auscultatory findings of aortic insufficiency, the peripheral evidences of aortic insufficiency, a changing musical aortic diastolic murmur and intractable left ventricular failure.[18] These cases have been diagnosed as chronic rheumatic heart disease in the past and woefully missed.[19]

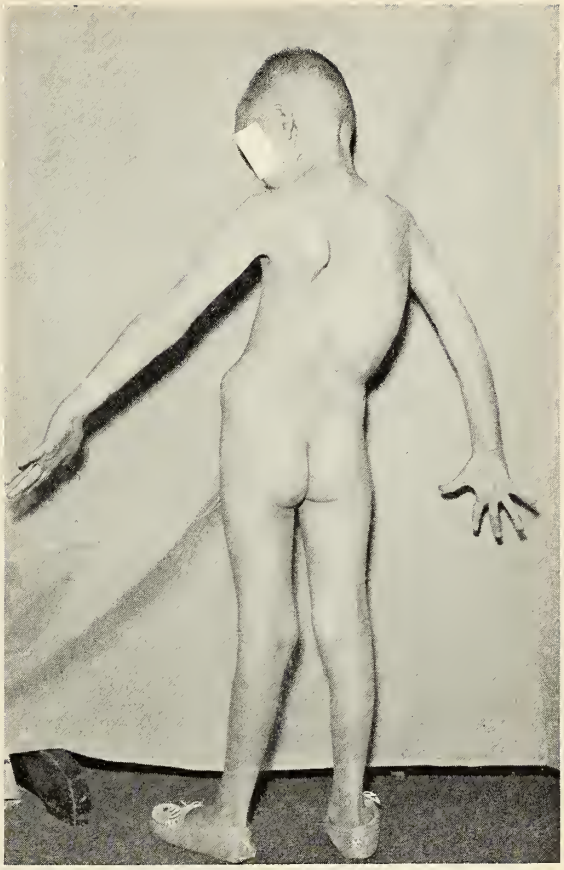
In mentioning various etiologic factors for aortic regurgitation the nefarious affinity of bacterial endocarditis for the aortic valve must not go unmentioned. In bacterial endocarditis the infection may establish itself on an already insufficient aortic valve, or the aortic insufficiency may have been minimal and have been greatly worsened by the subacute bacterial endocarditis. Indeed, rupture of the valve with all the classical physical findings may occur. Sudden and severe dyspnea with severe chest pain, a short and violent course of cardiac failure, the classical clinical findings over the precordium and in the periphery of aortic insufficiency in someone with bacterial endocarditis may make this diagnosis obvious.[20] Occasionally the patient himself will notice the sudden onset of a murmur in his chest.

Undoubtedly, functional valvular aortic insufficiency[21] is an entity, is seen primarily in association with the severe and late stages of hypertension. It is not uncommon in these people to hear an aortic diastolic murmur, but this murmur is usually soft, varies in intensity from day to day, may disappear and then return. There are never any of the circulatory manifestations of an aortic leak. The presence of a loud snapping aortic sound in addition to the diastolic murmur and in association with severe diastolic hypertension is suggestive of dilatation of the aortic ring.[22] It may be compared to functional pulmonary incompetence noted in cases of pulmonary hypertension.

Closely allied to the hypertensive type of aortic insufficiency is that due to arteriosclerosis.[23] Many of us have heard soft aortic diastolic murmurs along the left sternal border in patients with calcific nodular aortic stenosis. That some aortic leak may occur in this situation is not an unreasonable conclusion. Nor is it unknown



Marfan's Syndrome: Chest Deformity



Marfan's Syndrome: Kyphoscoliosis

or unacceptable, that a patch of arteriosclerosis will develop in a sinus or valsalva, encroach on one of the aortic valves and greatly distort it so as to produce some degree of insufficiency.[24] Again, careful auscultation with the diaphragm earpiece, with the patient sitting up, leaning forward and in deep expiration is required. In patients with other evidences of atherosclerosis one may be rewarded by finding ausculatory evidence or aortic insufficiency.

Congenital Origin

Finally, various congenital entities are dynamically able to produce aortic insufficiency. The syndrome of a ventricular septal defect with its expected systolic murmur and aortic incompetence with a diastolic murmur has been known for some time.[25, 26, 27, 28] In this situation, one of the aortic valve cusps is drawn down by a fibrous band toward the ventricular septal defect or is unsupported, thereby rendering the valve incompetent. This syndrome must be remembered because a systolic murmur and loud aortic diastolic murmur along the left sternal border are apt to be mistaken for patent ductus arteriosus and may lead to a fruitless and even dangerous operation.

A congenital bicuspid valve may manifest itself by a diastolic murmur, notably heard along the left sternal border and indicating an aortic leak.[29, 30] Congenital bicuspid valves are of clinical significance because they occur very commonly with coarctation of the aorta but are so often the seat of bacterial endocarditis.[31] It is an axiom in medicine that anyone who has subacute bacterial endocarditis with aortic insufficiency and a most innocuous history for rheumatic fever should be suspected of having a congenital bicuspid aortic valve.

Aortic diastolic murmurs are not infrequent in coarctation of the aorta.[32] When present, they most likely indicate an insufficient aortic biscupid valve. One must also appreciate that the murmur may be due to dilatation of the aortic ring, a consequence of the terrific hypertension or the result of a superimposed rheumatic endocarditis.

Finally, and by no means an exhaustive appraisal of various etiologic factors provoking aortic regurgitation, are those tragic people with

Marfan's Syndrome.[33] It has been my recent experience to evaluate a living case of Marfan's Syndrome and to examine a subsequently fatal case with subacute bacterial endocarditis engrafted on the aortic valve. This condition is also known as arachnodactyly. Once seen, their pathetic appearance can never be forgotten. The long tapering fingers, the deformed chest, the kypho-scoliosis, the hyper-extensible joints, the serious visual disturbance due to dislocated lenses in the eyes, the high incidence of aortic insufficiency, the dolicho cephalic head, and death at an early age is genetics at its worst. Death often occurs due to rupture of the aorta with dissection, especially during violent exertion, often sexual intercourse.

In this syndrome dilatation of the aortic ring together with stretching and sacculation of the aortic cusps may produce a profound degree of aortic regurgitation.[34, 35, 36] If death does not ensue from a dissecting aneurysm of the aorta, congestive heart failure is their lot.

Without endeavoring to be encyclopedic in character, various eponyms, clinical and physical signs and causes for aortic regurgitation have been presented.

My plea today, in the presentation of a paper devoted solely to physical diagnosis and etiologic factors, is that we rededicate ourselves to the rich sources of medical information to be gained from bedside diagnosis. May we fight off the ravages of administrative medicine, the lazy dependence on the x-ray department and laboratory, the unholy demands of the record room, the unpopular label of being a chart physician and the inordinate labors over insurance forms. When the public states that it wants to return to the old family doctor, they may mean that they want a rebirth of "the laying on of hands." But, more than that, the discipline and backbreaking hours of physical diagnosis certainly will be richly rewarding in improved clinical astuteness, more fundamental diagnoses and a higher caliber of medical practice.

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'a picture is worth 10,000 words'

A picture IS worth 10,000 words! Our cover art this month was prompted by the fact that the entire medical profession—from Surgeon General Burney on down—became worried about public apathy over immunization. The Des Moines polio outbreak, along with a deluge of stories (including a release by ISMA President Olson) seems to have brought about a greater interest in polio shots. Local papers toward the end of July reported that local pharmaceutical houses were short of Salk serum because of a heavy demand, especially since the Des Moines epidemic.



However, not only polio shots are left to go by the wayside through public apathy. Other crippling and killing diseases are still prevalent . . . diphtheria, smallpox, tetanus, typhoid. (Elsewhere in this issue you'll find factual data on some of these diseases.)

Our cover art was created by medical artist Rosebud Lane, of Letterman Army Hospital, San Francisco, at our instigation. Her instructions went something like, "Art work showing what polio and other immunization shots can prevent . . . something professional, yet which could also attract interest from the general public." Only two weeks later, we received the drawing you see here, done in ink and shadowed in wash. The "PI" on the boy's uniform, incidentally, stands for Polio Immunization, according to Miss Lane.

Path-Finder

Look Beyond the Laboratory Report

(Published under the auspices of the Indiana Association of Pathologists.)

A CASE of kidney stone was seen recently in which the attending physician wished blood serum calcium and phosphorus determinations, considering in the diagnosis possible hyperparathyroidism. The patient, being affiliated with a "laboratory" operated in conjunction with a "school for medical technicians" in the northern part of the state, asked that the determinations be made there. Reports of calcium 12.6 mg% and phosphorus 6.5mg% were obtained.

The attending physician, realizing that in general the calcium and phosphorus of the blood vary inversely, asked that the values be rechecked in a laboratory with a qualified pathologist in charge and a qualified medical technologist performing the work. This time serum calcium was 9.6 mg% and serum phosphorus 4.0 mg% with the patient receiving no treatment of any kind since the previous tests.

Since clinical interpretation in this instance was dependent entirely on laboratory results to rule in or out a serious disease, the physician accepted the results in the second laboratory for the following reasons:

1. He learned that the first "laboratory" mentioned had no M.D. association or supervision in any shape or form and was apparently operated on a simple "cook book" type of test performance by people with questionable background and training.

2. The second laboratory was supervised by a physician (pathologist), had qualified trained technologists in charge of department, and the attending physician also knew that this laboratory maintained adequate controls and checks on reagents and test procedures at all times. He learned that a normal serum control was run in conjunction with the test on the patient and also that a prepared solution of known strength was included in the determination, so that there could be no doubt that all reagents and calculations were dependable.

The moral seems apparent; namely, that in requesting *medical laboratory* work one must first select the proper test for the patient and then, even more important, select a true medical laboratory under medical supervision to perform the work dependably.

These medical personnel in the laboratory field are: your pathologist who understands not only the technical aspects of the procedures used but is also familiar with the medical problems involved, and the properly trained accredited medical technologist who is thoroughly familiar with the technical aspects of the medical laboratory field and who works only under the supervision of a qualified physician.

What has led to this lowering of standards in the laboratory field? As in many other fields, the main source of the trouble is the tremendous demand for medical assistants and helpers in the ancillary medical fields which has gained emphasis chiefly since the last war. Demand has exceeded the number of available students and the capacity of approved training centers to educate them. This has resulted in chaotic conditions of training in these fields similar to that of medical education in the early 1900's, before standardization and accreditation began.

The American Society of Clinical Pathologists has been a leader in establishing schools and qualifications for training medical technologists, but numerous commercial schools have been established outside hospitals and outside the realm of medical supervision by inadequately trained people who are not bound by the ethics and educational standards demanded within the medical profession. A few of these commercial schools use the names of physicians who lack any special training in the field of laboratory work. Many hospital administrators have hired these poorly-trained people with the helpless attitude that they must have someone to do the work.

It would be better for the patient, in instances like that mentioned above, to have no

laboratory work at all. A better solution to the current problem and one being used in many communities is for the pathologist and well-trained key personnel to train their own assistants and helpers locally where the limited scope of such trainees can remain under close supervision.

An indication of the serious pitfalls in laboratory tests has been shown in the past few years by numerous standardization surveys, sponsored chiefly by physicians, which have shown widely divergent results from different laboratories in testing the same substance. Such surveys have made everyone realize that a constant check and control of reagents and calibration of instruments must be maintained if results are to be satisfactory. This quality control, in fact, has reached the point where in properly operated laboratories a considerable amount of time and money is spent to maintain high standards.

The poorly trained, poorly supervised technician is not in a position to recognize incongruities and irregularities of test results and is not familiar with such quality control. For example, not long ago, the writer talked to one of these technicians in a small hospital who stated that his serology tests were running quite smoothly but that he had not had a positive for over six months. Anyone with experience with the delicate, sensitive flocculation tests for syphilis now in use would immediately realize that in such a period of time an occasional false positive would be seen and that, therefore, something is wrong with the testing procedure. The College of American Pathologists offers to qualified laboratories a group of carefully standardized solutions to be used in such quality control while several dependable and ethical commercial houses prepare a synthetic serum-type substitute for standardization and checking of procedure.

If we as physicians are guilty of supporting substandard laboratories manned by poorly-trained and poorly-supervised workers, we can probably be considered guilty of malpractice, morally if not legally. In some states in the East, even at this time, it has been legally established that a physician who uses test results from a laboratory operated by lay personnel is entirely and personally responsible for any errors that might be involved. The pathologist, however, who assumes responsibility for operating a laboratory also assumes responsibility for the quality of the work and in these states is legally liable for any errors, if such occur.

It is time, therefore, that the medical profession accept the responsibility of seeing that their patients get not just a laboratory report but a true laboratory result. The best way to do this is, of course, to know who is operating the laboratory and to send patients only to those laboratories under adequate medical control, with the same ethics and principles as are observed in any other field of medicine. ◄

Ninth Annual Scientific Assembly

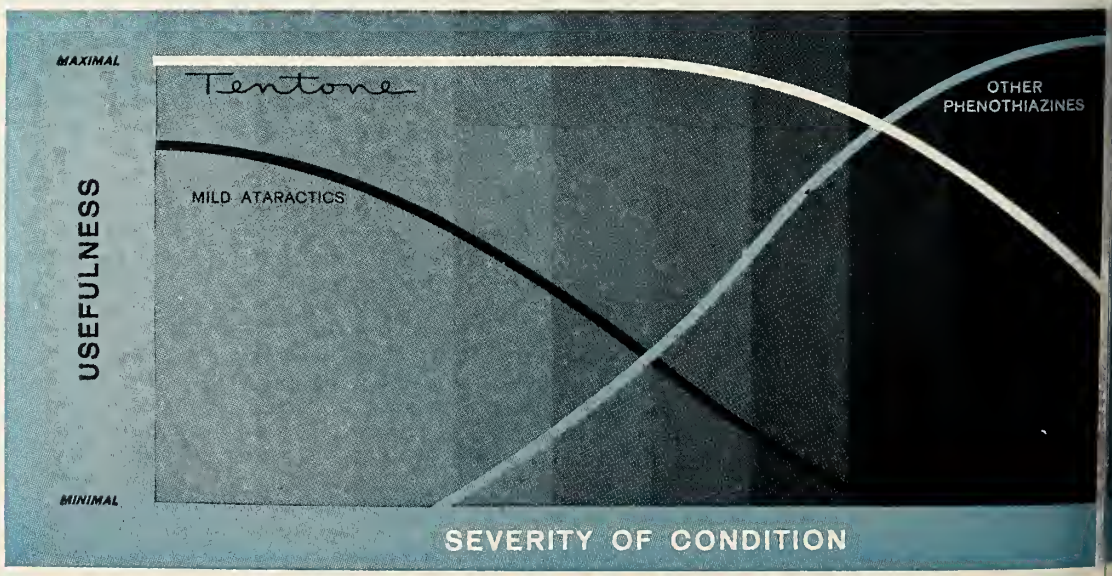
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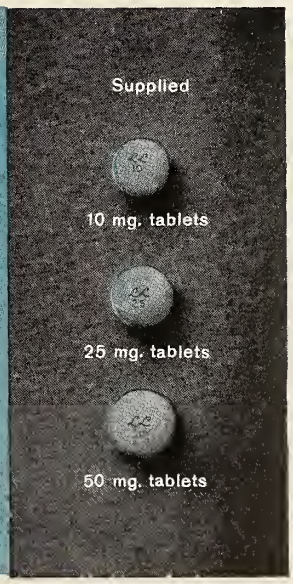
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Problems of the Knee Joints

GORDON W. BATMAN, M.D.

Indianapolis

CONDITIONS of the knee joints presents a topic far beyond the scope of a short paper, as we all know. One is faced with the alternatives of marked narrowness of the field of the discussion or somewhat wider generalizations, and it is this latter which I have adopted. I have tried to set out here the sort of thinking which, consciously, or unconsciously, is done in the consideration of a problem involving knee joints, in the arriving at a diagnosis and in the selecting of the course of treatment to be followed. Or which, at times, leads to the decision that the case at hand presents problems which should be attended by one more frequently faced with such problems, and the reference of the patient to a consultant. My comments are equally directed to the thinking of a physician in general practice or in limited orthopedics, however, as the problem is the same for each.

In organizing a discussion of such a subject, I must go back to the anatomy and the physiology involved.

The bones involved are the *femur* presenting two condyles rounded, from before backwards, with a groove between them on the front for the gliding of the *patella;* and the *tibia* presenting broad flattened surfaces, medial and lateral to a ridge for ligament attachment, upon which the femoral condyles rest. All of the surfaces of these bony parts which come in contact with each other in any normal knee position are covered with a firmly adherent articular cartilage. Where the rounded femoral condyles rest on the flat tibial surface, the resulting wedge-shaped space is filled with an intra-articular semilunar shaped cartilage. It is emphasized that these structures bear no weight—essentially just occupy space.

Attached at the borders of the articular cartilages on femur, patella and tibia is a synovial membrane which thus completes a closed cavity and which provides a small amount of, ever refreshed, synovial fluid within the cavity. The cavity is all but separated into three separate sections; one for each condyle and the third for the patella, with a large superior pouch so as to permit descent in flexion and retreat in extension. A partial partition or septum often lies above the patella separating the superior pouch partially.

External to the synovial membrane is a fibrous capsule of restraining quality, with four very strong bands dignified as ligaments. A medial collateral band restricts separation of the medial femoral and tibial condyles, as in abduction of the leg. A lateral collateral band restricts separation of the lateral femoral and tibial condyles, as in adduction of the leg. The inferior attachment of this ligament is attached to the proximal fibula which, in turn, is firmly anchored to the side of the lateral condyle of the tibia. Cruciate ligaments lie in the space between the condyles of the femur and are attached to tibia and femur, so that the anterior cruciate restricts forward movement of the tibia beneath the femur; the posterior cruciate restricting backward movement.

The motor force produces two motions, flexion of about 135 degrees and extention to or slightly beyond a straight line of thigh and leg segments. Flexion is produced chiefly by the hamstring muscles, the semitendinosis, semimembranosus and biceps femoris, with some assistance from the gastrocnemus, the sartorious and gracilis and the popliteus. Extention is produced by the quadriceps femoris, chiefly through the patella-ligamentum patella complex, with vastus

Presented before the Indiana Academy of General Practice at Indianapolis, March 18, 1959.

medialis and vastus lateralis blending with retinaculi medially and laterally also.

Numerous bursae are interposed between pressure areas. Of these, the semimembranosus, the infrapatellar and the prepatellar are of greater clinical importance, but the others are to be remembered.

The knee joint is highly vascular; with medial and lateral geniculate arteries above and below the knee anastamosing with each other and with vessels above and below their levels to form a dense network of arteries. Venous drainage is comparable and, it must be remembered, usually works against gravity.

Physiologically it must suffice to say that the hinge motion of the knee must itself swing smoothly and in proper relationship to hip and foot alignments, straightening fully to bear standing and walking weight, flexing to shorten for the swing-thru of stride, bearing full body weight in rhythmic sequence in gait. On uneven surfaces, such as curbs and stairs, the leverage to raise or lower body weight becomes tremendous. The power at a knee is awesome.

Alignment of Lower Extremity in Children

The best possible alignment of lower extremities is most desirable. Thus in infants and growing children, nutritional balance is of prime value. Examination to determine the presence of undesirable degrees of hip anteversion and retroversion should be a part of every growing child's examination. The best test is performed with the child prone, the parent or nurse pressing firmly on the buttocks to insure a fixed and horizontal pelvis. The examiner flexes both knees 90 degrees pointing legs up and using the length of each leg as a protractor. Both hips are rotated laterally, then medially. The angle of the legs with the verticle should be equal in each arc of rotation at about 60 degrees. But, for example, when one rotation is 75 degrees and the other only 30 degrees, then material hip distortion is present. In the very young, this, if symmetrical, can be treated by reversed fixation of the feet in shoes on a connecting bar. At later ages osteotomies are required. Any in-toeing or out-toeing gait suggests torsions.

Tibial torsion is another and similar residuum of intrauterine life which may not correct itself spontaneously. It is best examined by seating the patient at the edge of the examining table, the legs and feet hanging free. The position of the medial and lateral malleoli and of the heel will clearly indicate the alignment of the leg segment. If there is material torsion, shoes on a bar are applicable treatment if the condition is symmetrical. If it is unilateral, then closed osteoclasis is the treatment of choice. This is quick and rather certain and for these reasons, will often be advisable in symmetrical cases, though the suggestion of the deliberate fracture of a child's leg will certainly startle the mother.

Both knock-knees, due to relative overgrowth of the medial femoral condyle, and bowed knees, due to relative underdevelopment of the medial femoral condyle or occasionally to tibial bowing at high level, produce serious mal-alignments. I believe severe grades of this are less often seen now, probably due to better nutritional balance in infants. These deformities usually respond to medical measures, combined with shoe protection to the feet. Occasionally osteotomies are necessary but, if so, they should be deferred until growth is so nearly complete that final alignment can be provided.

The feet are also knee factors. Whenever the leg-foot alignment is improper in a child, correction of the shoe should be provided and continued until growth and extremity alignment have eliminated the improper leg-foot relationship. This usually consists of full shoes, with inner border heel wedgings, though each case should be individualized, and shoe wedgings should not be prescribed without proper analysis.

Effect of Treatment

To this point, we have talked about the general structures of a knee joint, and about the development of the joint and its relationships to the extremity as a whole. One must live long to see infants and children grow to adult stature, and one will not live long enough to see those he has supervised pass into middle and elderly ages of life. It is therefore difficult to say with certainty how important it is that minor, even major degrees of mal-alignment in extremities are in relation to the service of extremities over a lifetime. However, one sees adults with disabilities in extremities, in the presence of mal-alignments, in which the disability seems directly related to that poor line of weight bearing and function he has been forced to bear with in his work and social living. This is particularly true

with the individuals showing degenerative changes in a single knee compartment, habitually bearing more than its share of the weight and thrust of use. It is also seen in those patients with hip torsions in which the knee has been correspondingly and habitually strained. It is my firm opinion that the most that can be done to develop proper alignment in the extremities of growing childern will reflect serviceable comfort to them throughout their life, and favor freedom from degenerative changes in senile years. I would urge you to be critical of the pigeon toed, the out-toeing, the bowed knees and knock-knees of your patients. At the light weight of a child, such mal-alignments are not particularly symptom producing, but in adult life the reverse is true.

Knee Conditions in Adults

I believe I can best emphasize some of the conditions which we encounter in adult knees if I will sub-classify them into groups relating to the factor producing the disability of the patient.

These factors of cause may be listed as:

1. Disorders of alignment.
2. Disorders of muscle power.
3. Disorders of nerve supply.
4. Disorders of blood supply.
5. Disorders of infection.
6. Disorders of nutrition.
7. Disorders of neoplastic growth.
8. Disorders of trauma.
9. Disorders of degenerative change.
10. Disorders of function.

A brief discussion of each of these disorders can be made in the time available.

1. Disorders of Alignment:

Among other effects of disalignment at the knee should be mentioned the recurrent dislocation of the patella. The mal-alignment factor is knock-knee. The rectus femoris-patella-petellar ligament alignment is in sharp lateral angle from patella to tibial tubercle. The patella is drawn laterally on tension and on occasion will fully dislocate laterally. Spontaneous reduction is the rule. Frequently the patient learns to reduce the patella successfully. Once might be "accident," twice might be "coincidence," but three times and surgical treatment is clearly indicated. Repeated partial dislocation leads to mild symptoms and eventually to degeneration of patellar articular cartilage. This should early be recognized as a "trick knee" and surgically corrected prior to the development of demonstrable articular cartilage changes.

2. Disorders of Muscle Power:

Of these, the most disabling is quadriceps femoris weakness since this muscle provides the sole anterior support of the knee joint. Sometimes this is reflex protective paralysis as from a periosteal bruising of the patella or tibial tubercle. Any weakness from disuse or post-operative weakness may lead to gait and stance in flexion deformity. Such flexion stance and gait is uncomfortable, tiring and very materially disabling. Quadriceps tension increases intra-articular pressure within a knee and any painful knee will be "spared" by developing hip and knee flexion so that the gluteus maximus may take a greater share and the quadriceps a less share in lower extremity stabilization. There may be confusing hip and backache. Improvement in gait and exercises for muscle strengthening are indicated.

3. Disorders of Nerve Supply:

Perhaps the Charcot knee is still our best example, though knees in the diabetic or anemic patient with spinal cord changes are often seen with advanced degeneration, more extensive than related pain may indicate. These constitute major problems of management. Frequently the knee situation is overshadowed by the disability of the major illness. I have no panacea.

4. Disorders of Blood Supply:

Disorders of blood supply are infrequent, though I should pause to mention the harmful effects of the elastic kneelet and elastic bandage on an ailing knee. The *most* compressible structure in the knee area is its blood in vessels. If the knee is so ill as to warrant support, it is asking for rest—not a reduction in its blood supply. Bed-rest, crutches, a supporting cast are indicated—possibly aspiration, but not compression. Of primary importance in this classification is the recurrent hemarthroses of hemophilia. These arise from contusion and from functional pinching of the anterior fat pad. The history and aspiration make the diagnosis. The blood is extremely irritating to the articular cartilages and synovial membrane. The knee does not recover fully and recurrences are common. Again here, the primary diagnosis of hemophilia is

usually more problem than the knee. Preservation of full extention is an important point in knee management, to preserve weight bearing alignment.

5. Disorders of Infection:

Disorders of infection form an acute problem at the knee. This may be incidental, as in rheumatic fever and subside with the primary disorder. They may be metastatic foci, as with tuberculosis, gonorrhea or the pyogenic organisms, or direct in open injuries. In this group the knee requires diagnosis, by clinical examination, usually including bacterial study of aspirated fluid and by x-ray plates. Our weapons for treatment in this disorder are now greatly augmented. Proper antibiotic locally and systematically may often lead to recovery with remarkably well preserved function. It should be emphasized that tuberculosis, especially of the synovia, may need to be reevaluated from the long-held view that only the fusion of a tuberculosis of a joint is full guarantee of safe and permanent cure.

6. Disorders of Nutrition:

Disorders of nutrition are not often seen in adult knees. The principal findings are those of healed Osgood Schlatter's disease, and the late results of rachitis, with bowed or knock-knee deformity as I have mentioned. In the middle aged and elderly such knees frequently show degenerative changes due to faulty mechanics. Degeneration of one compartment of the joint is a common finding. In children with considerable growth remaining an improvement in nutrition will be rewarding.

7. Disorders of Neoplastic Growth:

Disorders of neoplastic type are common about the knee. Great synovial thickening, without increase of fluid, is an early stage in degenerative arthritis here. With local heat, and little or no effusion, negative x-rays and little real disability, the diagnosis should be suspected. Synovectomy may arrest the progress. Hydrocortone into the knee seems to help some cases. Villanodular synovitis is a particular form of synovitis and is amenable to x-ray after synovectomy. Bony tumors in distal femur and proximal tibia, of which the giant cell tumor is a common one, often give mild knee ache with fatigue. Examination of the knee is usually uninforming, though there may be local heat. The lesion is shown by x-ray. Malignant bone tumors of the area give similar clinical evidence, sometimes with more rapid development of symptoms.

8. Disorders of Trauma:

Disorders of trauma could be the topic for a full textbook. For purposes of diagnosis one can divide such disorders into those in which the traumatized knee shows x-ray evidence of the trauma and into those which, though obviously injured, show no x-ray evidence of the injury. In those cases where x-ray shows fracture or dislocation of the bones of the knee area, one must also consider the damage to x-ray lucent structures in planning treatment. Each case must be individualized. The problem is of great moment.

In those cases of trauma without x-ray evidence, the burden of proof lies with the physician. The knee is so vital to the process of living that errors must be avoided as far as possible. Unfortunately, little delay can be permitted.

Where pain and swelling prevent examination of the conscious patient, examination under anesthesia is frequently of great diagnostic value to test relative to ligament tear, or the click or locking from cartilage tear. Aspiration of the knee may be helpful in determining the degree of distention produced by blood, or by effusion, or by the combination of these factors. Aspiration will be helpful in determining this. It should be emphasized that aspiration of a knee joint is not to be undertaken lightly. The most strict sterility is of absolute necessity. A distended knee, either with blood or effusion, is a fertile field for the introduction of bacteria and the complicating of the condition by an introduced infection equals tragedy. The same general precautions for the aspiration of a knee should be carried out as if the knee was to be opened surgically. The burden of the risk of the procedure lies with the doctor. Following aspiration, examination of the knee may be more informing, especially under anesthesia.

One should not explore a knee surgically. His preoperative diagnosis should be so accurate that his operation becomes therapy. This is not always possible, but it should be one's aim. The situation is of pressing urgency but the operation is seldom emergency. Again, let me remark, that

the time to repair knee trauma is promptly after the accident and that x-ray negative traumas place full and heavy burden on the physician.

Where the trauma is belived to be derangement to a semilunar cartilage, remember that cartilages do not have the property to heal and that even minimal internal derangement rather rapidly leads to joint degeneration. Were this cartilage of real functional value or the surgery of great danger, this advice might be reversed, but there is no value and the risk is minimal.

Concerning x-ray positive trauma at the knee, I shall summarize, since the topic could be discussed almost endlessly. First, any damage to articular cartilage creates permanent damage. Second, any distortion remaining after reduction leads to permanent mal-alignment and disfunction. Third, almost all x-ray positive lesions have associated undemonstrated internal injury. One would conclude, therefore, that open reductions with surgery under direct visual control will be employed in a high percentage of cases. Again here, the decision not to open the area places a burden of great responsibility on the physician.

Yet another factor should be mentioned under any treatment. This is the necessity to obtain full extention, which is an absolute requirement for stance and gait without strain—and pain—plus as much flexion as possible for the convenience of graceful living. Methods to achieve this result must be worked out for each case.

9. Disorders of Degenerative Changes:

Disorders of degenerative changes are being seen more and more as our population ages and our traumas and other disorders increase. The otherwise vigorous patient handicapped or disabled by joint degenerations presents a pitiable picture. And even worse is that the process is progressive, self-perpetuating as its joint derangement begets further joint changes. Many of these cases show loss of those final degrees of straightening of the knees which imposes great strain on the quadriceps and gluteal muscles to maintain erectness. Even 5 degrees or 10 degrees of flexion contracture seriously limits standing and walking endurance. Often loose bodies within the joint cause pain, sudden upset of balance and chronic effusion. The knees are never comfortable—sleep is disturbed. X-ray evidences are frequently less striking than the patient's clinical disability.

Much can be done for these patients. The contracture can be overcome frequently by the use of an ottoman and active efforts to stretch contractures and to restrengthen the quadriceps extensor mechanism. Local heat, oft repeated gentle passive stretchings and other physical therapies are valuable. Injection of hydrocortone is frequently comforting and can be repeated almost indefinitely. Vigorous passive stretching under anesthesia is not helpful and plaster immobilization is valueless. Certain cases respond well to debridement of the joint, removing all blocking, rough and irregular surfaces and leaving smoother and freer surfaces for the patient to learn to use. The value of this can be demonstrated by the experience of having the patient request operation on the second knee, which we have had several times; though more often operation on the "bad knee" converts it to the more comfortable and usable status of the "good knee" and permits protection of the unoperated one. Occasionally, arthrodesis of the "bad knee" gives it trustworthy comfortable endurance and shields the unoperated one. Some 10 years ago, a patient requested arthrodesis on the second knee and has greatly increased the circumference of her activity, and been greatly comforted to this date, at the expense of decided awkwardness. These degenerated joints are tragic. To avoid them in late life, we must practice corrective measures on our growing patients.

To prevent knee flexion contractures in aging and sedentary patients, check their knee extension range of motion each time you see them and prescribe the use of an ottoman for all your arthritic patients and for all your patients who sit long hours. Observe their gait and stance to be sure they are extending knees fully. You will save patients much distress by this preventive service.

10. Disorders of Function:

Disorders of function are an infrequent finding in otherwise normal knees. However, an outline such as I am presenting is not complete without mentioning such conditions. The hypertrophied anterior fat pad occasionally is pinched in extension of the joint. A little blood in the knee leads to mild effusion, transient disfunction and full recovery. Habitual wearing of spike heels leads to incomplete extension of the knee

in stance and gait with knee ache, anterior thigh ache and, after a few years, to articular cartilage degeneration of patella cartilage. No doubt there are many other functional disorders. The popliteus syndrome, for example, in which the tendon of the popliteus muscle drops into the knee joint in hyper-extension when the knees are sagged by supporting the extremity at hip and heel only, in patients with decidedly relaxed ligamentous support. This is a rare event, and most disorders of function of the knee are actually rare experiences, requiring the sharpest of diagnostic skill.

All in all, knees are wondrously constructed, take a functional beating in a lifetime, without any added disease, disuse or injury being imposed upon them. That they last so well is perhaps the wonder. They do deserve our finest care. ◄

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An Approach to the Office Treatment of the Patient with Hypertension

*BURTON M. COHEN, M.D.**

Elizabeth, N. J.

"I repeat that . . . the primary cause of the increase in the mean pressure is not morbid rigidity of the arteriolar walls, or straitness of their calibre; nor again curtailment of capillary areas. The primary event is no doubt an increase of peripheral friction, one which can be reduced or removed more or less permanently by medication."

Sir T. Clifford Allbutt, 1895[1]

HIGH BLOOD PRESSURE affects more than 5% of our adult population,[2] and is a most frequent problem in office practice. Until recently we had little to offer our hypertensive patients except encouragement to develop a state of resigned symbiosis with their ailment. The value of any treatment, chiefly sympathectomy and severe salt depletion, was difficult to determine, when viewed in the perspective of the long, variable and uncertain natural history of the disease itself. Most physicians feared that lowering the blood pressure would compromise even further the circulation through vital areas which had already been altered by the hypertensive process.[3] Finally, we were not quite certain where normal blood pressure stopped and high blood pressure began, because critical investigators had challenged the accepted range of normal values.[4]

New Approach

In the past 10 years our approach to this problem has been changed dramatically because of the development of new chemotherapeutic agents, as well as a renaissance of older drugs. Not only has it been feasible to reduce abnormally elevated blood pressures,[5-8] but the expected catastrophies in regional circulations did not materialize as experience in judicious patient selection for treatment was gained. Dividends have seemed to accrue from the accompanying reduction in demands on the body as a whole, in the form of reversal or delay of complicating conditions and prolongation of life.[9] In the milder forms of hypertension, it seemed possible, in selected instances, to withdraw all drug therapy with persistence of normal blood pressure.[10] An attempt at lowering the blood pressure of patients with hypertension is justified and desirable for the following reasons: (1) despite our individual experience with isolated instances of the relatively harmless course of hypertension, the majority of those affected will develop associated symptoms as the disease continues.[2] (2) Analysis of the fate of large numbers of hypertensive patients demonstrates that few escape one or more of the characteristic complications.[3] (3) High blood pressure is not necessary or "essential." On the contrary, the life expectancy of the hypertensive patient is reduced to almost 50 years, the untreated disease runs its course

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over two decades, and arteriolar changes appear rapidly when blood pressure elevations are sustained.[11] Perera[12] suggests that the patient whom we first see with a systolic blood pressure above 200 mm Hg or a diastolic blood pressure above 120 mm Hg, has an average subsequent duration of life of only nine years. (4) There is no laboratory test or clinical clue which permits us to make a clear-cut or exclusive separation between the various stages, types or degrees of hypertension,[13] that is, to differentiate between the "Poor Risk" and the "Good Risk" patient. It is as futile to reserve effective hypotensive therapy until the onset of hemiplegia, cardiac infarction or uremia, as it would be to ignore silent gallstones or "just a little" cancer. (5) Many workers have provided convincing evidence that persistent aggressive chemotherapy may reverse or delay complications and decrease vascular deterioration, while life expectancy may be increased in the more virulent forms and the "malignant phase" of hyptertension.[14] (6) In the milder varieties of this disease, the use of drug therapy in early, potentially reversible, stages offers the hope of attacking the fundamental etiology,[10] although its true nature eludes us for the present.

Treatment in General

The clinical literature testifies that skillful drug manipulation may bring about a substantial and sustained reduction in high blood pressure readings. Many of the outlined programs, useful in expert hands in special clinics and university centers, are patently unsuitable for the management of the great mass of hypertensive patients because of the delicate adjustment and therapeutic hazards implicit in their use, as well as the economics of hospitalization for individual dose titration. The truly successful treatment should be one which can be carried out with the patient in his natural environment, rather than in the rigid artificial hospital surroundings.

Hypertension is a chronic illness which requires observation and management over a great many years, rather than during episodic acute hospitalizations prompted by vascular accidents or commercial release of the latest panacea. Over his long journey the hypertensive patient requires the diligent, sincere and persistent interest and attention of a sympathetic personal physician prepared to view the problem in the familiar setting of the everyday world. This concern by the family physician *is* fundamental treatment in itself. Hypertension is a true province of the generalist, who is the physician most highly qualified to assume the vital role of detection and long-term therapy. The first line of attack on the problem of high blood pressure must be launched in the daily office schedule of the family doctor.

For these reasons, we have been interested in evaluating anti-hypertensive drugs which might be suitable for office practice. All our data are derived from clinical investigation of patients seen in the office or various out-patient services. Diagnostic evaluation was carried out with the simple and inexpensive facilities at the disposal of any physician in his own office or with the aid of community hospital or commercial laboratory services.

Diagnostic Procedure

Thorough appraisal is the first step on the road to successful therapy. We must determine the approximate severity of the illness in each and every individual, because the possible benefits and dangers of treatment may vary in different states and stages of hypertension, and some of the known causes of high blood pressure demand specific treatment which is useless in primary hypertension.[15]

Office study proceeds easily if a summary sheet is used with a place for all the appropriate data in a form which can be reviewed at a glance. The History and Physical Examination forms obtained, at modest cost, from the American Heart Association are most convenient.

Family background is informative, because hypertension, at least in the United States, is an inherited illness.[16] We rarely encounter this disorder before adolescence;[17] similarly, its appearance for the first time after age 40 to 50 should also be cause for suspicion, particularly of potentially curable forms.[18] A history of albuminuria antedating hypertension, recurrent urinary tract infections, obstructive uropathy, glomerulonephritis or the nephrotic syndrome make it more likely that we are dealing with intrinsic renal disease than with primary hypertension. Blood pressure paroxysms classically suggest pheochromocytoma, although the majority of these tumors are accompanied by sustained hypertension. Muscular weakness, asthenia,

paresthesias, tetany, oral dryness, polyuria and orthostatic hypotension form the diagnostic constellation of Conn's Syndrome of primary aldosteronism.

The blood pressure is determined in all extremities. The cuff should be applied snugly, since casual application produces falsely high readings for both systolic and diastolic blood pressures.[19] Correction for the larger arm of the overweight patient must be made, using the tables published by Pickering.[20] Chiefly systolic hypertension in the arms with lower leg readings, absent or weak femoral pulses and lag between time of onset of the radial and femoral pulsations are characteristic of aortic coarctation. Patients with pheochromocytoma and primary aldosteronism may suffer with orthostatic hypotention. Striae, "buffalo-hump" distribution of obesity, purpura, plethora and virilization are hallmarks of Cushing's Disease and the even rarer adrenogential syndrome. The skin lesions of neurofibromatosis and Sturge-Weber's Disease should prompt a search for the frequently associated pheochromocytoma.

Arterial changes seen on eyeground study are graded by us according to the criteria of Keith, Wagener and Barker.[21] This has prognostic import, for less than 30% of patients with the hemorrhages, cotton-wool exudates and papilledema of Grades III and IV may be expected to survive three years without active therapy.[22] A characteristic "retinal sheen" has been considered diagnostic of toxemia of pregnancy, and has not been seen when pre-existing hypertension complicates non-toxemic pregnancy.[23] Abdominal masses hint of polycystic kidney disease, renal or adrenal tumors.

Laboratory Studies

Laboratory studies are conducted during one extended office session, or may be spaced over several visits. The hemogram is always determined. A clear urinalysis has been considered inconsistent with underlying chronic genitourinary disease. The presence of "Glitter" or "Sternheimer" cells in microscopic examination of the stained urinary sediment is a valuable lead to presence of chronic pyelonephritis. Urine specimens may now also be cultured in the office, using the convenient media and sensitivity discs commercially available. Blood urea nitrogen, phenolsulfonphthalein and urinary concentration-dilution tests are adequate for estimating kidney function. Glycosuria occurs 20 times more often in pheochromocytoma than with primary hypertension.[24] Both Cushing's Disease and Conn's Syndrome exhibit alkalosis with low blood potassium and chlorides, but the patient with Cushing's Disease does not usually display the low fixed urinary specific gravity or the persistently alkaline pH seen with primary aldosteronism.

The standard chest x-ray is invaluable for evidence of rib-notching due to dilated intercostal vessels with aortic coarctation. Although we have used the inexpensive "Dock Type" Ballistocardiogram to look for the absent K-waves of coarctation, the alterations of blood pressure and pulses in this anomaly are easily as informative.

Sedative effects from the sodium amytal test are inconvenient for the ambulatory patient. The cold pressor test may be performed easily in the office; a rise of 30/20 mm Hg separates out the hyper-reactors. Tenal contrast studies are performed by our urologic colleagues. The phentolamine ("Regitine") test is the most practical and least risky test for pheochromocytoma in the stage of sustained blood pressure elevation. A fall in blood pressure of more than 35/25 mm Hg following use of this agent is considered suggestive, and suitable blood or urinary aliquots are mailed to laboratories able to determine catecholamine levels. Steroid studies may be similarly obtained by the family physician.

This survey attempts to weed out the 5% of all hypertension which is curable. We also should use the data to classify the severity of hypertensive disease. This is done by assigning numerical values to the different factors and findings; their sum determines the "severity index"[25] or "grade" of hyptertension. This "hypertensive Morse Code" enables the physician in French Lick, for example, to understand quite precisely what his colleagues in Gary or Elkhart mean by the term "Grade III Hypertension"; our studies use the conventional Smithwick[26] classification.

Treatment

All patients with high blood pressure, of whatever grade, profit from certain general steps, beginning with a thorough and leisurely discussion of the nature of hypentension, its effects, the goals of therapy and the projected program.

TABLE I.

BLOOD PRESSURE RESPONSES OF PATIENTS WITH HYPERTENSION TO CHLOROTHIAZIDE*

Other Therapy	No. of Patients	Blood Pressure Control			Chlorothiazide			Daily Dose in Mg
		S	D	M	S	D	M	
None	47	188	110	136	157	93.6	114.6	825
Various	93	175	102	126	143	85	104	675

*Chlorothiazide ("DIURIL", Merck, Sharp & Dohme)

Reassurance and encouragement are the twin themes of indoctrination. We permit moderate use of salt, tobacco and alcohol. The obese patient should be brought to near-optimal body weight. Appetite suppressants may be helpful in treating patients with poor self-discipline, and are *not* contraindicated.[27] Dahl suggests[28] that the fall in blood pressure accompanying weight reduction may be due to the decrease in daily salt intake which automatically accompanies the restriction in total calories. Sedatives, calmatives and tranquilizers have individual roles in this general "medical housekeeping."

For many patients, usually Smithwick Grades I and II, these measures alone suffice. If the blood pressure remains above 160/100 mm Hg, more "active" therapy should be started. There are few "ground rules" in the treatment of hypertension. As Wilkins[29] concludes, a successful approach demands persistence of the physician, cooperation by the patient and gradual titration of drugs singly or in combination, to attain a reasonable blood pressure level. Side effects are best handled by reduction of daily drug rations, and may be prevented by the use of sub-toxic doses of several hypotensives in concert. Instead of trying to master the individual properties and dose forms of the several hundred proprietary anti-hypertensive agents, we suggest that the physician become proficient in the use of one or two preparations within each class of agents, much as he would familiarize himself with one or two digitalis forms for selected situations.

Saluretic Drugs

This specific treatment of the ambulatory patient begins with what we call the "Induction Phase" in which one of the new "saluretic" drugs is prescribed. These agents increase the excretion chiefly of sodium and chloride, of potassium in lesser degree, and increase urinary volume. They are most dramatically helpful with hypertensive heart failure, but are also so effective in the "dry" hypertensive that some investigators[30] believe that they possess hypotensive properties apart from electrolyte and body water effects.

Chlorothiazide, the first of these to be introduced, is the most familiar saluretic. We prescribe 500 to 1000 mg daily, usually administered in the morning, to avoid the annoying nocturnal diuresis of doses given later in the day. We have given chlorothiazide to 140 patients of Grade II to IV severity over the past two years (Table I). In 47, chlorothiazide was the first antihypertensive drug given, and a drop in average mean control blood pressure from 136 (188/110) to 114.6 (157/93.6) mm Hg was noted. In 93 patients considered to have reached a "hypotensive floor" on other therapy, the addition of chlorothiazide caused a further fall from an average mean control blood pressure of 126 (175/102) to 104 (143/85) mm Hg, demonstrating the synergism of these saluretic drugs with more potent agents, often allowing reduction in daily ration doses of the latter (Figure 1). Saluretics should be used cautiously in patients already receiving ganglionic blocking drugs or following sympathectomy, because the salt and water depletion produced can unmask postural hypotension or precipitate a variety of vascular insufficiency syndromes.[31]

Side effects in 25 of these 140 patients (17.8 per cent) consisted chiefly of calf muscle cramps, paresthesias, nausea and vertigo. Three patients developed a generalized dermatitis, and two had purpuric manifestations. Hypokalemia occurred only twice, although potassium supplements were not prescribed routinely in the non-edematous patients. Altered consciousness, with neurologic signs resembling ammonia intoxication, was a

TABLE II

SALURETIC-INDUCED ARTICULAR SYMPTOMS

Pt.	Age	Sex	Grade	Gout Known	BUN Up	Uric Acid Control	Uric Acid Treatment	Time of Onset of Symptoms after Rx
Chlorothiazide:								
FB	79	M	III	Yes		6.8 (mg %)	10.9 (mg %)	8 days
KA	63	F	IV		Yes	3.9	13.6	4 "
CK*	73	F	IV		Yes	3.9	12.6	10 "
SB	63	M	IV		Yes	5.9	15.8	5 "
CG	65	F	III			4.8	12.1	9 "
JD	49	M	II	Yes		6.3	9.8	6 "
LG	81	F	III	Yes		5.0	11.0	13 "
GG	64	M	III	Yes		4.8	13.2	3 "
WR	61	M	III		Yes	4.6	12.4	16 "
JR	52	M	III			5 1	11.0	11 "
AC	56	F	III			3.9	8.6	6 "
Hydro-Chlorothiazide:								
CK*	73	F	IV		Yes	5.0	12.2	11 "
JT	63	F	III		Yes	4.6	10.8	14 "
		F 7 M 6		4	5*	4.9 (mg %)	11.8 (mg %)	9 days

*Pt. CK experienced articular symptoms on both chlorothiazide and hydro-chlorothiazide.

reversible finding in one instance. Of special interest was the development of acute joint symptoms and signs in 11 patients within two to three weeks of beginning chlorothiazide. Marked elevation of blood uric acid was discovered in all of these, four of whom were known to have antecedent gout, and four of whom had underlying nitrogen retention due to renal insufficiency (Table II). This ability of chlorothiazide to produce hyperuricacidemia and articular symptoms in both gouty and non-gouty subjects, has received brief notice elsewhere.[32-34] Colchicine, salicylates and/or probenecid, have brought striking relief with subsequent recurrence.

We have studied two new saluretic agents, hydrochlorothiazide and flumethiazide (trifluoromethylchlorothiazide), in our ambulatory patients. Forty-six patients received hydro-chlorothiazide. The data concerning 21 patients who received this drug as initial therapy, as well as 25 patients in whom it was substituted for chlorothiazide, indicate that a starting dose of 50 to 100 mg daily is average, and that 50 mg of hydrochlorothiazide may be substituted approximately for 500 mg of chlorothiazide.

Flumethiazide, with or without Rauwolfia whole root, has been administered in tablets containing 400 mg of potassium chloride as well to 45 patients over six months of continuous therapy (Table III). This experience suggests that flumethiazide, like hydro-chlorothiazide, possesses the antihypertensive properties of the parent chlorothiazide, except for individual dose variations. Four hundred mg of flumethiazide may be substituted for 500 mg of chlorothiazide or 50 mg of hydro-chlorothiazide, although individual requirements vary (Table IV).

TABLE III.

BLOOD PRESSURE RESPONSES OF UNTREATED HYPERTENSIVE PATIENTS TO FLUMETHIAZIDE* AND FLUMETHIAZIDE-RAUWOLFA WHOLE ROOT**

Therapy	No. of Patients	Blood Pressure Control S	Control D	Control M	On Therapy S	On Therapy D	On Therapy M	Daily Dose in Mg. Fl.	Daily Dose in Mg. R. W. R.
Flumeth.	25	189.4	120	142.7	164.2	107	126	1,456	---
Flumeth.-R.W.R.	20	195.5	121.7	146.0	161.0	102	121	1,320	165

* "Urolog", Squibb
** "Rautrax", Squibb

TABLE IV.

SALURETIC AGENTS USED IN THE TREATMENT OF HYPERTENSION

Chemical Name	Available as	Equivalent Initial Doses
Chlorothiazide	"DIURIL"	500-1000 mg
Hydro-chlorothiazide	"HYDRO-DIURIL" "ESIDRIX"	50-100 mg
Flumethiazide		
plain	"ADEMOL"	400-1000 mg
with KCL	"ADEMAK"	400-800 mg
with KCL & Rauwolfia WR	"RAUTRAX"	400-800 mg

Side effects from these two new drugs are qualititatively similar to those noted with chlorothiazide, with two important differences. Although two patients receiving hydro-chlorothiazide developed gouty episodes similar to those seen with chlorothiazide, no such articular reactions have been noted to date by patients treated with flumethiazide. Skin reactions, while infrequent with hydro-chlorothiazide and chlorothiazide, have not been encountered with the trifluoromethyl derivative. We have substituted flumethiazide for both other saluretics when skin rashes appeared with subsequent regression of eruptions and persistence of hypotensive effects. Introduction of the trifluoromethyl group into the chlorothiazide molecule may, therefore, be responsible for decreased toxicity, without loss of potency, resembling effects produced with other pharmacologic agents[35] modified in similar fashion.

Ancillary Drugs

After one or two weeks of saluretic therapy, if the blood pressure is not adequately controlled, one of the Rauwolfia derivatives is added. These compounds are mildly hypotensive, sedative and tranquilizing, effects presumed due to depletion of cerebral serotonin. In combination with chlorothiazide, hydro-chlorothiazide or flumethiazide, small amounts of Rauwolfia produce a satisfactory drop in blood pressure, and can be expected to handle most patients with Grade I and II severity of disease. One hundred mg of Rauwolfia whole root, 0.1 mg reserpine or 0.5 mg syrosingopine, once or twice daily, are added at this point and combined treatment continued for at least two weeks, since Rauwolfia activity may not appear for at least that long. Principal Rauwolfia side effects in our patients have been nasal congestion, weight gain or failure to lose weight in the obese, and several severe depressive reactions. Syrosingopine, a synthetically altered Rauwolfia[36, 37] offers the promise of Rauwolfia-induced effects on blood pressure without troublesome psychic reactions.

If the blood pressure response is not optimal after at least two weeks of combined saluretic-Rauwolfia management, we choose to add veratrum. This is a highly potent agent of great antiquity,[38] which has been employed in this country for 100 years.[39,40] Veratrum lowers the blood pressure through reflex vagal stimulation and central vasodepression. The pulse slows as the blood pressure falls. Widespread vasodilatation takes place which includes the circulation to the brain and kidney;[41-43] renal insufficiency is not a contraindication to its use. Normal vasomotor responses and liability are preserved, and therapeutic effects are unaccompanied by tachycardia, a fall in cardiac output or venous pooling, so that postural hypotension and collapse do not occur. Pulmonary, collagen-like, neurologic, aortic and gastrointestinal catastrophies common to other hypotensive agents, have never been reported. Veratrum has many of the prerequisites of the hypothetical "ideal" anti-hypertensive drug.

Until recently, veratrum has usually been reserved for the treatment of hypertensive crises,[44-48] because of conflicting experience with oral forms[49-51] and the frequency of vomiting with near-therapeutic doses of the impure forms available.[52-59] In 1954 we began to use cryptenamine, then a newly prepared alkaloid of veratrum viride, because of a wide margin between its hypotensive and emitic doses in laboratory studies.[60] Our results in series[61-64] now totaling 109 individuals, have received confirmation by others[65, 66] who agree that this is a safe and effective drug. Saluretic-Rauwolfia priming enhances the hypotensive response to cryptenamine and minimizes side reactions to this agent which may be prescribed in smaller amounts.[67-68]

In the Grade III or IV patient receiving saluretics and Rauwolfia, cryptenamine is started as 2 mg following breakfast and a similar dose at bedtime. After one week of this triple-drug therapy, another 2 mg tablet is added in mid-afternoon, and the dose revised upward at weekly intervals. All patients are instructed not to eat for three or four hours after each dose to

TABLE V.

BLOOD PRESSURE RESPONSE TO CRYPTENAMINE

No. of Patients	Smithwick Grades		Blood Pressure Readings						Average Daily Dose in Mg.	Average Mos. of Therapy
			Control			Cryptenamine				
	III	IV	S	D	M*	S	D	M*		
65	40	25	223	124	157	161	94	117	11.8	27

* Mean Blood Pressure is calculated as the sum of the diastolic Blood Pressure and one-third of the Pulse Pressure.

TABLE VI.

BLOOD PRESSURE RESPONSE TO CRYPTENAMINE-RESERPINE*

No. of Patients	Smithwick Grades		Blood Pressure Readings									Average Daily Dose in Mg.	
			Control			Cryptenamine			Cryptenamine-Reserpine				
	III	IV	S	D	M	S	D	M	S	D	M	Crypt.	Res.
44	27	17	220	125	156	178	103	128	151	92	111	10.0	0.125

* Available commercially as Unitensen-R, Irwin, Neisler & Co.

minimize possible gastrointestinal effects. Table V summarizes the data for 65 patients who received cryptenamine alone and indicates an average drop in mean arterial blood pressure of 40 mm Hg. When reserpine was added to the regimen of 44 other patients with like severity of hypertension, a further blood pressure fall ensued (Table VI). Headache, angina, palpitation and dyspnea were improved, in descending order of frequency (Table VII), and regression of eyeground changes, decrease in cardiomegaly and "improvement" in the abnormal electrocardiograms took place in most patients during an average of 30 months of continuous therapy (Table VIII). It is noteworthy that vomiting, which occurred only twice, could be attributed to intercurrent gastrointestinal disease alone. Side reactions, reported by 30% of the patients, were limited to mild dyspepsia, diarrhea, bitter taste and perioral paresthesias. When a stable dose of cryptenamine is determined, a transition to convenient cryptenamine-Rauwolfia (reserpine) or saluretic-Rauwolfia combination tablets simplifies the program.

Long Term Treatment

We continue the optimal dosage of drugs for each patient at the same level for a minimum of 9 to 12 months, unless increased sensitivity, which is more common than drug tolerance in our experience, is observed. After this time, the daily ration of cryptenamine is decreased slowly over the next three to six months, and often may be discontinued completely. Saluretic-Rauwolfia therapy is maintained and then decreased slowly until a minimum daily ration results which keeps the blood pressure at reasonable levels. A rising blood pressure, or return of accompanying symptoms, is an indication for titrating doses upward or for adding discontinued agents. We maintain the final minimal daily drug program indefinitely.

Utilizing this office approach over the last five years, during two of which saluretic agents were employed in every patient, we have experienced only five deaths in slightly less than 200 ambulatory patients who were observed for periods averaging 27 months of continuous therapy. Two patients each expired of coronary occlusions and cerebrovascular accidents, and one patient died in uremia. It has rarely been necessary to add hydralazine to the triple-drug program, and then only in tiny doses; since introduction of the saluretic agents, ganglionic blocking agents have not been required, nor is rigid salt restriction mandatory. Hypertensive heart failure has usually responded to primary reduction of the elevated blood pressure without recourse to digitalization.

Emergency Situations

Finally, a few words concerning certain urgent situations (Table IX). These include (1) the accelerated or malignant phase of hypertension; (2) hypertensive encephalopathy; (3) hypertensive heart failure; (4) acute nephritis; (5) toxemia of pregnancy and (6) cerebral hemorrhage. These potential threats to life require prompt and energetic action. If the patient is seen first at home or in the office, aqueous cryptenamine 1.0 mg (0.5cc) is administered intramuscularly at once and hospital entry is arranged. If the blood pressure has not fallen to 160/100 mm Hg within 30 minutes and the patient is in hospital, an intravenous needle is inserted and connected via a 3-way stop-cock to a slow drip of 5% glucose in water. Blood pressure readings are taken at 1 minute intervals for 2 to 3 minutes to establish a control base line, while 0.5 cc (1 mg) of aqueous cryptenamine is diluted with 20 cc of 5% glucose in water. With a house officer or nurse recording the blood pressure in the arm every minute, cryptenamine administration is begun at the rate of 1 cc per minute until the first 20 mm Hg fall in systolic or 10 mm Hg fall in diastolic pressure occurs. If no such reduction occurs, cryptenamine administration is continued at the rate of 1 cc per minute until this response is noted, and further doses are given until the blood pressure reaches 150-160/100; lower levels are undesirable because nausea and emesis may occur, while the therapeutic benefit is not enhanced. Further fractional doses are given at necessary intervals to maintain the initial effect, and when the interval between injections reaches 30-60 minutes, intramascular cryptenamine may be substituted for further intravenous drug. Finally, a gradual transition to oral saluretic-Rauwolfia-cryptenamine programming is instituted. Our personal experience with 14 patients receiving cryptenamine intravenous therapy indicates that satisfactory responses were obtained in all but one patient, who expired of a cerebral hemorrhage.[69] Success here requires the personal attention of the physician who must devote the same meticulous attention to the control of hypertension that he would to any surgical emergency; this responsibility cannot be delegated!

Summary

To summarize, we have presented our office approach to the management of patients with arterial hypertension. We are well aware that any such program is an empiric one, because the basic cause of this illness is unknown. Meticulous evaluation is necessary to discover reversible causes of hypertension, as well as to "tailor" treatment individually; this does not require complicated nor expensive apparatus. We have emphasized the use of a program combining, in stepwise fashion, the new class of saluretic agents, Rauwolfia derivatives and cryptenamine. These agents, acting in concert, provide safe and effective therapy for the great bulk of hypertensive patients who place their confidence and hopes for the future in the hands of their per-

TABLE VII.

THE COURSE OF SYMPTOMS FOLLOWING TREATMENT WITH CRYPTENAMINE AND CRYPTENAMINE-RESERPINE.

Symptom	No.*	Improved	Same	Worse	% Improved
Headache	43	38	3	2	88.0
Angina	21	16	4	1	76.0
Palpitation	29	19	8	2	65.5
Dyspnea	27	14	9	4	51.0

* Expressed as the number of patients presenting initially with the particular symptom.

TABLE VIII.

OBJECTIVE CHANGES FOLLOWING TREATMENT WITH CRYPTENAMINE AND CRYPTENAMINE-RESERPINE.

Finding	No.*	Improved	Same	Worse	% Improved
Fundus Changes	59	38	19	2	66.0
Cardiac Enlargement	35	23	9	3	65.7
Abnormal EKG	45	25	15	5	55.5
Albuminuria	43	27	12	4	62.7
Azotemia	28	10	14	4	35.7

* Expressed as the number of patients initially exhibiting the abnormal manifestations recorded.

TABLE IX.

URGENT SITUATIONS RESPONDING TO PARENTERAL CRYPTENAMINE

1. Accelerated Phase ("Malignant") of Hypertension
2. Hypertensive Encephalopathy
3. Acute Hypertensive Heart Failure
4. Acute Nephritis
5. Toxemias of Pregnancy
6. Cerebral Hemorrhage

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Narrative, Supplementary Text
to accompany the film

"The Eye in General Medical Diagnosis"

Edited by

CHARLES P. TOLMAN, Director
Glaucoma Research Project

TODAY, upwards of thirty medical specialties are recognized by the American Medical Association. These subjects are in no way divorced from general practice. Since the beginning of the art of medicine, the family physician has treated the whole patient, and, in so doing, he practices a substantial scope of the specialties.

In his general physical examinations he must identify the chronic diseases and pathology of the specialties, because it rests with him to refer a patient to a specialist if he deems it advisable. During the general physical examination, tonometry can be done in two minutes.

Among the medical specialities ophthalmology is perhaps most closely related to general physical diagnosis. Pathological conditions in many organs of the body are reflected to the eyes, or may directly affect the eyes. Conversely, eye strain and ocular pathology, as in glaucoma, can and do produce misleading symptoms in other organs.

Two of the instruments developed in the field of ophthalmology have a use and purpose which are important in the general practice of medicine —the ophthalmoscope, which in a few minutes and in skilled hands may be used to discover the presence of as many as a dozen or more different chronic diseases; and the tonometer, which can indicate the presence of glaucoma.

In fetal development we observe the eye as an extension of the brain. It is therefore intimately related to the nervous system.

In normal vision, the cornea, lens, retina, optic nerve, with its terminus in the brain, function in a manner which may be compared with a closed circuit television system.

Light from an object falls on the cornea, passes through this transparent medium, is refracted by the lens, and the image is projected upon the retina.

Here, the seven million cones, and between seventy-five and a hundred and fifty million rods, each acting as an individual photoelectric cell, transmit impulses, corresponding to the intensity of the light, to their respective cell-groups in the brain. Thus we "see" a picture.

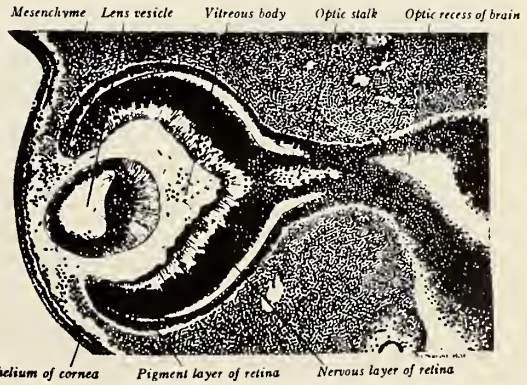
Damage to any part of this system, from cornea to brain cells, will affect vision in degrees ranging from minor difficulty in seeing to total blindness.

The eye has often been called "the window of the body," because through it the brain sees the world. But windows work both ways.

With suitable illumination, for example a pocket flashlight, much can be learned of the anterior segment of the eye.

To see the posterior segment, an ophthalmoscope is required because we must look through the lens of the eye itself.

For this reason the ophthalmoscope is pro-



Foetal development eye and brain. Meridional section through the lens, optic cup and optic stalk of a 10 mm. human embryo (Prentiss). X 100. Closure of the choroid fissure has converted the optic stalk into a double tube.

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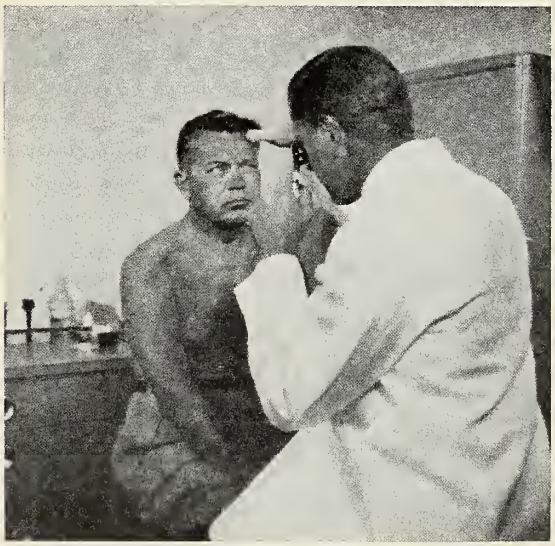
vided with a series of compensating lenses. The lens is chosen which, in cooperation with the lens of the eye, brings the retina into sharp focus. Blood vessels are clearly visible. The condition of the arterioles, venules and capillaries often applies not only to the eye itself, but also to the brain and the rest of the body.

Learning how to use the ophthalmoscope correctly is a process too lengthy to explain in the short demonstration possible here. However,—

Persistent effort to gain skill with the ophthalmoscope is most rewarding to the general practitioner. He will first learn to recognize abnormalties, and if in doubt as to their interpretation, refer patients to an ophthalmologist.

By such referrals and by consistent use of the ophthalmoscope in his general physical examinations he will gain an understanding of the whole patient. The advantage of early discovery of a disease will be frequently realized.

Among the more important findings during an examination of the fundus is the presence of sclerosis of the retinal vessels. The picture varies with the degree of sclerosis, being first observed as an increase of the light streak on



the vessel walls. A little later there is increased tortosity of the vessels and indentation of the veins at the points where the arterioles cross. The vessels now increase in diameter and tortuosity, veins especially dilate and hemorrhages may occur near the vessels.

Diabetic retinopathy is recognized by punctate or larger hemorrhages, microaneurysms and whitish exudates.

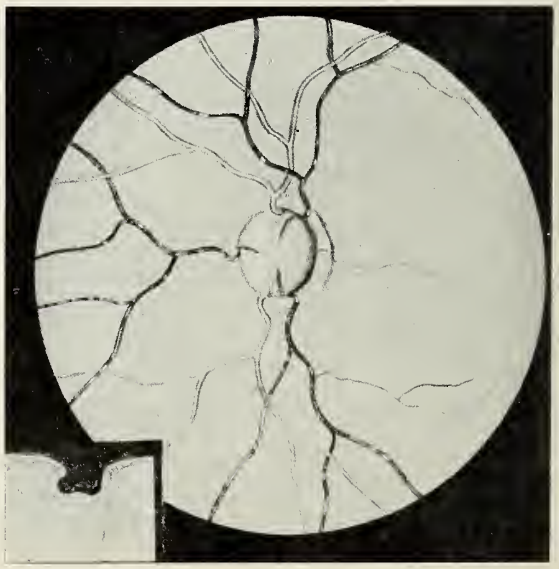
Exudates, fleecy-looking patches obscuring vessels, and edema of retinal tissue plus hemorrhage are suggestive of renal pathology.

In addition, a great number of other systemic diseases may be recognized by the use of the ophthalmoscope, many of them at an earlier stage of their development than would have been possible by physical and laboratory tests routinely employed.

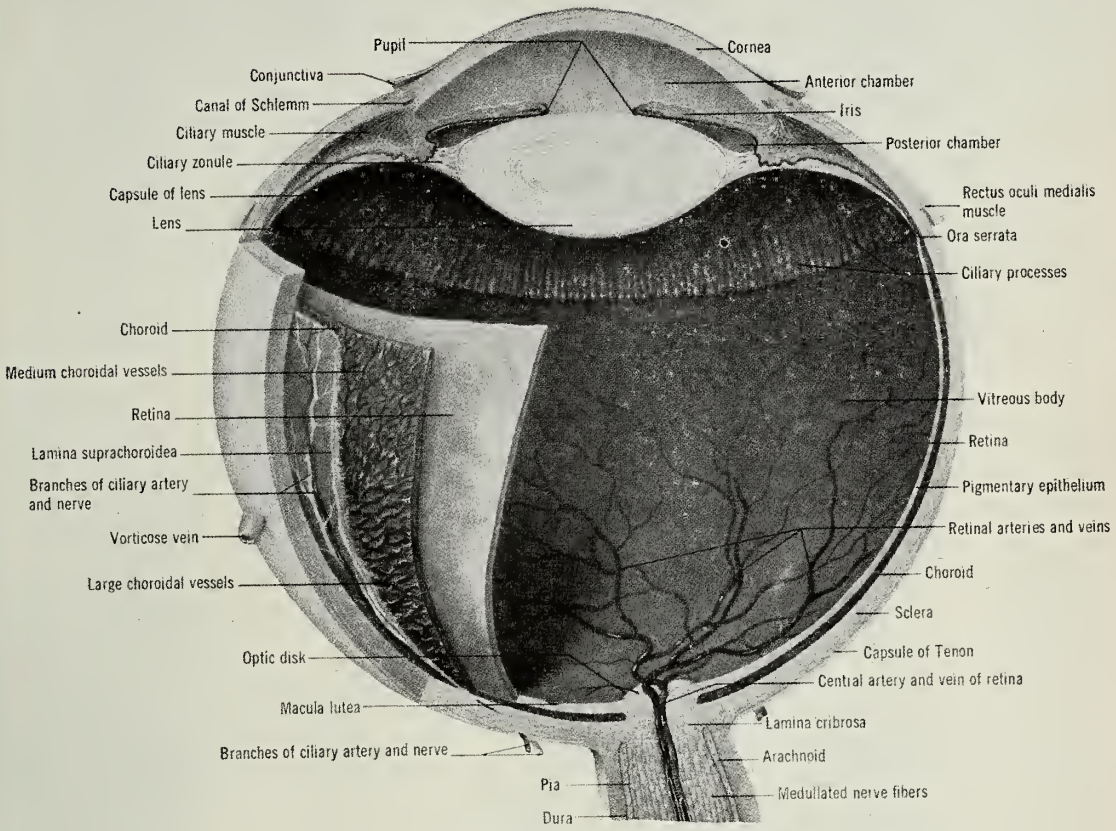
Among the diseases which may be identified by skilled use of the ophthalmoscope, some often earlier than by other means, are

Arteriosclerosis
Blood Diseases (e.g. Leukemia)
Brain Tumor
Diabetes
Eclampsia
Glaucoma
Hypertension (High Blood Pressure)
Lipemia
Malignant Tumors (Some of them)
Multiple Sclerosis
Nephritis
Nephrosis
Retinopathy of the Toxemia of Pregnancy
Syphilis
Toxoplasmosis
Tuberculosis
Tuberous Sclerosis (Bourneville's disease)

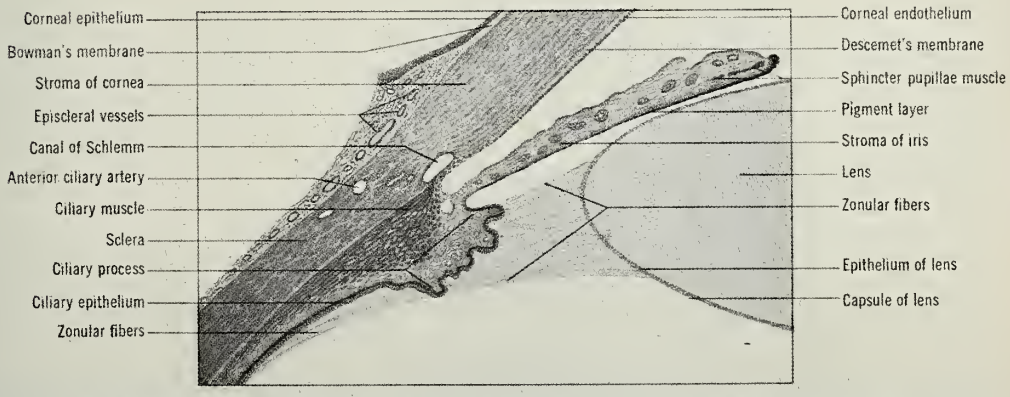
Glaucoma, one of the most prevalent of chronic diseases, may be diagnosed by this method in its advanced stage.



Anatomy of the Eye



HORIZONTAL SECTION OF EYEBALL—LOWER HALF



MICROSCOPIC SECTION THROUGH CILIARY PART OF EYE—LOW MAGNIFICATION

The characteristic appearance of depression of the optic nerve-head caused by increased intraocular pressure is a sign that glaucoma is far advanced. Nevertheless, something can still be done to conserve residual vision. Use of the tonometer, plus other tests to be discussed later, should be part of the standard procedure in every general medical examination, especially in persons over 40, to aid in detecting the disease at a much earlier stage.

The seriousness of glaucoma as a public health problem has been recognized by the United States Public Health Service.

The service is encouraging projects in early

case-finding and is sponsoring evaluation of tests and procedures for the detection of glaucoma and research in the epidemiology and etiology of the disease.

Recent estimates have listed total blindness caused by primary glaucoma as amounting to 4100 new cases annually, or 15% of all new cases of total blindness. As a result of another survey covering 35,000 people it has been calculated that there are at least one million people with undiagnosed glaumoca.

Glaucoma is characterized basically by an instability of the intraocular mechanism which is concerned with the production of, and drainage away of the fluid produced within the eyeball.

Normally, the aqueous humor produced in the posterior chamber passes through the pupil into the anterior chamber and drains through the angle of the anterior chamber at an even rate of flow.

In glaucoma, for reasons yet unknown, the fluid does not drain away at the rate it is produced, with the result that pressure throughout the eye rises.

This may occur suddenly, accompanied by alarming and distressing painful symptoms—the condition of acute glaucoma. The conjunctiva appears congested, the cornea is cloudy, the pupil dilated, and the lids are edematous.

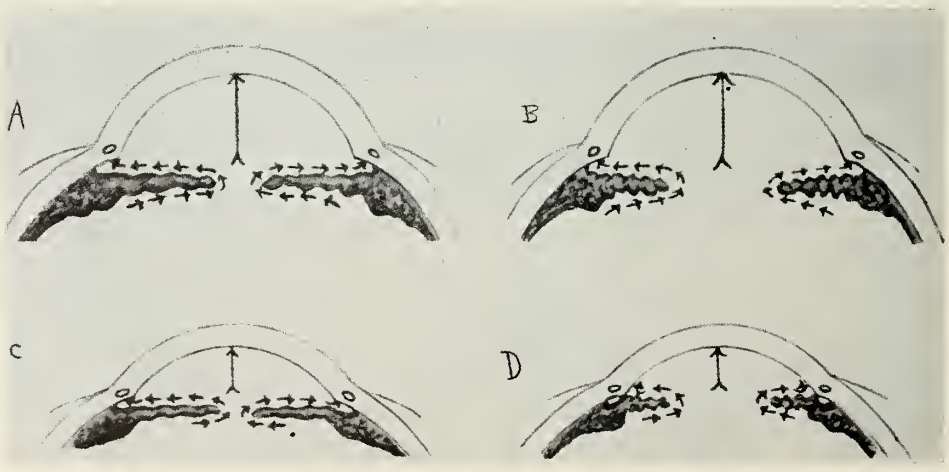
In the majority of cases, however, the condition developes slowly and insidiously, with no pain or discomfort in the early stages—in which case it is termed chronic simple glaucoma. The eye appears to be normal upon routine examination.

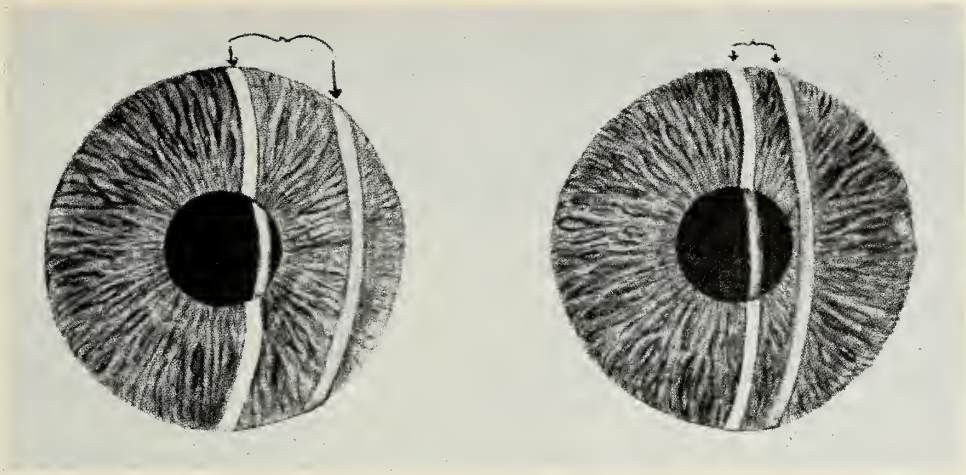
In chronic simple glaucoma the anterior chamber is usually deep, permitting the intraocular fluid to drain through the angle (fig. A) although at a decreased rate of flow. This drainage is not blocked when the iris is dilated (fig. B).

In eyes predisposed to angle closure glaucoma the anterior chamber is usually shallow and the flow of fluid drains through the angle if the angle remains free (fig. C). When the iris is dilated, the angle becomes blocked, thereby preventing drainage of the fluids (fig. D). In these eyes, physicians are cautioned against prescribing the oral administration of any of the belladonna-like drugs which tend to dilate the pupil and may cause a glaucomatous attack.

A simple examination using the slit beam in an ophthalmoscope will reveal the depth of the anterior chamber. The examiner stands directly in front of the patient. The ophthalmoscope is held at the temporal margin of the orbit and slightly tilted to focus the thin beam of light on the cornea. A reflex beam of light will be observed on the iris. The distance between the two beams of light indicates the depth of the anterior chamber (fig. A). In a shallow anterior chamber, the beams of light are closer together (fig. B).

The basic cause of the condition is unkown; but, regardless of the type, the high intraocular pressure causes degenerative changes in the nerve fibers and blood vessels supplying the retina. The process is irreversible, but may be checked by drugs or surgery. Ocular hyptertension, if allowed to become sufficiently high, exerts a pressure which depresses the head of the optic





nerve, forming a cup, and constricting the blood vessels.

Peripheral vision gradually becomes more and more reduced. The final result of this pressure is atrophy of the optic nerve—and blindness.

Hypertension in the eye is thus an important sign of glaucoma. It is indeed fortunate that the tension of the eye can be measured objectively, because in early chronic simple glaucoma it is often the only objective sign, and there is usually no pain or ocular discomfort.

Regardless of the instrument used, an estimate of the intra-ocular pressure is derived by measuring the resistance of the eye ball to an external force applied on the cornea.

In the standard Schiotz tonometer, commonly used by opthalmologists, the cup-shaped footplate is placed gently on the cornea, while a plunger sliding freely within a cylindrical tube rests also on the cornea. The amount of indentation caused by the weight of the plunger on the cornea reflects the amount of pressure within the eye.

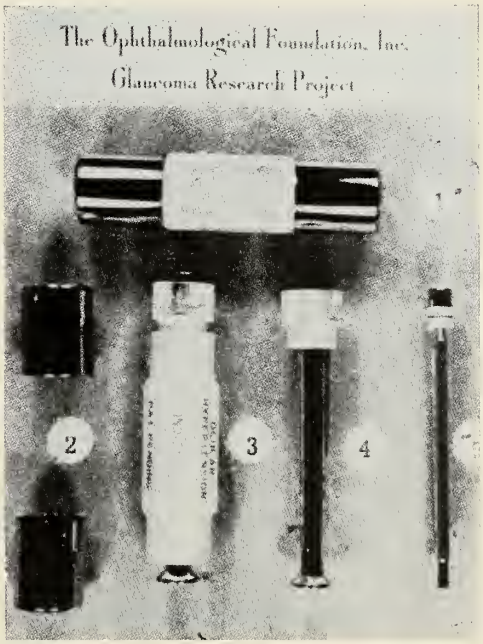
This movement is transmitted to a lever, whose long arm records the displacement, and indirectly, the relative pressure within the eye.

The Schiotz type of instrument, in spite of its delicacy, is essential to the ophthalmologist. Its fine scale divisions, for example, are necessary in determining the effect of therapy in the control of the disease.

The Schiotz instrument requires special care. It must be dismantled, cleaned and reassembled after used.

It must be checked at an instrument checking station once a year to insure its accuracy. Signs of friction must be watched for because this is a common source of error in reading. It must be handled carefully at all times and will not stand the rugged treatment of being carried in a general practitioner's bag.

For the above reasons, a special tonometer has been developed for the use of the general practitioner. This is called the Ocular Hypertension Indicator to differentiate it from the standard tonometers. It is not intended to supplant these tonometers, because it is a screening instrument and as such, shows the three necessary gradations of pressure, normal, hypertension and emergency hypertension. It is a self-contained unit (1) which requires no carrying case, and



Ocular Hypertension Indicator showing separate parts.

can readily be carried in the pocket. The Ocular Hypertension Indicator is simple to use and its reliability is not affected by rough handling.

With the protective caps (2) removed from each end, the instrument is seen to consist of the handle (3) which holds the footplate assembly (4) inside of which slides the plunger (5). The footplate and plunger are counterparts of those on the Schiotz tonometer and work on the same principle, but instead of the delicate indicator, a Vernier scale with a magnifying lens has been substituted for the reading. Some presbyops who have difficulty in reading the optical scale would naturally use the Schiotz or similar type of instrument. The description of the technic of tonometry is the same whether the Ocular Hypertension Indicator or Schiotz is used.

Two closely spaced parallel lines are engraved around the top of the plunger—and a single reference line is engraved on the corresponding part of the index which is permanently fastened to the metal tube which terminates in the footplate. The function of the footplate is to establish a "zero" against which the indentation of the plunger is measured. With the instrument held vertically in place on the cornea, a magnified image of the scale is reflected upward by the prism of the lens, through the cylindrical magnifying surface, through the top of the lens to a focus of approximately nine inches. Thus, the position of the two parallel lines with respect to the reference line is determined by the depth to which the plunger indents the cornea.

On this diagram, note that the space between the two lines is exactly divided by the reference line. The Indicator has been so calibrated that when this is the case, the ocular tension is equal to 25 millimeters of mercury—in other words, a normal tension, according to the 1948 standard scale for the Schiotz tonometer. The graph against which findings of the indicator are correlated is the standard scale derived from calibration of the more complicated Schiotz instrument.

If the two lines are not centered with respect to the reference line, but are displaced upward, toward the red dot, the tension is above 28 millimeters; hypertension exists. The greater the displacement toward the red dot, the higher the tension. When the lower of the two lines is directly aligned with the reference line, the pressure may be 44 millimeters or more.

Conversely, displacement of the two lines away from the red dot indicates a degree of hypotension.

Let us repeat these readings, demonstrating with the instrument itself.

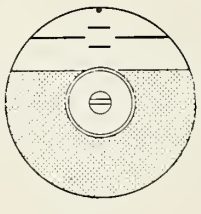
Illustration I is a normal reading, the reference line exactly dividing the space between the other two lines, indicating between 22 and 28 millimeters of mercury. In Illustration II, the two lines are displaced toward the red dot, showing that the tension is above 28 millimeters. And at the point shown in Illustration III, it may be 44 millimeters or more.

For sterilizing the Ocular Hypertension Indicator before taking tensions, the footplate and plunger are first wiped with Zephiran, one to three thousand. This must be removed by dipping these parts in water or physiologic saline solution, after which a light shake will get rid of the excess fluid.

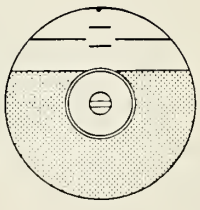
Positive diagnosis of Glaucoma cannot be made on a single tonometric reading. Instances, although rare, of Glaucoma at low tensions; patients with abnormally rigid ocular coats (cornea); patients whose ocular pressure is momentarily raised by excessive tenseness of eye muscles during tonometry; and patients with intermittent high tension who chance to be screened during normal tension make diagnosis of Glaucoma the responsibility of the ophthalmologist.

Tonometry is contra-indicated when the eye is inflamed, congested or ulcerated.

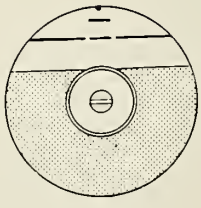
For the patient's comfort during tonometry, the cornea is anesthetized, and for this a surface



Illus. I



Illus. II



Illus. III

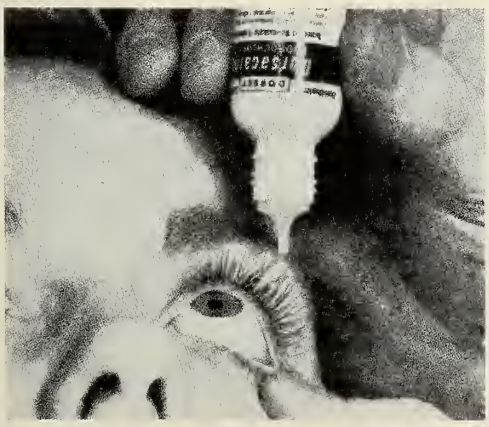
anesthetic should be chosen having the following properties: fast action, minimal stinging sensation, minimal effect on the cornea and short duration.

Patients should not leave the office while the eyes are still desensitized, because a foreign body entering would cause no pain, and the free movement of the eyes might cause serious damage to the corneal epithelium. For the patient's convenience, therefore, the short period of anesthesia is very important.

For tonometry the patient must be fully prone on the examining chair or table. Because the tonometer is a gravity actuated instrument and must be operated in a truly vertical position, it is essential that the patient should be looking directly upward when the instrument is placed upon the cornea. It is important that the patient be made as comfortable as possible and reassured if he shows signs of apprehension because in a tense state the eyelids or extra-ocular muscles will compress the eyeball and cause a falsely high reading of pressure.

The surface anesthetic of choice is instilled into the outer, lower angle of the conjunctival cul-de-sac, after depressing the lower eyelid.

After a brief interval—about a minute—and holding the outer sleeve vertically, the doctor gently lowers the instrument. The plunger first comes in contact with the cornea, followed by the footplate. Should the instrument not be placed centrally on the eye at first it must be raised clear of the cornea, and then moved and replaced at the correct position. Under no circumstances should the instrument be dragged on the surface of the eye.



Instilling anesthetic in conjunctival cul-de-sac.



Closeup O.H.I. applied to cornea.

The doctor should take particular pains to develop deftness and skillful handling of the eyes. The patient is usually in a nervous condition and skillful manipulation will do much to instill confidence and alleviate this nervousness.

In order for footplate and plunger to operate freely, the handle must be held so that it neither presses down on the footplate nor lifts it from the cornea—which would alter the reading. The reading is taken from a position directly over the lens, at a distance of about nine inches, which is its approximate focal length.

The second important test which may indicate the possibility of glaucoma is checking the patient's visual fields. While thorough charting of the fields is a complicated process, generally done only by an ophthalmologist or a specially trained technician, an adequate estimation of the extent of side vision may be achieved by simply using a white-headed pin on the end of a pencil as a test object.

The patient keeps one eye covered, and looks straight ahead with the other at the examiner's eye (right eye of patient to left eye of doctor) as the doctor brings the test object in slowly from the side. The patient is asked to indicate when she first sees the object. With normal vision a person is aware of this at nearly 90 degrees from his line of sight. A decrease down to 20 degrees is considered to be "industrial blindness."

Reduction of side vision to 20 degrees is an important factor considered in industrial insurance cases and is stipulated in the exemption for blindness in the Federal income tax regulations.

Here is a case in which the patient could not

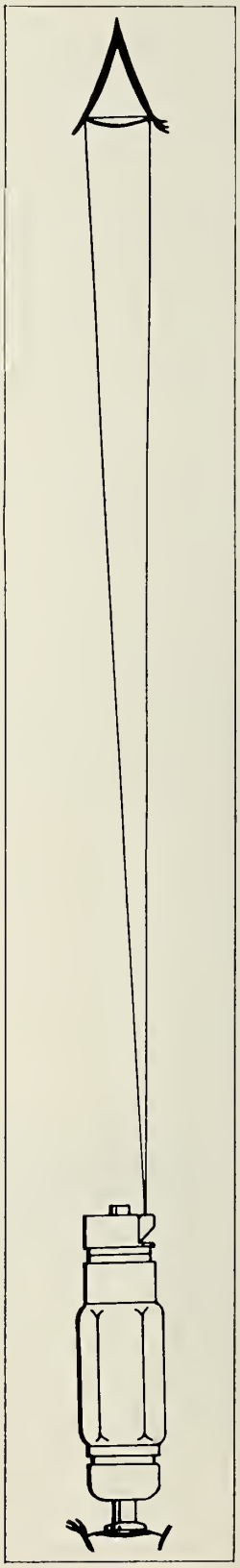
see the object until it was at about a 45 degree angle. Such a decrease in side vision, especially if coupled with ocular hypertension, is an indication to the doctor that the patient may have glaucoma. It must be remembered that loss of side vision denotes a late stage of chronic simple glaucoma. The disease could and should have been recognized much earlier by means of a tonometer.

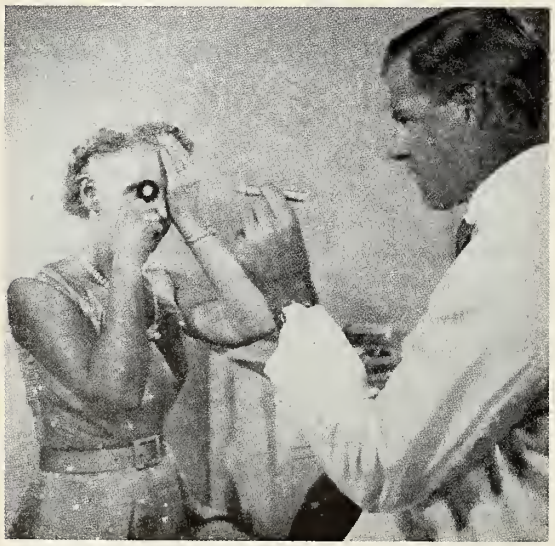
The patient should be asked whether she sees anything unusual about lights at night. If she describes colored rings or "halos" about them she may be asked to hold up this lens, which reproduces regular progression of rainbow colors in concentric circles often seen by someone with advanced chronic simple glaucoma. A positive "halo test" is another sign suggestive of Glaucoma.

Other warning signs and symptoms to be kept in mind are: brief attacks of blurred vision; delay in the adaptation of the eyes to dark surroundings; a sense of fullness and mild aching in and about the eyes; the need for frequent change of glasses or need for unduly strong reading lenses.

In respect to blurred vision, the doctor should have in mind the provocative water drinking test for Glaucoma. For example, many people habitually drink one or two glasses of water on arising, have at least one cup of coffee for breakfast, possibly a glass of fruit juice or other fluids, and milk on cereals, to a total of four glasses of fluid which constitute a water drinking test. These people, if glaucomatous, are likely

(Note: The Ocular Hypertension Indicator may be obtained through any medical supply or surgical instrument concern.)





Observer's Eye approximately 9 inches (22½ centimeters) above O.H.I.

to have dim vision in the course of one-half hour after breakfast.

Although examination with an ophthalmoscope is generally not revealing until Glaucoma is well advanced, as we have pointed out, it is wise wherever possible to look at the retina and optic disc for any evident signs of abnormality.

The physician must be exacting in his examination for Glaucoma, and maintain a high index of suspicion.

The test for ocular hypertension must be made instrumentally, not by finger palpation, since the difference between normal and pathological pressure is often as little as two millimeters of mercury; the fingers cannot be trusted to "remember" this slight difference. ◄



Early Recognition of Glaucoma

Remarks by M. Richard Harding, M.D., in connection with the showing of the film "The Eye in General Medical Diagnosis," before the Indiana Academy of General Practice, in Indianapolis, March 19, 1959.

This film is an excellent presentation embodying the cooperative efforts of some of the country's renowned ophthalmologists. It is supplied by the Glaucoma Research Project of the Ophthalmological Foundation.

I hope the movie will stimulate you to use the eye as a route and the ophthalmoscope as an instrument to better diagnosis of many systemic ills of the body, as well increase your vigilance regarding glaucoma. The Ophthalmological Foundation hopes to sponsor community-wide glaucoma surveys and will supply the Ocular Hypertension Indicator (small tonometer referred to in the film) to any physician who requests it. Glaucoma patients will soon carry a card stating their diagnosis and medication as many diabetics do.

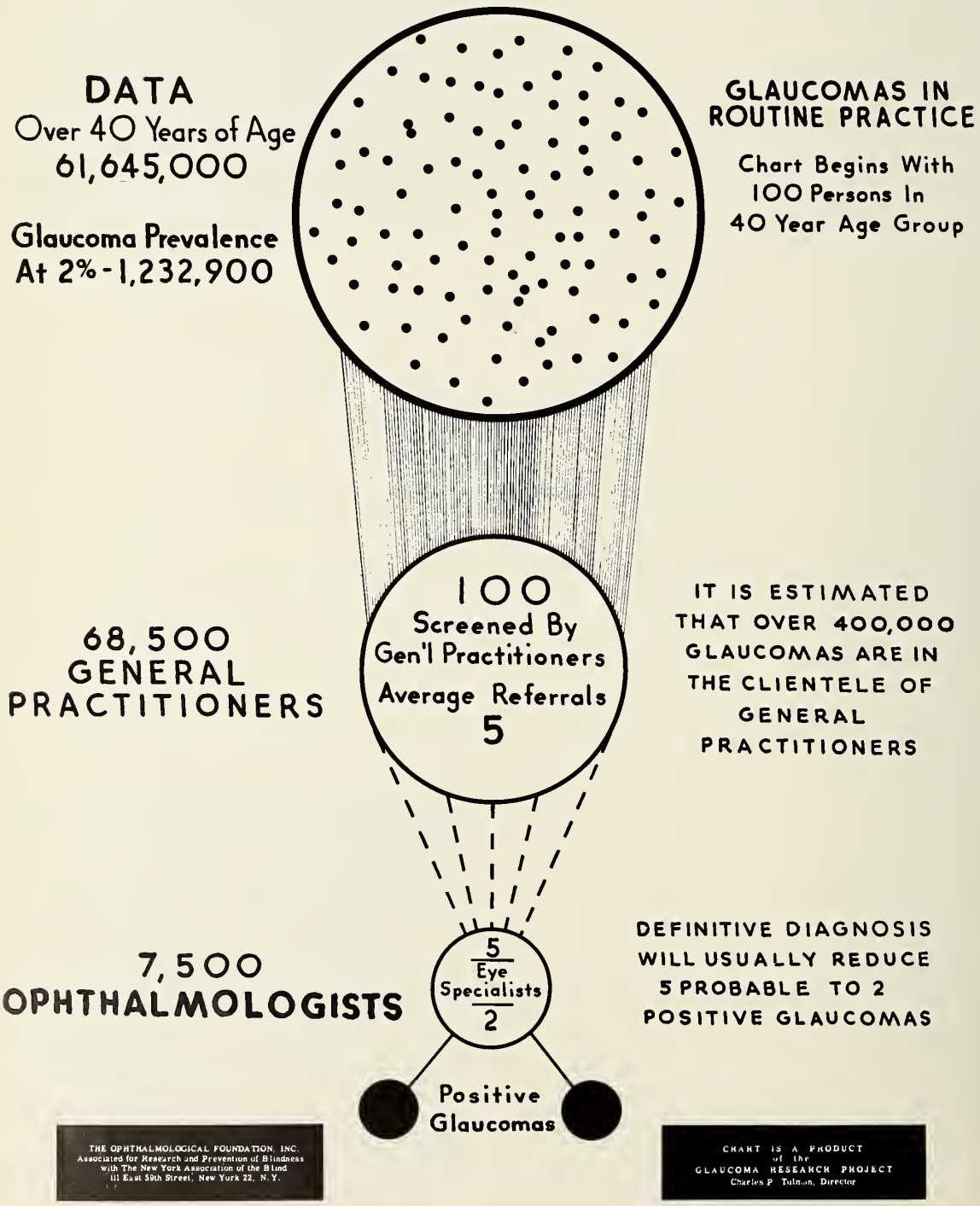
With an audience here of approximately 100, there are probably two who have chronic simple glaucoma though you are unaware of it. A measurement of your intraocular tension or a simple visual field test would start you on the road to conserve your vision. One of these screening tonometers is available in the Examining Clinic under direction of your Health Committee. Now is the time for you to be checked as well as learn first hand the use of the O.H.I.

I know that history-taking is an increasingly inclusive task, as one must inquire as to whether a given patient is allergic to this antibiotic, to that food or this drug, or more recently is he taking one of the growing family of tranquilizers. But you should add a question regarding any history of or medication for glaucoma. One tragedy that frequently occurs in a well-managed glaucoma patient, using his drops faithfully, is that when hospitalized for some other illness he

The PROBLEM of GLAUCOMA CONTROL

Victims Have No Pain or Visual Discomfort

It Can Be Controlled Through Routine Checkups By The GENERAL PRACTITIONERS



completely forgets his eye medicine until he returns home. Often this is all that it takes to precipitate a relapse and cause further damage to the vision. So I implore you to quiz your patients over 40 regarding this ever-important problem, especially before ordering an antispasmodic for stomach or intestinal relaxation.

Lastly, a paradox which I often encounter is the patient who says "Oh yes, I'm taking a tranquilizer, or a mild sedative for my nerves," but on further questioning I subsequently find that they are drinking 6-8-10 and even up to 20 cups of coffee per day! Now this is ridiculous, as you know, yet it is one of those obvious things that is easily overlooked. Two or three cups of coffee contain a therapeutic dose of caffeine which more than neutralizes the effect of a tranquillizer or mild sedative; moreover it is enough to raise the intraocular pressure 5-6 mm. of mercury or more! So, doctor, watch the coffee pot, and—be on the lookout for that next glaucoma patient. ◄

How Much Federal Aid Did the Pilgrims Get?

Extension of Remarks
of
HON. HARRY FLOOD BYRD
of Virginia
in the Senate of the United States

Friday, April 24, 1959

Mr. BYRD of Virginia. Mr. President, I ask unanimous consent to have printed in the Appendix of the RECORD a statement which appeared in the U. S. NEWS & WORLD REPORT entitled "How Much Federal Aid Did the Pilgrims Get?"

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

How Much Federal Aid Did the Pilgrims Get?

They were in a depressed area. No one guaranteed them high prices for anything. Their only roads and schools were built by themselves. For security they did their own saving, or starved.

All they had was character. All they did was work. All they wanted was self-respect.

The sum of those three traits became America.

But what's going to be the sum of the traits you see today—the traits of character, or, rather, lack of it, that demand more money for less work, put security above self-respect, pamper self-pitying criminals instead of punishing them, give away resources we desperately need to protect ourselves, listen to weaklings that want Government to take care of them when they should take care of themselves.

Long years of early-American self-respect and hard work built America, but the traits you see today can destroy it, in half the time.

Reprinted from the *Rhode Island Medical Journal,* May, 1959.

Feeding Problems in the Preschool Child

*W. D. SNIVELY, JR., M.D.**

Evansville

THERE'S a great army of pale and peaked children abroad in the land, an army of children in the pastel tints. Like depleted land that is not worth tilling, they are submarginal, nutritionally inferior. They sit at America's table of plenty, like wan, pitiful little ghosts, unable to enjoy the most abundant dietary the world has ever known. Many of them haunt the reception rooms of physicians who see children. And when they are presented to the dector by their parents, it is almost invariably with the all too familiar complaint, "My child won't eat!"

Although such children may appear superficially normal, on examination they are found to be retarded in their growth, irritable, victims of repeated digestive upsets and infections. Typically the parents report that they are always tired. Their striking pallor has led Dr. Preston McLendon, professor of pediatrics, George Washington University, to describe them as children in the pastel tints.

Their story typically follows a definite pattern. While the presenting complaint is: "My child won't eat," these children *do* eat, but it's between meals. Their fare consists largely of starchy foods washed down with palatable liquids. Meat, eggs, cheese, fish and other solid protein foods are refused.

I would like to emphasize the widespread prevalence of this ubiquitous ailment and to outline a means of helping parents solve the paradoxical problem of childhood nutritional deficiency in a land of plenty.

Presented at the Eleventh Annual Scientific Session, Indiana Academy of General Practice at Indianapolis, March 19, 1959.

* Vice-president, medical director of Mead Johnson & Co., Evansville, Ind.

Typical Instance

Let's take a typical instance. Johnny Brown, a 4-year-old child, was brought to the doctor because he tired quickly, was "nervous," and refused to eat at mealtime. When his parents would succeed in getting food into his mouth, he would sometimes hold it there for hours. An only child, he lived with four adults—his parents and grandparents. At meals, he was the target of a barrage of coaxing and bribing. He nibbled constantly between meals, washing down crackers and cookies with milk and soft drinks. He could neither be bribed nor browbeaten into eating meats and other solid foods at the table.

He was underweight and under height for his age. His tissues and muscles were soft and flabby; his posture was poor. He had many decayed teeth and his skin was pale. He was irritable and resented the physician's examination. His blood count and smear revealed an anemia; there was no other evidence of disease.

Johnny is representative of a vast number of nutritionally submarginal children seen by physicians from coast to coast and from border to border, in Canada and Mexico, in Egypt and South America.

Strangely enough, this ailment usually affects children whose parents are the most anxious to give them every benefit. In fact, the immediate responsibility for the disorder of which I am speaking rests upon *parents who try too hard.*

The problem begins with the infant's precipitous drop in growth rate which occurs shortly after the end of the first year. During the first year, the baby gains about 16 pounds, as much as he will gain in the next four years added together. His rate of weight and height gain begins to drop about the fourteenth month and

continues down until a sort of valley of minimal growth occurs during the third or fourth year. After this, the rate of growth accelerates, reaching a peak in adolescence that almost equals the gain during infancy.

Now what has baby's drop in growth rate to do with appetite problems? It has a great deal to do with them because appetite depends not upon activity but upon growth rate. This explains why we do not have appetite problems with the baby lying placidly in bed while we do have them with a runabout, who is going like a "whirling dervish" from morning to night. The baby's rate of growth is high and his appetite ravenous. The runabout's rate of growth is low and his appetite relatively tiny.

Most parents are entirely unaware of the drastic decrease in growth rate, and hence, in appetite that occurs soon after the end of the first year. So when the fourteenth-month-old child apparently desires less food, mother finds it difficult to give less food. She can't understand the wasting away of the formerly voracious appetite. While the child's appetite and desire for food have decreased, mother's desire to poke food into him has not lessened one whit.

Unfortunately, many parents are poorly informed regarding the facts of nutrition and growth. Instead of possessing a sound body of knowledge, many of them are armed only with a motley assortment of fables. I'd like to discuss nine of them that we've encountered in our practice and in our talks with parents. Many of these fables are made to sound credible by incessant repetition over such media as television, radio and movies.

Fable No. 1

"Infants and children should be given more and more food as they become older and more active."

The facts: Infants and children should be fed in accordance with their appetite, which is determined largely by growth needs. These vary from time to time. During the first year, the infant grows at a rapid rate. Shortly after the first year, his rate of growth drops drastically. The preschool child is in a valley of minimal gain; hence, in a valley of minimal appetite.

Fable No. 2

"All that is needed for good nutrition is a quart of milk a day."

The facts: While milk contains important nutrients, it is not a "complete" food; it is not the alpha and omega of nutrition. Preschool children tend to substitute milk and readily gulped tidbits for a balanced diet when parents try to force food at mealtime.

This is no new and extreme concept. In 1931 Doctor Joseph Brennemann, the father of modern pediatrics, said: "Milk, the great 'protective food,' has been crammed down our and our children's throats, in season and out of season, although the observing, practical pediatrician has long known that even in the use of milk, children should be dealt with as individuals and that the slogan of 'a quart of milk or more a day' originated in the laboratory, and has a sweeter sound to the milk producer than to the pediatrician."

Fable No. 3

"Children need vegetables in great quantity if they are to be well nourished."

The facts: Fruits are just as nutritious as vegetables and many children find them more palatable. Fruits can be substituted for vegetables with no qualms whatever.

Fable No. 4

"Minerals, especially calcium, and vitamins are substitutes for food."

The facts: While minerals and vitamins are essential to a balanced diet, they are not substitutes for other nutritional essentials.

Fable No. 5

"Protein is of importance only for dogs and livestock."

The facts: Protein is of basic importance not only for animals, but for children. Its amino acids, the "building blocks for growth," are needed by children just as they are by animals Animal fanciers would not tolerate mistreatment of their charges with the food permitted many preschoolers. An interesting incident was related in the *Saturday Evening Post* recently. A pet dog, suffering from severe malnutrition, was taken to the veterinarian. The little dog's child master was in good health. It developed, upon investigation, that for some months doggie and boy had been exchanging breakfasts. The little boy had been eating the dog's well balanced, high protein dog food, while the dog had been eating the child's sugary cereal with cream, milk, and sweet roll. The boy was far wiser than his

elders when it came to what constitutes a nutritious breakfast!

Fable No. 6

"Children will starve and lose weight unless forced to eat."

The facts: No normal child will starve with food in front of him unless an attempt is made to force him to eat. Such forcing is a sure way of getting him to eat less, not more food. When food is forced, rebellion is inevitable and mealtime becomes an unpleasant time for the whole family. The child loses his appetite when he comes to the table and will eat willingly only between meals when he is free from parental pressure. Parents who force food at mealtime train the child's appetite to "leap-frog" mealtime.

Fable No. 7

"Hunger is a harmful sensation, hence children should never be permitted to remain hungry."

The facts: Hunger is the only stimulus to eating for the young child. The child who is never allowed to become hungry never really *eats,* thus he is deprived of one of the real pleasures of life.

Fable No. 8

"Children will choose a sound diet regardless of what foods are permitted them."

The facts: When children are allowed to eat what and when they will, they often choose a high carbohydrate diet, washed down with palatable liquids; when they have once become conditioned to an intake of milk, sweets and starches, they continue to crave it unless drastic steps are taken.

Fable No. 9

"Each child requires three 'harvest-hand' meals daily."

The facts: No child, especially the preschool child, should be expected to eat three large meals a day. When parents permit the unmolested appetite to be the guide and make a limited number of sound foods available to the child, he will eat enough to obtain optimal nutrition whether one good meal or three.

And there are other fables. I've only mentioned the worst ones. Poems taught to school children suggest that milk, bread and vegetables make them "grow and grow and grow." One of them goes like this:

"Apples red, apples red,
Milk and bread, milk and bread,
Such good food we children know,
Makes us grow and grow and grow."

And another chant from my area runs:

"I will grow so fine and tall,
But simple Sal will stay so small.
Guess one thing she doesn't know,
Milk and vegetables make you grow."

Have you heard the popular song called "Bimbo"? It epitomizes the sort of nutritional advice to which parents are constantly exposed: The song tells about Bimbo's "bright blue eyes" which "light up like the stars" when he is fed candy bars. It tells how chewing gum and cracker jacks help him to "start his day off right" and how the children follow him to beg for a bite. It then tells how Bimbo chews on his gum with candy very much in evidence, and it finishes with a plaintive, but perfectly reasonable, query as to when is Bimbo going to grow?

It isn't difficult to see how the problem of parents who are trying to provide the proper nutrition for that complex individual, the toddler, is multiplied and compounded by the existence of these fables. Even when parents have the facts, provision of optimal nutrition for the runabout is not easy. For the runabout is in reality a changeling. He's a transition individual, neither a baby nor yet a child. I like to think of him as "little Mr. In-Between." Periods of transition, whether from war to peace, from adolescence to adulthood, or from infancy to childhood, are always difficult. They are certainly difficult for the toddler, preschooler, runabout, little Mr. In-Between, call him what you will.

One of his preplexing transitions concerns the form in which food is taken. During the first year, he took his nourishment as liquid through the mechanism of sucking. During the second and following years, he must learn to chew his food and to employ the utensils of adult eating. This is a fundamental transition, and hence, a difficult one.

Little Mr. In-Between has other problems. In spite of the drastic slowing down in his over-all rate of growth, his muscles and bones develop importantly during the preschool years, out of all proportion to the slowing down of his total nutritional needs. The requirement for protein,

which provides the building blocks for growth, increases rather than slackens during the preschool period, and this in spite of the fact that the over-all nutritional requirement is much less.

While the physical growth rate decreases during this period of change, emotional and social growth increase. The child begins to become an individual, assertive, independent, even negativistic. Although he is definitely "choosey," he is also uncertain and incapable of making choices.

Parental misconceptions concerning nutrition on the one hand, and the inherent problems of the preschool transition period on the other, added up to *malnutrition* and pastel tinted children.

For the dropping off in the child's appetite all too often causes parents and others in his environment to beg, bribe, browbeat, belabor and even beat the child in an attempt to get him to eat. All this pressure is applied at mealtime, and so the child begins to regard meals, not as pleasurable periods, but as ordeals. You all know what happens when something unpleasant occurs at mealtime; you lose your appetite. So does Johnny. And so, after awhile, he takes to eating between meals, and he eats the foods that are conveniently available, most of them starchy foods like cake, bread, cookies, candy, and sandwiches; and he usually washes them down with milk or some other palatable liquid.

Inadequate Diet

The end result of all this is a diet that is strikingly inadequate in protein, since it contains little or none of the solid high protein foods such as meat, eggs, cheese, chicken and fish. And after this low protein intake has gone on for a year or two, parents find they have a pastel child on their hands, a pale child without much energy, usually skinny, irritable, with flabby muscles and perhaps a potbelly. After this condition has gone on for years, he usually has a mouth full of decayed teeth.

Since the common characteristic of the diet of all of these children is a low intake of solid protein foods, my colleague, Dr. Harold D. Lynch, and I have designated the condition, "childhood hypoproteinosis." And although we can't prove it chemically at the present time, it is obvious that the symptoms manifested by these children are the same as one sees in experimental or controlled protein deprivation.

Now it is certainly important to emphasize that this dismal chain of events that I have described doesn't happen to most children, but it does happen to a disturbingly large number and that's why we have pastel children in every city and every state of "America the beautiful." Correspondence from physicians tells us that they also have them in Canada, Mexico, Argentina, Egypt, Germany, Sweden, England and Switzerland.

The diagnosis of childhood hypoproteinosis is readily made by the physician. It is based first on the story of a low intake of solid protein foods. Probing and careful appraisal of the history are required. Quantitative, detailed food diaries are sometimes helpful. Not all the findings which I have mentioned are present in every child with the disorder. Typically two, three or more are.

There are no adequate laboratory tests for mild protein deficiency. The level of protein in the blood, sometimes helpful as an index of protein nutrition, is not helpful in childhood hypoproteinosis, since these children have a decrease in their blood volume which makes an abnormally low total blood protein content appear normal. The hemoglobin level *is* a fairly good index of the state of protein nutrition as long as the child is not suffering from iron deficiency.

Why, What and How?

Now we come to that important question: "What to do about it?" This can well be discussed under the headings of *Why? What?* and *How?*

1. *Why* is good nutrition important?
2. *What* foods does the child need for proper nutrition?
3. *How* does one influence the child to eat such foods?

Why? Parents must first of all be made to realize *why* good nutrition is important. They must accept the fact that the child's health depends, in large part, upon what he eats. The Germans have a saying: "One is what he eats." He certainly is. Food has a tremendous impact on the lives of every one of us, an impact that begins months before we come bawling into this world and that continues throughout our allotted span. Health, which requires proper nutrition,

means vigor, good resistence to infection, good color, firm musculature and its corollary good posture, strong, straight bones, sound teeth and the joy of living. A poorly nourished child does not possess these attributes.

What? Next, parents must be told *what* foods the child needs for this elusive, but desirable, thing called health. They must know the importance of protein; must realize that foods providing generous amounts of this essential nutrient must replace palatable liquids and high carbohydrate tidbits. They must realize that a nutritionally deficient child cannot be restored to health by a tonic or an "appetite promoting" supervitamin. A tonic does not relieve the parents of the difficult responsibility for the new way of family life that is required if Johnny is to develop sound eating habits.

Having explained that protein is the "keystone nutrient," essential for growth, for defense against infection, for repair of tissues, for manufacture of enzymes, and so on, we give the parents a diet list specifying generous amounts of solid protein foods. When milk has been consumed to the exclusion of other foods, we omit it from the diet until the disorder is corrected. Frequently, this omission is the key to success, for it makes the drastic change in eating habits easier for both parents and child.

To many parents and to some physicians, omission of milk may seem like a drastic step. Shakespeare said:

"Diseases desperate grown
By desperate appliance are relieved,
Or not at all."

Since so many children have gone through buoyant childhood to healthy adulthood without drinking any milk at all because of allergy or distaste for it, I would not classify omission of milk as a "desperate appliance." But I would emphasize that in the child who has been drinking milk to the exclusion of other foods, complete omission of milk from the diet is an absolute essential for relief of the nutritional problem. When even a little milk is permitted, all too often the child who is "addicted" to it will swig it first, spoiling his appetite so that he wants no solid food for that meal.

A typical menu with high protein content is as follows:

Breakfast

Fruit juice
Egg and bacon or ham
Cereal or whole-wheat toast and butter

Lunch

Fruit
Cottage cheese, egg or meat
Whole-wheat bread or rye bread and butter

Dinner

Meat, fish or chicken
Vegetables or fruit
Whole-wheat bread and butter
Fruit dessert

For the child who has not consumed excessive quantities of milk, we permit a small glass at the end of the meal if desired. We urge that nothing be given between meals except fruits, vegetables and water; for soft drinks, milk and the like provide convenient vehicles for the washing down of between-meal tidbits.

How? Parents must be told *how* to influence the child to eat the necessary foods. There must be a specific time and a specific place in which the child is given the opportunity to eat. The time is mealtime and the place the table. The desirability and the attractiveness of food are lost if the child can have it at any time and at any place; nothing appears attractive if it is too plentiful, and certainly nothing is pleasant if it is forced. Obviously, the child must want to eat. This goal cannot be accomplished by drowning him in a sea of food.

Hunger is the chief stimulus to eating. It must be encouraged and permitted to develop if it is to exert its effect. It's fun to eat when hungry. The child who has never experienced the sensation of hunger is an underprivileged child. For this reason, we urge that only fruit, vegetables and water be permitted between meals. How many parents have longed for the day when their child would eat a hearty meal, all the while keeping him so filled up between meals that he never had the opportunity of becoming truly hungry.

Not only should the opportunity of eating be limited to mealtime, the period should be made short and pleasant. Let the child make his own decision. To eat or not to eat, that is the question, and he provides the answer. If he does not care to eat, he should be dismissed from the table promptly, not to return. He should have no more food until the next meal.

Children, as members of the family group, are not privileged characters. They are to eat the family fare. We suggest that small amounts of the proper foods, with emphasis on protein, be placed before the child, and that he be given additional amounts if he desires them but *only* if he *desires* them.

Let's sum up the program:

Good health depends heavily upon good nutrition.

The solid protein foods—meat, eggs, cheese, fish—are the key foods for good nutrition for the preschool child.

Milk must be temporarily omitted from the diet if it has been consumed to the exclusion of other foods.

Each meal set before the child should "feature" at least one solid protein food.

The time to eat is mealtime and the place is the table. When the child comes to the table, he should be given the privilege of making a decision—whether to remain at the table and eat or leave the table with the understanding that if he does, he is to have no food until the next meal.

Between-meal snacking should be limited to fruits, vegetables and water. Even with these non-satiating foods, moderation should be practiced.

Parents should be well versed in the details of the program and so should the other individuals in the child's environment. Although we take pains to explain the program, we also provide parents with a mimeographed sheet presenting the program as "The Ten Commandments of Good Nutrition."

The program which I have outlined is based on the management of several thousand pastel tinted children. It is the only remedy we have found. Given parental cooperation, it is amazingly successful. Certainly parents should not undertake such a program unless they are first "sold" on it and unless they are determined to implement it conscienciously. It should be carried out only under the supervision of the physician.

Is the program an easy one? Indeed it is not! Even though parents are convinced of its value, even though they work hard at applying it, grandparents, aunts and uncles, well-meaning neighbors, teachers and playmates can innocently sabotage the child's nutrition. Such sabotage can be minimized by convincing the child of the worthwhileness of the program and by soliciting the help of other individuals in the child's constellation insofar as is possible. Let us remember that our goal in all this is health, a priceless commodity. Almost any effort is worthy of that goal.

Prevention of childhood hypoproteinosis is better than cure. It can be achieved by consultation between parents and physicians at the end of the first year. The physician points out that the child's growth, hence his appetite, will drastically decrease after his first birthday. The mother is made to understand that during the preschool period the child's nutritional requirements will be much smaller. She is helped to realize that she must sublimate her maternal instinct for getting food into her offspring into active interest and enthusiasm for Johnny's total growing-up process.

In this conference at the end of the first year, we urge that the bottle be abandoned. There are many reasons against the bottle habit following the end of the first year, sanitary, nutritional and psychologic reasons. We suggest that milk be limited to a small glass at the end of each meal. We discourage the pernicious habits of between-meal snacks and sweet desserts. The child is developing his *lifelong* eating habits; how important for him to learn to enjoy sound foods. We explain to parents that the satisfaction of hunger is among life's basic pleasures. They are urged not to deprive their child of this pleasure.

Conclusion

It's far better and easier to prevent the childhood malnutrition I have described than to treat it. But if it has developed, the transformation of children in the pastel tints to ruddy, buoyant, energentic youngsters with sound teeth and sturdy musculature is a worthwhile endeavor for physicians and parents in every corner of the land.

Optimal health requires optimal nutrition; as the English physician Parsons said:

> "Only the 'optimum' is good enough for our children and this should be the goal for which we strive." ◄

For an excellent common-sense application of the concept presented in this article, see the book for mothers, *Your Child Is What He Eats,* by Harold D. Lynch, M.D., published by Henry Regnery Company, Chicago, 1958, available in all book stores.

Condensed Cardiology:

Normal Electrocardiogram in Angina Pectoris

To be presented as a regular feature of The Journal. This is the first of a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

CHARLES FISCH, M.D.

Indianapolis

IN OUR sincere and enthusiastic search for a tool that would allow a diagnosis of coronary disease we have unintentionally elevated the electrocardiogram to a position unequalled by any other laboratory procedure. Not infrequently, however, are we dissapointed and even on occasions surprised to have a patient die shortly after recording a normal cardiogram. Regardless of what we may think of the specificity of this procedure the fact remains that a certain irreducible number of "false negative" tracings is to be expected simply because of the genesis of the cardiogram.

An electrocardiographic training is a graphic presentation of an electrical potential generated by a transfer of ions across the membrane of myocardial cells. It tells little about hemodynamic function of the heart and only indirectly and by inference permits an occasional anatomic diagnosis. These limitations should in no way detract from its tremendous value in clinical

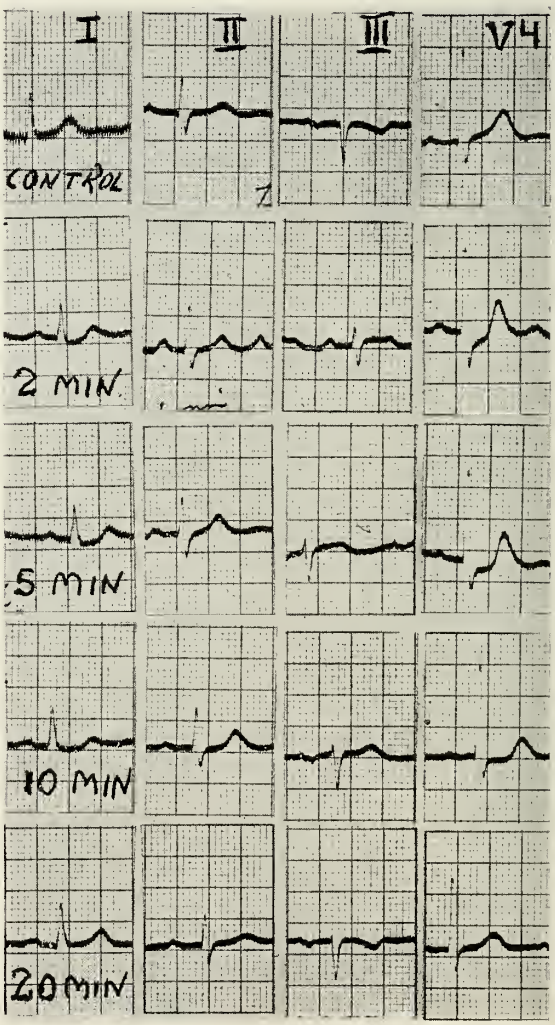


Figure 1. A 45-year-old man had an "atypical" history for angina pectoris. Entire physical including the resting (control) EKG was normal. Following a master-two-step the S-T segment in leads I and V-4 became depressed and straightened and the T wave in lead III became upright. These EKG changes paralleled the appearance of the "atypical" pain and allowed an unequivocal diagnosis of coronary insufficiency with a normal resting cardiogram.

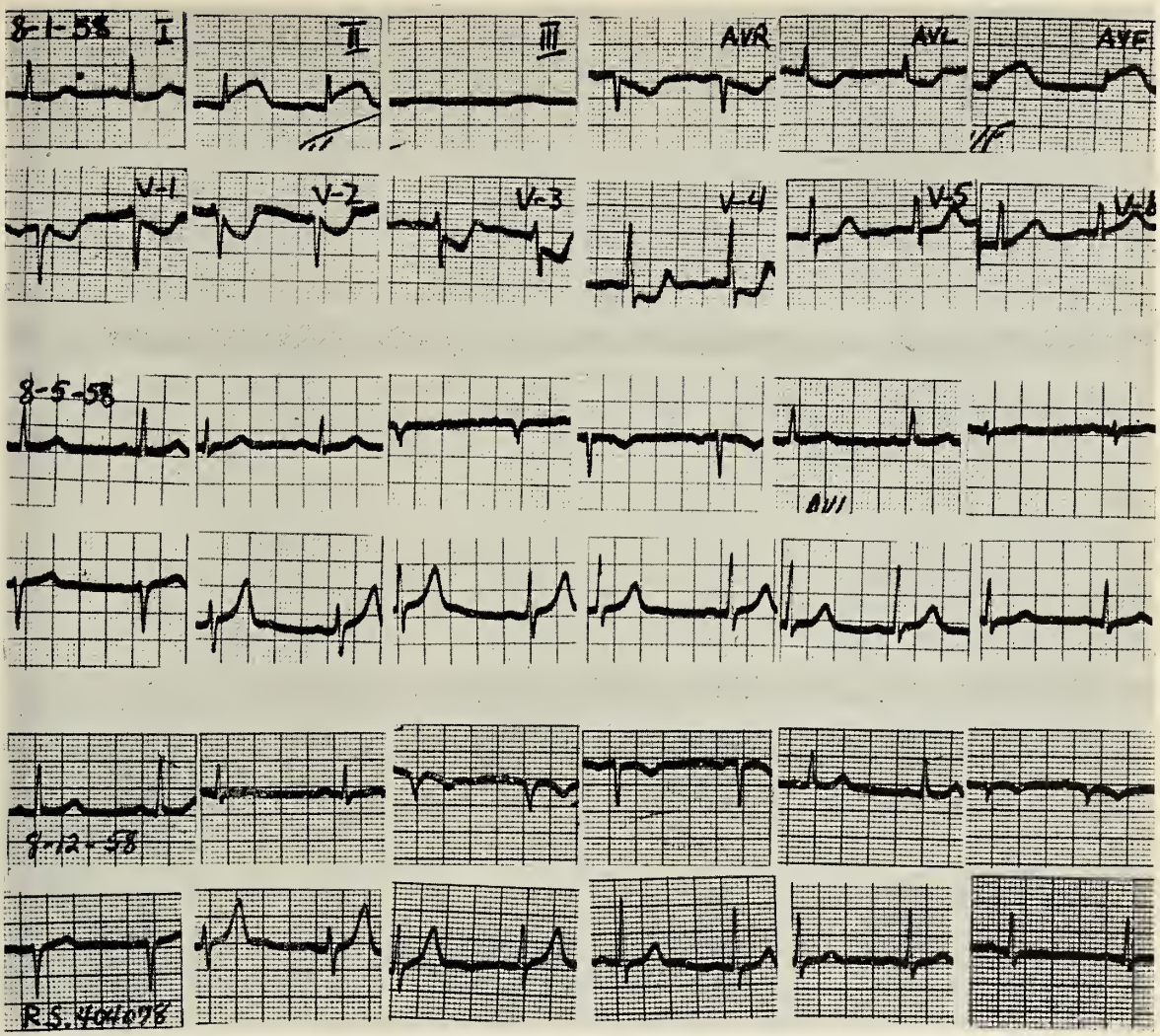


Figure 2. A 55-year-old man was admitted with a classical history for myocardial infarction. EKG on 8-1-58 shows injury of posterior wall with reciprocal depression of S-T segment over the interoseptal portion of the heart. A repeat EKG on 8-5-58 if read separately would have to be interpreted as normal. Subsequent tracings, however, (8-12-58) showed the evolution of a classical posterior myocardial infarction. These tracings illustrate the difficulties inherent in interpretation of isolated cardiograms without any knowledge of the clinical history. On the other hand comparison of EKG taken on 8-5-58 ("normal") with the one taken on 8-1-58 disclosed the appearance of tall R in V2, V3 and lowering of R in AVF indicative of loss of voltage of posterior wall such as follows myocardial infarction.

medicine. It is the only method available for accurate analysis of arrhythmias. The tracing *may* be specific in myocardial infarction, pericarditis, hypertrophies or may present the earliest evidence of electrocyte disturbance. Indirectly, by recording delays in conduction, (P-R, QRS), the cardiogram gives us some idea about the state of the myocardium. Furthermore, it has the reproducibility and freedom from technical errors seldom seen in a laboratory procedure.

Unfortunately, in coronary atherosclerosis manifested by angina alone, the cardiogram is often normal and may become abnormal only upon exertion. The electrocardiographic changes (ST-T segment) observed in patients with coronary disease appear as a result of change of electrical potential secondary to myocardial anoxia due to diminished blood supply. It follows, therefore, that a patient having considerable coronary disease but with anoxia of myocardium only on exertion, and a sufficient supply of oxygen at rest may have normal resting cardiogram. This weakness, or better, nature of

electrocardiography cannot be over emphasized. Its appreciation by the physician will lead to a more cautious interpretation and application of the cardiogram to the patient.

It is our feeling that for the diagnosis of angina pectoris a detailed and repetitious history remains our best tool and unfortunately for this time consuming technic there is no substitute. An abnormal EKG confirms the clinical impression of coronary insufficiency. On the other hand a normal resting tracing should not detract from such a diagnosis, especially if the latter is based on an unequivocal history of angina of effort. In patients with normal resting EKG and with an "atypical" story of angina electrocardiographic studies during physical stress are indicated. Such a procedure, if performed properly, will often yield ST-T changes of anoxia. In no instance, however, should a patient suspected of having coronary insufficiency be considered free of this disease solely on the basis of a normal resting cardiogram.

In this brief presentation reference was made only to the instances of angina of effort with normal cardiograms. The differential diagnosis between the ST-T changes of myocardial ischemia, and the multitude of other conditions resulting in similar electrocardiographic alterations is beyond the scope of this discussion.

THE PRONOUNCEMENT OF DEATH

One should not hurry in pronouncing death if relatives are present. To offer a specific example: sometime ago a physician was called to care for the son of a fellow practitioner. The child was obviously dead but the attending doctor realized that the father had not consciously accepted the fact. Thus, for a short period, the doctor busied himself with the child while at the same time, with appropriate remarks, prepared the parent for the pronouncement of death. Some may criticize this approach. Others will recognize it as one of the highest forms of the practice of the art of medicine—an art which takes into consideration the emotional response of those to whom the physician ministers.—Edward R. Bloomquist: "If a Man Must Die," *The New Physician,* February, 1959.

We doctors, while we still retain that measure of control over our practices allowed us by the inspired popular clamor of patients to be dosed, must make the decision whether to give up all along the line and merely hand out the pills, or not. No individual can *dictate* that decision, but I shall here attempt to *influence* it by saying this much: all drugs—even the very best and least noxious of them—are, psychologically or physically, potentially toxic agents; and none of them should be used unless such use cannot reasonably be avoided.—Harry Beckman: "Must All the Drugs Be Used?" *Wisconsin Medical Journal,* March, 1959.

The hardest conviction to get into the mind of a beginner is that the education upon which he is engaged is not a college course, not a medical course, but a life course, for which the work of a few years under teachers is but a preparation.—Sir William Osler, *U. S. Armed Forces Medical Journal,* July, 1959.

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Classes: $1.00 each, 3 for $2.50; Luncheon, $2.50.

WEDNESDAY, OCTOBER 7, 1959

	First Period 8:00 to 8:20 a. m.	**Second Period** 8:30 to 8:50 a. m.	**Third Period** 9:00 to 9:20 a. m.
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The complete schedule of classes for the 1959 Instructional Courses, offered as a special feature of the Annual Convention of the Indiana State Medical Association at Indianapolis, is published below. Classes will be held on Wednesday, October 7, 1959, at the Murat Temple.

The Indiana Academy of General Practice will give its members approval for Catagory No. 1 credit.

Admission to each class will be by ticket. Classes will be limited to 30 physicians. Cost, $1.00 per class, or $2.50 for all three classes. Plan your course to include all three classes, and indicate second choices. Enclose your check made payable to the Indiana State Medical Association.

A NEW FEATURE—A "buzz-session" luncheon will be held at noon Wednesday, Oct. 7, at the Athenaeum at which time there will be an opportunity to exchange views. Tickets for the luncheon, $2.50, includes gratuity.

Total cost, 3 classes plus luncheon, $5.00.

ORDER NOW — classes are filled early!

INSTRUCTIONAL COURSE SCHEDULE
WEDNESDAY, OCTOBER 7, 1959

FIRST PERIOD 8:00 to 8:20 a. m.	SECOND PERIOD 8:30 to 8:50 a. m.	THIRD PERIOD 9:00 to 9:20 a. m.
Course 1 Cardiac and Non-Cardiac Chest Pain DAN L. URSCHEL Mentone	**Course 7** Obstetrical Emergencies GORDON C. COOK South Bend	**Course 13** Tonsillectomy and Adenoidectomy —Accepted Procedure, Pre- and Post-Operative Care; Management of Hemorrhage RALPH V. GANZER South Bend
Course 2 Infant Feeding JOHN R. SCOTT Indianapolis	**Course 8** Allergy—When to Suspect It and What to Do About It BENNETT KRAFT Indianapolis	**Course 14** The Chronic Skin Rash Problem JAMES E. ENGELER Lafayette
Course 3 Office X-Ray Problems and Pitfalls LOUIS C. BIXLER South Bend	**Course 9** Office Laboratory for Every Doctor's Office ELGIN P. KINTNER Maryville, Tenn.	**Course 15** Efficient Office Management OTIS R. BOWEN Bremen
Course 4 Work-Up of an Abdominal Pain Problem JAMES M. LEFFEL Indianapolis	**Course 10** Diagnostic Problems of the Liver JAMES W. HURLEY Elkhart	**Course 16** Problems of the Urinary Stream TRUMAN E. CAYLOR Bluffton
Course 5 Foot Problems of Children MORRIS S. FRIEDMAN South Bend	**Course 11** Work-Up of a Back Problem GEORGE J. GARCEAU Indianapolis	**Course 17** Diagnostic Approach to the Patient with Shoulder Pain LELAND G. BROWN Muncie
Course 6 How to Do an Efficient Neurological Examination CHARLES W. CURE Indianapolis	**Course 12** Hypnotism in General Office Practice ELLIOTT A. HILSINGER Cheviot, Ohio	**Course 18** A Simplified Approach to a Complete Examination of a Gyn Patient EDWARD P. MININGER Elkhart

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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ANNUAL CONVENTION

THE PROGRAM for the Annual Convention October 5 to 9 has been arranged on a new format.

According to recent custom the important business sessions are scheduled so as not to interfere with any of the scientific presentations. The scientific program has been concentrated mainly in four interesting sessions on Wednesday and Thursday, the two days of the week on which doctors are able to be away from the office with the least difficulty.

The Executive Committee and Council will meet well in advance of the other convention activities on Monday afternoon, October 5th.

The first meeting of the House of Delegates is set for 9 a.m. on Tuesday, the 6th, and the Reference Committees will conduct hearings at 2 o'clock that afternoon. The traditional buffet supper, smoker and stag party will be on Tuesday evening at the Murat Temple.

Problems of medical insurance will be discussed at a special symposium on Blue Shield at 4 p.m. on Tuesday.

The two big scientific days will each have a morning and afternoon session with three or four recognized authorities presenting papers on important clinical subjects, followed by a panel discussion in which the speakers of the session will participate.

The instructional courses will be conducted from 8 to 9:30 on Wednesday and Thursday.

The general meeting on Wednesday morning will be devoted to carcinoma of the breast. George Crile Jr., John Beeler, James Katterjohn and Bronson Ray are to be the essayists.

On Wednesday afternoon the subjects to be

discussed will deal with the endocrine system. J. Donald Woodruff, James T. Priestley and Bronson Ray will speak. C. Naunton Morgan of London, England, will also discuss the anatomy of the rectum and colon.

Thursday morning will be concerned with constitutional disease. Charles W. Mayo, Leonard Lovshin, N. Henry Moss, Glenn Irwin and Robert Salesse will each discuss a topic and will then join in a panel discussion, as will the essayists in each of the general meetings.

The Thursday afternoon session will cover diseases of the colon, headache and emphysema with Charles W. Mayo, Arthur DeBoer, Leonard Lovshin and John Hickam. C. Naunton Morgan will join in the panel discussion.

The sections will conduct business sessions. In addition to organizational affairs, the Sections on Public Health and Preventive Medicine, Obstetrics and Gynecology, and Surgery will hold luncheon meetings with guest speakers.

Friday, October 9th, is reserved for the final meeting of the House of Delegates, the Executive Committee and the Council. The annual golf tournament and trap-skeet shoot will conclude the convention.

COMPREHENSIVE MEDICAL INSURANCE

COMPREHENSIVE medical insurance, by definition, is that type of insurance which covers part or all of the beneficiary's medical expenses which are incurred outside the hospital.

Plans for providing such insurance may differ from each other in many details, depending on the medical items of outside-the-hospital service which are covered, and depending upon the method of providing the physician services. One of the most distinctive features of the various plans is the presence or absence of free choice of physician.

The Health Information Foundation recently reported on the results of a survey of two such plans in New York City.* The study was conducted by the National Opinion Research Center of the University of Chicago.

The two voluntary health insurance plans in New York have many points in common but differ in the manner in which physician services are provided.

Group Health Insurance (GHI) offers free choice of any physician in New York City. The patients are cared for in the doctor's office or are seen by him in their homes. GHI pays a fee for each service on the basis of a fee schedule.

Health Insurance Plan of Greater New York (HIP) provides enrollees with physicians' services in 31 medical group centers in the New York area and pays these groups on a capitation basis.

Both plans cover physicians' services in home, office or hospital, as well as laboratory, diagnostic and other services, differing only in minor details. In both plans the enrollees are covered by Blue Cross. Neither plan covers drugs and medicines outside the hospital, medical appliances or dental care.

Subscribers interviewed in the survey were drawn from three New York unions, members of which were free to join either plan under collective bargaining agreements. The two samples were comparable in terms of age, size of family, sex and other factors.

The gross costs per person for all medical care during a one year period were almost exactly the same for both plans. Likewise the proportion of enrollees in each plan whose medical expenses were at various dollar levels was the same.

Both plans covered about one-third of the subscribers' total medical expenses. This is higher than the proportion of total costs which are covered by health insurance plans which insure in-hospital services only.

The survey showed that the members of both plans had similar experiences in regard to utilization and costs of services *outside* hospitals. They differed in utilization and costs of *in-*

* Progress in Health Services, Vol. VIII, No. 6, June, 1959, Health Information Foundation.

hospital care and surgery. Their attitudes toward their plan also differed markedly.

HIP met 80% of enrollee's costs of all physicians' services, as compared to 59% for GHI. Almost all of the increased spending by GHI members arose from the fact that under the plan the beneficiaries were free to go to any physician, and in instances where the particular physician had not agreed to accept the fee schedule as full payment, the patients paid the difference directly.

GHI subscribers used more hospital care and surgery than did HIP members. GHI subscribers had 11 hospital admissions per 100 persons as contrasted to 6.3 per 100 for HIP. GHI subscribers reported 7.6 hospital procedures per 100 persons as against 4.3 procedures for HIP members.

GHI members were found to be more satisfied with their plan and with its physicians. Questions were asked concerning the doctor's interest in the patient, amount of care taken to explain what the trouble was, waiting in the office, and degree of consideration for patients by office personnel.

Ninety per cent of the GHI members were "entirely satisfied" or "fairly well" satisfied with the plan. On the other hand only 79% of the HIP subscribers were classified at this level of satisfaction.

Another marked difference between the members of the two plans was evidenced when they were asked for the chief reason why they chose their plan. 61% of the HIP enrollees gave "nothing to pay" as their chief reason. 88% of the GHI beneficiaries gave "free choice of physician" as their main reason.

One excellent feature of both plans was that they were more effective for families with higher medical expenses. Those families in the lower range of total costs had one-fourth of the expenses paid by the plan. Those families in the higher range of total costs had an average of more than 40% of all medical and dental costs covered.

The survey demonstrates that people vary in their attitudes toward insurance plans. A majority of the HIP enrollees signed up because they were anxious to pay less, and actually accomplished this objective. GHI enrollees paid more for their total medical care and accomplished what most of them wanted—"free choice of physician."

AMERICANS FOR CONSTITUTIONAL ACTION

AMERICANS for Constitutional Action is a politically bi-partisan voluntary organization formed for the purpose of preserving and strengthening our system of constitutional government as it was originally conceived.

It seeks to coordinate the actions of individual citizens and all similar organizations who are dedicated to the preservation of the American system of government and constitutional safeguards of freedom.

The Constitution of the United States was written specifically to prevent the development of an all-powerful central government. The words of George Washington are used by ACA to highlight the problem. "Government is not reason, it is not eloquence—it is force! Like fire, it is a faithful servant, but a fearful master."

The expanding powers of the Federal Government and its gradual and expanding entry into competitive business has inevitably whittled away state sovereignty and personal liberties.

The objective of ACA is to stimulate by all proper means the endeavors of all citizens to maintain their freedoms.

Dr. Walter B. Martin, past president of the AMA, Gen. Robert E. Wood, former chairman of the board, Sears, Roebuck and Co., and Charles Edison, former Governor of New Jersey are some of the members of the Board of Trustees. Admiral Ben Moreel, former chairman, Jones and Laughlin Steel Corporation, is chairman.

Information may be obtained by writing Robert B. Snowden, Cotton Exchange Bldg., Memphis 3, Tenn.

POLIO IMMUNIZATION

A FOURTH DOSE of polio vaccine given at least one year after the original three-dose immunization has been found to raise the immunity level to new and significant levels. The fourth dose has been found to be effective even several years after the third dose.

Of course, no one can have the fourth dose until he has had the first three. So far it has been so difficult to convince the public that the first three doses were good for them, that the question of recommending and publicizing the fourth dose has been a trifle academic.

The national advisory committee recently did recommend the fourth dose, and stated that while the opinion had been valid for some time, it had not been published because of the widespread lack of enthusiasm for the basic three-dose immunization.

However, the announcement is well made. Those who have been prudent enough to avail themselves and their children of the immunization should benefit from the information that the fourth dose is effective. Those who have avoided the advantages of the polio vaccine probably are not entitled to it anyway, first three doses or fourth dose.

Recommendations of the advisory committee were recently published by the Indiana State Board of Health as follows:

1. Completion of the basic series of three injections of Salk type polio vaccine is recommended for all persons under 40 years of age who have not yet been vaccinated or who have received fewer than three doses of vaccine. Vaccination of persons age 40 and over can also be beneficial; however, it is less urgent since polio occurs less frequently in older individuals. *The recommended basic schedule for all persons,* except young infants, is three doses of 1 cc. each as follows:

An initial injection
A second injection 4 to 6 weeks after the first
A third injection 7 to 12 months after the second dose

2. *A basic schedule of four injections is recommended for infants less than six months of age* consisting of a series of three injections of 1 cc. each of polio vaccine, spaced one month apart beginning before six months of age and as early as two months of age, followed by a fourth injection of 1 cc. seven to 12 months after the third dose. Polio vaccine for infants and young children may be given as separate injections or in quadruple vaccines which combine polio vaccine with diphtheria, pertussis and tetanus vaccine. The schedule recommended by the manufacturer of such quadruple vaccines can be followed when this product is used.

Infants under six months of age do not always develop an adequate antibody response from two initial injections so that the third primary injection appears desirable. Vaccination early in infancy is recommended. However, complete information on optimum dosage schedules will require further experience with the separate and quadruple vaccines.

3. It is recommended that a booster dose of 1 cc. of poliomyelitis vaccine be given to persons under 40 years of age who have completed the basic series of three doses at least one year previously and especially if several years have elapsed since the completion of the basic series of injections. Such booster dose is expected to increase antibody titers in persons whom the antibody levels have fallen, or in whom the initial antibody response was weak, thereby providing possible added protection against poliomyelitis.

4. A booster dose of 1 cc. of polio vaccine for vaccinated persons is especially indicated when individuals may be entering situations or traveling into areas where the incidence of polio is high:

(a) When local epidemics of polio are beginning, an emergency booster dose may be given as early as one month following the previous dose of vaccine regardless of the number of previous doses.
(b) When preschool children are to enter school.
(c) Pregnant women prior to the polio season, for the vaccine not only provides added protection against polio for the mother but also provides a passive immunity to the unborn baby.
(d) Persons traveling into areas where the sanitation may be poor or polio is known to be present.

Medical Panorama—

STATE MEDICINE BEARS FRUIT IN ENGLAND

A. W. CAVINS, M.D.

Terre Haute

Not always is the most significant news on the front page, as witness the little "squib" reprinted below. This comes from "Foreign Letters" in the *J. A. M. A.* for May 16, 1959.

Why is it of real interest? Read it yourself, and then remember the early rosy promises of the British health service that new hospitals and medical centers would be built, etc., etc., to give the people wonderful care under State medicine. It now appears that their scheme is working along the usual lines of a bureaucracy and with the usual results. Many reports have come out of England attesting the lack of new facilities and the inadequacy of old, but here is a concrete example of the other side of the picture: decline in both quality and quantity of personnel. The decline in number of practicing midwives is freely admitted in this short piece. The deficit in quality is found between the lines. The situation is sad, but logical.

Maternity Hospital to Close.—*Wiltshire mothers may soon be having their babies at a Royal Air Force station, because the Devizes Maternity Hospital is to close. Another, at Chippenham, is to be cut to one-half its bed capacity. An acute shortage of qualified midwives is the reason. Other small maternity units in different parts of the country have recently had to close or restrict admissions. Midwifery must be made more attractive if sufficient maternity beds are to become available. At present only about 20% of the nurses who qualify as midwives practice as such. Some hospital authorities have advocated a pay raise in the smaller country units, where the responsibility of the individual midwife may in any case be heavier as she has to work more on her own. Ministry of Health medical and nursing teams will soon be visiting some of the areas hardest hit. Their task will be to discover the reasons for the shortage of midwives, to advise on remedial action, and to make recommendations on which future policy can be based. Nursing staff leaders have told Ministry of Health and hospital authorities representatives that their proposals for pay increases for 17,000 midwives and 50,000 student nurses were inadequate. More should also be done to improve the status of the midwife.*

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Where Do We Stand?

A. L. MARSHALL, JR., M.D.

AS A RESULT of legislation passed by the 1957 session of the Indiana General Assembly, Hoosiers for the second consecutive year have available a realistic and clear-cut picture of the immunization status of all children entering school for the first time. Under the law, parents are required to report to school officials whether or not their child (or children) has been immunized against smallpox, tetanus, pertussis (whooping cough), diphtheria and poliomyelitis. This applies only to those children entering school for the first time. School officials, in turn, are required to submit this information to state health officials for compilation.

The first report, covering the year 1957, was carried in the August (1958) issue of THE MONTHLY BULLETIN, and the maps reveal the status by county for 1958. A comparison of the two years indicates that a slight improvement has occurred, but the status for the state as a whole is still far from being satisfactory, if we hope to prevent epidemics.

Diphtheria, pertussis and poliomyelitis are still to be reckoned with as killers and cripplers of children. Tetanus continues taking its toll, and although this disease need not be feared from the standpoint of epidemics, it is nonetheless a killer. An individual ill with tetanus has only a fifty-fifty chance of survival, in spite of the miracle drugs.

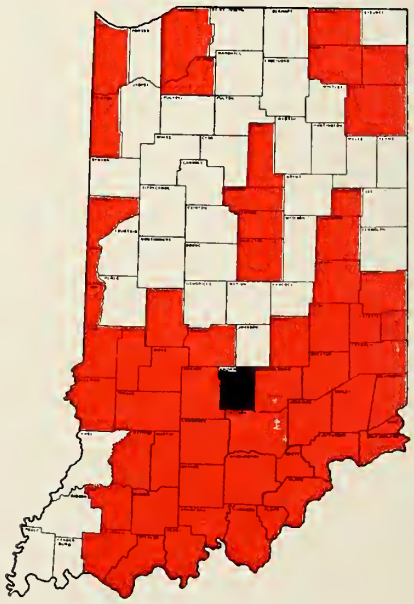
These same diseases—diphtheria, tetanus, pertussis and poliomyelitis—are extremely hazardous to the infant and the young child. People living in the counties shaded in blue, were indeed fortunate not to have had an epidemic in 1958. It could happen in 1959. (These counties have less than the necessary 70% of the first grade children immunized for the diseases mentioned.)

Smallpox is hazardous to individuals of all ages, and with the immunization level as it is for this disease among first grade children, it can be assumed that it is approximately the same for other age groups. If this is true, the state is potentially a "powder keg" which could explode into a statewide epidemic if a carrier were to pass through and ignite it.

In reviewing the information contained on the maps, it is clear that Indiana—so far as the immunization level is concerned—stands on the brink of a precipice. If we are to prevent outbreaks or epidemics of the communicable diseases, it is imperative that individuals contact the family physician about immunization for themselves and for their children.

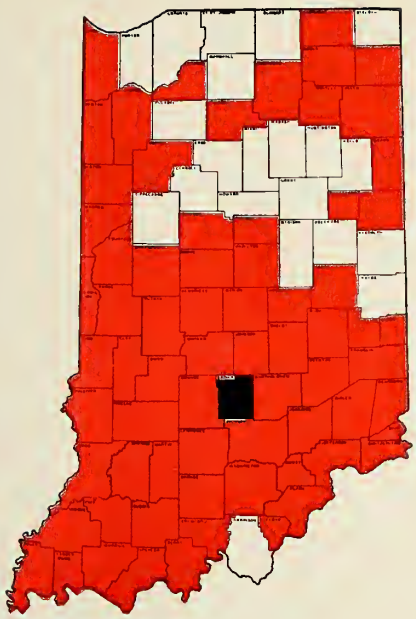
Keep a family record of the shots each member has received. Remember—initial protection against these diseases may not seem to be too much of a task, but certain immunization procedures require boosters, "from the cradle to the grave." Children, particularly, should be immunized well in advance of school age, since these diseases take their greatest toll among infants and pre-school children. ◄

POLIOMYELITIS

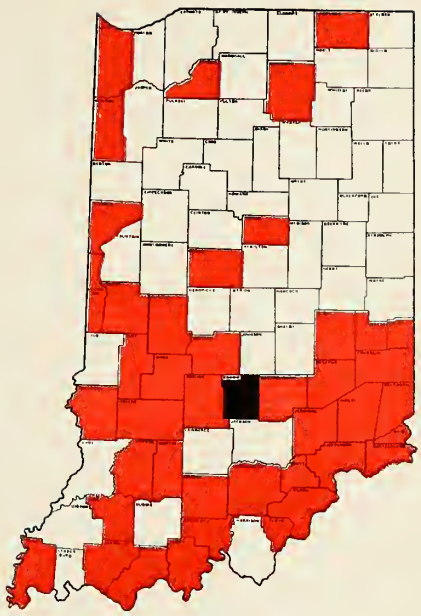


Dr. Marshall is director of the Division of Communicable Disease Control, Indiana State Board of Health. Story and maps from The Monthly Bulletin, June, 1959, published by the Indiana State Board of Health.

SMALLPOX

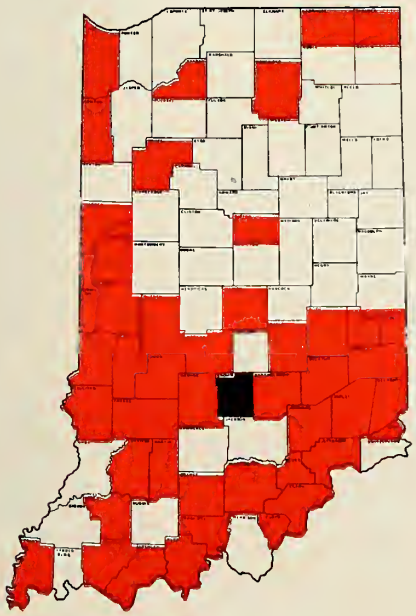


DIPHTHERIA

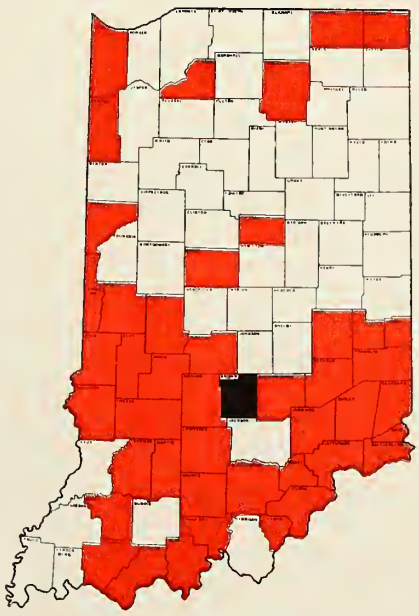


The white areas of the maps represent those counties which had 70 per cent or more of the children entering schools for the first time in September, 1958, reported as having been immunized for the specific disease mentioned. The areas shaded in blue represent the counties which reported that less than 70 per cent of the youngsters were immunized in the various disease categories. The area shaded in black represents the county not reporting.

WHOOPING COUGH



TETANUS



"What Relative Value Studies Mean To the General Practitioner"

LESTER D. BIBLER, M.D.

Indianapolis

IN ORDER to answer this question, it is necessary to review the origin of this study and why such studies should be undertaken.

The Medical Practice Committee of the AMA was created by the action of the House of Delegates at the Clinical Session in Boston in December of 1955.

Nationwide interest in this subject was stimulated by the action of the American Medical Association House of Delegates during the 1958 Clinical Session when the House instructed the Committee on Medical Practice to ". . . inform each constituent medical association, through regional or other meetings and through proper utilization of *J.A.M.A.,* the *A.M.A. News,* and other suitable news media, of the purpose, scope, and objectives of such study, the steps to be followed in conducting studies, the problems which may be encountered, and the manner in which the results can be applied."

Actually, however, the concept of the relative value study originated with physicians in California. Francis J. Cox, M.D., was one of the pioneers. Several years ago the California Medical Association conducted such a study and made its results available to the medical profession. The successful application of relative values in providing physicians with an index of values, through which they can judge the value of their services and also help patients understand the basis of their charges, is reflected in the fact that a number of constituent medical associations have already adopted such studies in their states. To date, in addition to California, at least a dozen state associations have made such studies, and a number of other associations are contemplating studies.

It is the opinion of the National Committee, that it is impossible to create any dollar schedule of fees for payment of medical or surgical services that would be satisfactory to all parties concerned. This is true of a large community such as Indianapolis or a small one such as Birdseye.

It is evident that the principle of prepaid medical insurance is an absolute necessity for the continuation of the private practice of medicine as we know it today. If it were not for this principle of medical insurance, state and Federal controls would probably be in effect and the family physician would be a lost entity of Medical Practice.

If one will sit down and carefully review the history of medical care and the application of the insurance principle to the cost of medical care that has developed in the nation during the past 10 years, one must conclude that whether physicians approve or disapprove, in principle, the fact remains that we are going to exist and work with a relative value from this point on. If you do not believe this, talk with your neighbor, your banker, your counselor, your minister and even your patient and hear what he has to say.

There are certain fundamental ideas which one must develop with this concept of thinking. The fundamental objective of the family physician or of a group of physicians, is to promote the science and art of medicine, and the betterment of public health. In the present day and age the pursuit of these two objectives will require a complete understanding of the social and economic conditions relating to health and medical care of the public.

The people who receive help in pre-payment of cost of medical care through application of the insurance principle encompass many groups, many types and many categories. It has been evident to all of us who practice the art and science of medicine and deal with the public that some continuing personal financial responsibility on the part of the individual patient in the assumption of these costs has been most healthy and proper.

At the same time we should recognize that the service principle of insurance must apply to a certain segment of the population who are in the marginal economic income group and will remain there indefinitely. These are the people we have always taken care of to the best of our ability. But let us face facts; they also are the group where neglect and error and failure to seek proper medical advice in the past have led to deterioration of public health.

It is impossible to consider only the welfare of patients with no thought of those people who provide that care, the physicians. In this concept of the welfare of the patient as a whole, which some entertain, one must constantly recall that the doctor himself in order to survive must remain independent and continue to use his intelligence correctly. He must act as an individual. Public opinion and public action cannot deny him any right, desire or choice of action in serving the public so far as medical care is concerned. To do so removes the very reason of his being.

One of the greatest stumbling blocks in discussing the costs of medical care with the public as a whole has been the fact that the costs of medical care have risen by geometric proportions during the past 10 years. This has not happened by reason of charges made by individual physicians to the public as a whole, but includes the costs of hospitalization, drugs, investigative procedures, the development of many ancillary services other than those furnished by physicians alone. It is recommended that an immediate educational program to separate and identify in the public mind the cost of physician services from these other ancillary costs in the field of medical care should be instituted.

Finally it should be stated that in the present economy of the United States there are certain groups covered by state or Federal law wherein medical care is furnished through plans de-

Continued on page 1344



he deserves

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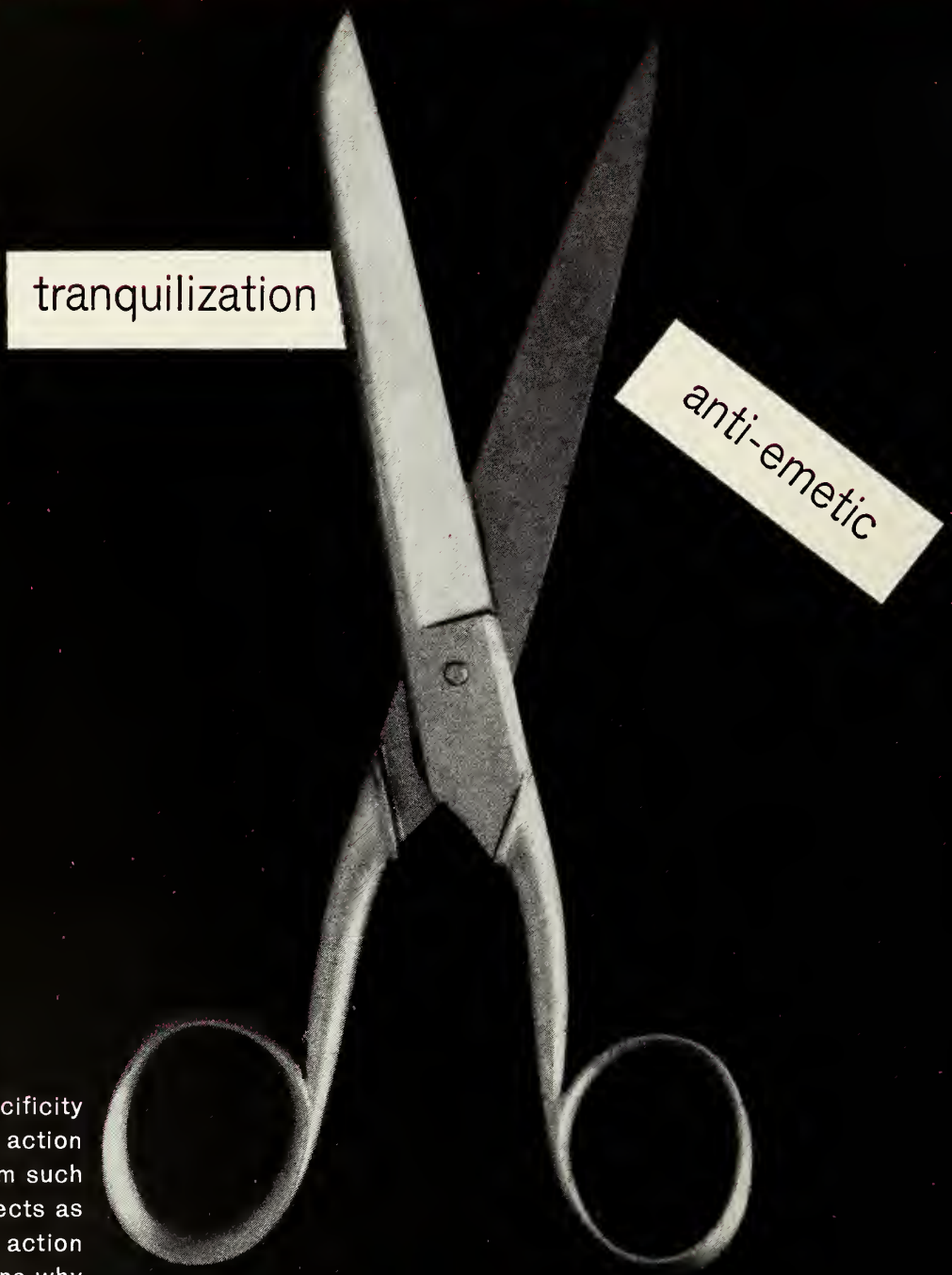
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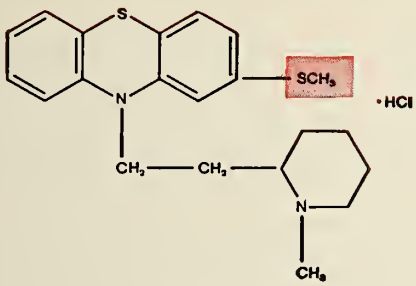
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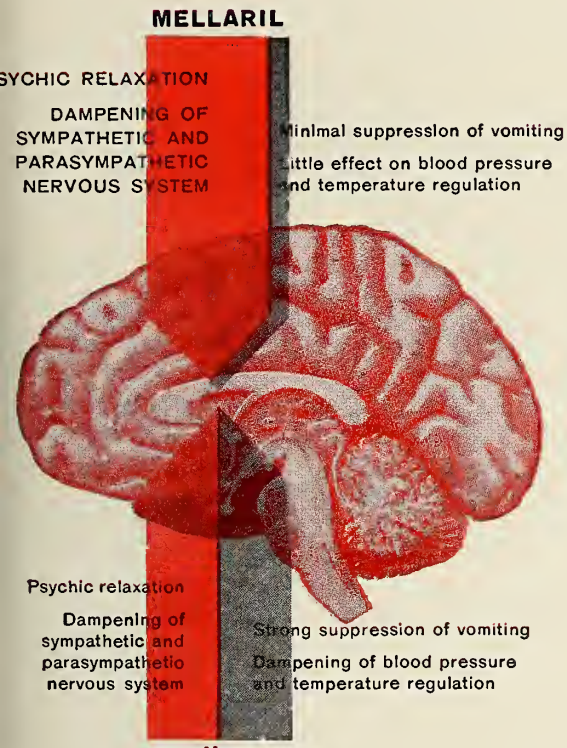
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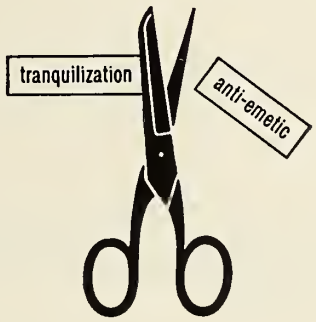
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[1] Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959

SANDOZ

Relative Value Studies

Continued from page 1341

veloped by reason for need. Examples might be the old age assistance program or the medicare program. You must remember that the patients involved in these pools of the population must participate by reason of legislative action if they are to receive the benefits provided by law. You must remember that in the law there is no obligation binding any individual physician to participate. If on the other hand a physician chooses to participate in programs of this type, his individual rights and the rights of this group, perhaps a minority group of physicians, must be protected. So also the rights of the individual patients to obtain the best of medical care must be preserved.

If these relative values are not presented by us physicians, then someone else will prepare a schedule that will not be satisfactory to us. *That is what happened in England.*

In the development of the relative value study as a whole it has been constantly stressed that medical services as a whole should be divorced totally and completely from comparison with the services of surgery, from the services of radiology, from the services of laboratory and pathology. These four separate categories, these broad segments of medical care, should be kept separated one from each other. This segregation becomes of increasing importance when the relative value theory is applied to the lower income groups or to the marginal economic income groups.

The theory of creating a relative value rather than a dollar value is one which has caused a certain amount of misunderstanding generally to physicians. It is perfectly self-evident that a very wide divergence of dollar values in any schedule of fees for medical services must exist. There is a variation in cost of operation of a physician's office between urban communities and rural communities, between one area of the United States and the other. There is a geographical variation in fees and this is a recognized fact. How then did we develop the theory of a relative value? If a routine office visit was worth a value of $5 in one area it should by comparison and investigation be simple to determine the dollar value that should be assigned for a complete history and physical examination that would require the expenditure of an hour or more of time studying and evaluating a serious and complicated medical problem. This second service is obviously worth more in dollars than the first. To give the routine office visit a relative value of one unit then the second service (the complete history and physical examination) should and could be determined worth a value in excess of one unit.

Following are a list of questions and answers which may be of help in providing more information:

1. What are "relative values?" Relative values are numerical unit designations which express the relationship value one professional service bears to another. These values are, in effect, reflections of the time and effort expended to perform these services, as well as the experience and competence of physicians who provide these services.

2. Are relative values "fee schedules?" Definitely not! This confusion arises perhaps because relative values are derived from the customary charges physicians in a given community or area may make for professional services. But the values themselves *are not* fees. Relative values indicate relationships only.

3. Is it not true, however, that relative values can be used to establish fee schedules? Yes, it is; but only to the extent that they are guides or standards which have little or no statistical validity. But this is only one of the uses to which relative values, as secured through a Relative Value Study, can be applied. It has other applications which are of importance to the patient and to an insuring agency, in addition to the physician.

4. Do relative values set any physician's fees? They do not. They eliminate inequities which may exist in fee schedules. They help to interpret fees which physicians charge. They help the physician to interpret his fees. And they help the patient and the public better to understand the basis on which the physician's charges are made.

5. What are some practical applications of relative values? Relative values provide effective tools for use by individual physicians, county and state medical associations, Blue Shield, Blue Cross, private insurance companies, management or union-administered health, welfare

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Relative Value Studies

Continued

plans, and Federal and state governments in the field of prepaid medical care insurance. They play an important part in serving as guides in determining adequacy of coverage for purchasers of insurance. The absence of such guides has frequently resulted in confusion and economic injustice for the physicians and for the insured. Criticism of the medical profession often results from disappointment with health insurance and inevitably is reflected in demands for socialized medicine and other radical departures from voluntary health insurance concepts.

6. Once a Relative Value Study has been made and put into effect by a medical association, is it static and unchangeable? No. Periodic re-surveys at perhaps 5-year intervals should be made in order to keep abreast of changes in medicine. As procedures are introduced, and as others become obsolete, as new methods of doing the same procedures increase or decrease the amount of time or skill required, relative values will change.

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7. What are the components of a Relative Value Study? There are three basic parts to a relative value study, only one of which has to do with fees *per se*. First is the nomenclature and code number listing of professional procedures and services. Second, is the assignment of the relative values in terms of units. Third, is the application of a coefficient to the relative values to transform them into a schedule of fees. It should be emphasized, however, that this coefficient does not appear in any published Relative Value Study.

8. Why not develop two relative value studies, one for general practitioners and one for specialists? Precisely for the reason that relative values *per se* have nothing to do with recommending or setting anyone's fees. The values are based, among other factors, upon time, effort, competence and experience. The survey replies will contain what is believed to be sufficiently valid information from physicians in the various specialties including general practice to develop a single set of relative values for each segment of the study. Moreover, and most important, the replies to each procedure listed in the survey schedule will come only from physicians who are actually performing the specific procedure listed. A dual list is therefore considered unnecessary.

I am fully aware that this is not an easy task even within a state. Many variations must be considered and understood, including the differences between charges by general physicians and specialists for similar services and the differences in charges that result from long experience, from special training and even the desire to limit the volume of practice. However, it is *believed* that, with proper attention and understanding, these and other variations from a so-called normal can be handled fairly under a relative value study. ◄

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Several Problems Besetting Private Practice Need Clear-Eyed Appraisal, Prompt Action

*PATRICK J. V. CORCORAN**

Evansville

WE ARE in a new phase of our professional relationships and the practice of medicine is being subjected to increasing pressures. We can close our eyes to these and be passively changed by yielding reluctantly here and there to whatever extent is necessary. Such rear guard, defensive tactics will undoubtedly result in a whittling-away of our present status, dictated largely by the direct, clear-cut plans of those who want to change us.

The alternative, is for us, *now,* to formulate a positive program based on a clear-eyed appraisal of what we stand for and what we can reasonably expect to achieve; and, then promptly and decisively proceed to obtain it.

There are several problems besetting private practice. The first is that of the pressures of time; namely the 24-hour-a-day, 7-day-a-week responsibility to patients, who, in turn, no longer have that personal feeling for the doctor which used to prevail. The old-time doctor was figuratively a member of the family and usually given consideration as such; the demands upon him were fewer, perhaps in part because of the lack of telephone, automobile and other facilities for easy communication day and night. Moreover, the health needs of people were much less compared to the demands they presently make; patients now require treatment of almost every ailment, minor and major, with a burgeoning need for service. This has resulted in a functional shortage of doctors, which is highlighted by the beginning practitioner, who becomes so busy so soon. This presents the social paradox that our profession faces a long, if not lengthening, work week, whereas there are sustained efforts to shorten the work week of almost everyone else. In today's high-pressure tempo, the erosion of the doctor's own family life and of his personal satisfaction is woeful. This physiological stress probably exacts an incalculable attrition of his own life expectancy.

A second problem is the expansion of medical knowledge to the point that a busy doctor has a problem in remaining abreast of all medical fields; frequently this is difficult even in a limited area. In my own specialty, it is impractical to remain expert in all of its divisions. I have been impressed by the number of our colleagues in this and in neighboring communities, who have left, or are leaving, or would like to leave, in order to take further training. The impetus to do so probably comes from the doctor's own professional soul or from his wife and family, based on either or both of these two problems just mentioned.

Correlated with this is the banding together in partnerships or clinic groups or other technics of sharing the burden so as to cope with these stresses.

Third: The art of medicine is changing toward an impersonalized scientific care: segmented, fragmented and compartmentalized. This is abetted by the lay press which devotes an increasing emphasis to medical and health ininformation. The recent controversy over emergency medical care in this community merely confirms that many of our patients are less concerned with a personal relationship to a doctor than they are with prompt, technical skill by *some* professional functionary. This trend is increasing. Patients shop around. Many seem to have less and less loyalty to a particular doctor; specialization deters it; in the eyes of the patient, or consumer, health care is becoming

* Talk given by Dr. Corcoran as retiring president of Vanderburgh County Medical Society at the society's annual meeting May 12, 1959.

more and more a utility than a professional service.

A fourth problem, which is getting worse, and due in part to the depersonalization of doctor-patient relationship, is the placing of a dollar value on unsatisfactory results of treatment. This blossoms into malpractice lawsuits. The threat of such suits hangs ever-present like a storm cloud over the shoulder of each practitioner, inhibiting and even intimidating progressiveness in practice.

The fifth item involves the snowballing costs of hospital care and other paramedical expenses, which seem to have no end in sight. The practicing physician has less and less control of total patient care but must accept much of the criticism. Scrutinize the hospital and medical bills of your patients and imagine how you would feel to be confronted with such charges. Consider how long we can expect the public to put up with this steadily worsening situation. Efforts to curtail the frequency and length of hospitalization might be very seriously considered.

A sixth question is the intra-professional problem of inequities of fees among our various segments. This relates particularly to any revisions of fee schedules and indemnity allowances by insurance carriers.

I would call attention to the American Medical Association Committee on Medical Practices, whose chairman is Dr. Lester D. Bibler of Indianapolis, which has recommended that relative value studies be seriously undertaken.

Pressures to change and modify health care presently come from three sources. In the order of their importance they are: First, the labor unions. The unions are merely the most effectively organized of consumer groups; they have a clearly thought-out program with articulate and vigorous leadership. They will persist and probably step up their activities in providing what they conceive to be better care for their people.

The second, and probably next most important pressure, will come from the government, and I mean the Federal Government. Political leaders are responsive to the opinions of the most numerous part of the electorate. After the next national election I predict that rising hospital bills, increasing health insurance premiums and the

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Several Problems

Continued

unwieldy mechanics of the so-called "market economy" of the fee-for-service technic of private medical care will result in government-sponsored proposals to change or enlarge health services. These will be attempts to satisfy the demands of the voters.

The third source of pressure is a group, composed among others of health insurance carriers, large employers, consumer alliances, and, to an extent, hospitals. These are the so-called third parties—they are paying the bills or are otherwise concerned with the economics of health care. Their primary concern is to get the best buy for their money. They may not be too friendly or understanding of our profession if they encounter a vague and ill-defined estimate of the costs of medical care. Until we can give them a firm and predictable cost basis for a specific period of time, they cannot underwrite these programs which are needed to satisfy the consuming public.

We are still in a position to deal from strength. We know what good health care is. We can provide it—and should! Our strength must be expressed as a group, and we should answer other groups in terms they can understand.

We have a good case, but we should state it unequivocally. We must be very selective in making our decisions. Effectiveness will depend upon group action. We are unlike a union in that we already have what most other groups are seeking; our efforts must be directed towards retaining or strengthening the good features of our profession. Neither are we businessmen; the profit incentive is very definitely secondary for the preponderant majority of us. We differ from other groups in many vital respects. We must come promptly and unemotionally to evaluate these.

Let us then, without delay, evolve a realistic program agreeable to the majority of our profession. We can never satisfy all and we cannot afford to be held back by the vocal few. The majority is not always right, but this is, nonetheless, the only practical way to decide it. Whatever program is adopted should then be vigorously pursued with discipline and dispatch. ◄



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The Position of Insurance In the Doctor-Patient Relationship

*ALBERT V. WHITEHALL**

YOUR SECRETARY-TREASURER, in his letter confirming your gracious invitation to appear before you this morning, said "We would like to hear from you constructive criticism of the internist and would like to know your opinion of what the public and the insurance companies expect of us." This is an inspiring challenge, for it recognizes that in the framework of our voluntary system of private enterprise, private medicine and private insurance must work together in public service. We must work together with good, mutual understanding. We must remember that the public is our judge.

Through the Health Insurance Council, the insurance business reaches out to its partners in public service, the providers of health care, in the search for a better understanding of our respective roles and relationships. My observations here are a part of that search. I hope you will find that I have addressed myself to some of your specific problems, although I have chosen to express myself rather generally.

The practice of medicine, as we see it in America today, is characterized by two articles of faith:

1. Freedom of choice of doctor and hospital.
2. The doctor-patient relationship that we believe to be essential to good medical care.

Freedom of choice, of course, is at the very heart of our competitive system of private enterprise. We know that a monopoly, in any field, becomes dictatorial, vulnerable to political pressures and unresponsive to the needs of individuals. A long time ago, an old lawyer told me: "You don't bargain with monopoly; you take what you get."

Competition, on the other hand, means that you do have a choice. Competitors struggle for public favor by offering the public something better. Your product, or your service, may be the best today, but if tomorrow your competitor turns up something better, your customers or your patients have the privilege of choosing that. That keeps business on its toes; that's how we make progress in this country. The public is the beneficiary of competition. Clean, vigorous competition is one of our most effective incentives to quality and continued improvement in our services.

It's interesting to note here that freedom of choice is probably more significant in the second choice than the first. The presence of a competitor—the privilege of changing our choice at any time—is a precious freedom that we'd lose under a government system. It is a better incentive to quality than most regulation.

It seems to me that the emphasis we place on the doctor-patient relationship is a natural result of freedom of choice. I asked my wife, when I wrote this, what she thought the "doctor-patient relationship" means. "Well," she said, "you must have confidence in your doctor; if you don't, you'd better get another doctor."

I know a woman, a soldier's wife, who had three children born in military hospitals. She had pre-natal care in every instance, but she never saw the doctors who delivered her babies until the day of their birth. Her opinion of military medicine is very poor. That personal confidence, the doctor-patient relationship, is very hard to establish when the patient has no choice.

Continued

*Director of Health Insurance, Life Insurance Association of America and Vice Chairman, Health Insurance Council. Presented at the Annual Meeting of the Florida Society of Internal Medicine, Miami Beach, May 3, 1959.

Position of Insurance

Continued

We know that the mental attitude of a patient is often an important factor in physical recovery. The successful doctor knows that the mental attitude of the patient is very important to his own success. The doctor's reputation and prestige, indeed, his economic survival, depend upon the confidence his patients have in him.

So the doctor takes special care to assure the confidence of the patient. Some of this, of course, is just ego-building—assuring the patient of his own personal importance as an encouragement to recovery. Much of it is precautionary—to avoid the patient exercising his sacred right of free choice—in the direction of another doctor! All of it adds up to the doctor-patient relationship—*"the feeling I have when I'm glad I chose to place myself in good hands."*

It seems to me that the doctor's effort to establish and strengthen the doctor-patient relationship—the patient's confidence—may be in three areas:

First, he learns all he can about the patient's needs and problems.

Second, he carefully explains the care he provides. The doctor sells the idea of good care and enlists the cooperation of the patient in his own care and recovery.

Third, he carefully explains the cost. The doctor who says to me, "Don't worry now, I'll tell you later," doesn't ease my mind at all. I want to know now and be sure where I stand. Worry is closely related to uncertainty.

Now—in giving a layman's viewpoint of the doctor-patient relationship—I have led up to my first major point:

The relationship of the individual doctor and patient has a parallel at the collective level: the relationship of the medical profession to the public as a whole. Indeed, it is not unfair to say that the future of medical practice in this country depends upon what American medicine does to maintain public confidence.

You see, you in your practice, never take the attitude of your patient for granted. Your patients are always judging you. The public is judging the medical profession, too—always. Today is not more critical than yesterday. Our voluntary system puts pressure upon us all to do our best and to demonstrate that we are doing a good job.

How does the medical profession maintain and strengthen the doctor-patient relationship at the collective level? Very much as the individual doctor does:

First, medicine must learn all it can about the public's needs and desires and attitudes. *You can't ignore public opinion.*

Second, medicine must explain the care it gives. Our magazines are telling medicine's story to a wide and keenly interested audience. The marvels of today's medical care are pretty well accepted by the public.

Third, medicine must explain its costs. The medical profession must take the public into its confidence if it wishes to continue to enjoy public confidence. The mystery has gone from the therapeutic side of medical care, and public confidence is strong on that point. But the mystery remains on medical costs and most of the criticism we hear of medicine today is on the economic side.

So this is my second main point: *The doctor-patient relationship at the collective level, between the medical profession and the public as a whole, can be strengthened by a better public understanding of medical costs and standards of charging.*

And, now I can get to the title of this talk—the position of insurance in the doctor-patient relationship. I will state it this way as my third major point:

Payment of the doctor for his services is an essential part of the doctor-patient relationship. The medical profession must make its contract directly with the public; it should not try to bargain with insurance on fee levels.

I have observed that some specialty groups, such as your own, have sought to have insurance companies change their policies so as to give that specialty its deserved recognition. There is a feeling, partially true, that you could make a contract with us that would be influential, at least with the patient. There are reasons why you should not do this, and why we cannot bargain with you.

In any contract between medicine and insurance, medicine would place itself, to that degree, under control of a third party. Do you really want this? Aren't you better off to take the

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Position of Insurance

Continued

longer range, though more difficult approach of selling your cause to the public? I assure you, the insurance business is keenly sensitive to consumer demand. We have many varieties of coverages and our agents are eager to sell every bit of protection your patients will buy. You tell them what to expect in the way of professional fee levels and insurance can tailor its contracts to the joint needs of doctor and patient.

Admittedly, patients and doctors sometimes look to the insurance fee schedule as a guide to what a proper professional fee should be. The insurance business deplores this. Not all insurance schedules are intended to be adequate; we do not presume to set your fees. This is your prerogative. But, you must exercise it in such a way that the public clearly understands you and gains confidence in you.

Even if it were to medicine's advantage to bargain its fee levels with insurance—and I have just said it is not—there are reasons why insurance cannot bargain on this point.

You see, in the first place, the insurance business is simply the custodian of the public's money. We have no right to give it away or even to bargain it away. We are not a part of your bargain with the public. It is our function to underwrite that bargain and to make it possible. The money we pay in health insurance benefits is that of our policy-holders, entrusted to us for certain, definite and limited purposes.

A second factor is that it should not be the function of the insurance mechanism to control the economies of medicine. But we point out to you that the public will not permit costs to be uncontrolled. It is part of medicine's bargain with the public that it exercise a prudent control over costs; and it is essential to the maintenance of public confidence that such control be demonstrated in a satisfactory manner.

It is probable that insurance has intensified this problem of self-control. Insurance helps the patient pay his doctor bill. This has meant fewer bad debts for doctors, fewer charity cases. But this fine state of affairs can also be a trap. For the patient who would have resisted paying your fee from his own pocket is now eager to see your bill paid—by his insurance. Individually the patient will seek to induce you, perhaps unconsciously, to do things that will increase the cost of the medical or hospital care. Collectively, these are the same citizens who will turn upon you, and scream that all doctors are opportunistic, undisciplined and greedy—and that they have a case to prove it!

The fact is that doctors have done much more about controlling the economics of health care than the public realizes, and more than even doctors sometimes realize. The insurance business believes that the control of medical costs must be undertaken by the medical profession itself, and explained to the public as part of the collective doctor-patient relationship I have referred to. We all agree that self-control is the best control.

I must make it clear that I am not referring to controls through grievance committees. A grievance committee can only reach the infrequent gross overcharges, and although one flagrant case can multiply a thousand times in the gossip that goes around, these are not the real causes of inflation in medical costs.

The really effective control that I have been thinking of here is for the medical profession to take the public into its confidence in establishing fairly exact standards of professional charges and fees. I submit to you that this is also one of the most effective measures for maintaining and strengthening public confidence in the medical profession. And I repeat—doctors must not look to the insurance business to establish those standards; this is the doctor's job and a part of the collective doctor-patient relationship. Insurance should not come between the profession and the public.

As a matter of fact, the insurance business is somewhat nervous over even discussing the idea that doctors should permit their standards of charging to be a matter of public knowledge. We're afraid you doctors will think the insurance companies are trying to force the profession into a rigid pattern for our own selfish interests. We do have this selfish interest; if you doctors lose your freedom, we lose our accident and health business; and the public loses a system that has the most effective incentives to quality and good service.

The idea of permitting the public to know how professional fees are determined is not as strange to doctors as it is to insurance companies.

Five years ago, the medical society in San

Joaquin County, California, adopted the idea of a fee schedule based on the average income of the community rather than the income of each patient. The doctors there are so pleased that this year several other counties have set up similar foundations in which the community-wide fee level is one of the basic concepts.

Even in the Bronx, in New York City, *Medical Economics* reports, doctors have found it desirable to hang a plaque in their waiting rooms announcing the price of office visits and home calls.

I'm sure you can think of many other instances where doctors have avoided the public uncertainty over fees by a frank disclosure. This is not a new concept, although there are differences of opinion as to its desirability.

Is the idea of an orderly approach to professional fees such a shocking idea? Not to the courts of law, where the concept of a "reasonable and customary fee" is often used. Not to the California Medical Association which pioneered several years ago in a scientific study of the relative values of the more common procedures. Nor to the American Medical Association, whose House of Delegates, last December, recommended that state medical associations conduct similar studies in their own areas, using the California format for uniformity.

Most doctors, I am certain, try to have their charges bear a reasonable relationship to the accepted standards of the community. I saw this demonstrated in a county medical society meeting in a semi-rural community. A local employer had just bought a major medical expense insurance program for his employees. He pleaded with the doctors not to increase their fees simply because of the existence of insurance and the absence of a fee schedule. One old doctor burst forth: "We all know what the going rates are in this area. What's all the shooting about?"

This illustrates my fourth and final major point, I think. The fact is that while the doctors all knew the going rates in the community, the public didn't. And so—quite naturally—the public was suspicious. It is my opinion that until doctors establish reasonably clear levels of charges so that the public may understand, every doctor and every fee will be subject to the suspicion that inevitably accompanies uncertainty.

So my fourth and final point is that health insurance, like most good things, is a mixed



they deserve

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blessing. It has lowered the financial barrier between doctor and patient, and thus brought more doctors and more patients together. *But there is grave danger that an over-dependence upon health insurance may squeeze out an essential element of the doctor-patient relationship: the awareness that, even with health insurance, it is the patient who pays the doctor.*

If the patient or the doctor, or both of them, forget this fact, then insurance has interfered seriously with one of the most important elements of our voluntary system and one of the strongest incentives to quality. You—the doctors—must not let that happen. The satisfactory doctor-patient relationship is your best guarantee of continued freedom from external regulations and restrictive controls. You must take affirmative steps to be sure that the patient deals with you and that you do not let his insurance come between you. Insurance stands behind you both in the transaction—not between you. And the medical profession must maintain public confidence by making its deal with the public.

In summary, then, here are the points I have suggested for your consideration:

First, the relationship of the individual doctor and patient has a parallel at the collective level: the relationship of the medical profession to the public as a whole.

Second, the doctor-patient relationship at the collective level, between the medical profession and the public as a whole, can be strengthened by a better public understanding of medical costs and standards of charging.

Third, payment of the doctor for his services is an essential part of the doctor-patient relationship. The medical profession must make its contract directly with the public; it should not try to bargain with insurance on fee levels.

Fourth, there is grave danger that an over-dependence upon health insurance may squeeze out an essential element of the doctor-patient relationship; the awareness that even with health insurance it is the patient who pays the doctor.

My plea is that, for the preservation of our voluntary system, American medicine give primary attention to strengthening public confidence in medical costs and standards of charging through more adequate public information. The public today has great confidence in the quality of medical care. There is equal faith in the ability of voluntary health insurance to finance it. But it would be a serious mistake to take these for granted.

Voluntary health insurance has been the principal bulwark of American medicine against the encroachment of government and monopolistic regulation. We are proud to be your allies in preserving the voluntary system of private enterprise because we believe our way of life produces pressures upon all of us to perform more efficiently in our service to the public.

But health insurance is simply a useful tool. Like any complex instrument, it must be understood, and it must be used properly. I hope I have demonstrated to you that the proper place of health insurance is *beside* you and your patient, *beside* you and your public, and *not between* you. ◄



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If the Bomb Is Dropped, Then What . . . ?

*HAROLD S. ZEIS,**
Superintendent,
Indiana State Police

IF THE BOMB is dropped, then what . . . head for the hills . . . roll over and go back to sleep . . . turn on the lights and telephone the boss or the neighbor? What would you do if the enemy struck without warning, and brought war to *your* community . . . to *your* doorstep?

Now, I want to make it emphatically clear that I'm not predicting war. I'm not anticipating war. For the record, I join with the millions of Americans and other peoples of the world in the fervent hope that we humans will somehow learn to live in peace, and that armed conflict will never come again.

But, if we are realistic in our thinking, we must conclude the possibility of war exists. No one these days can be unaware of the unrest that casts a dark, unwholesome shadow over the earth. No one dare overlook the possibility that an enemy—in desperation or in sheer idiocy—might push the wrong button.

And so we in Indiana must prepare ourselves against that eventuality—one we pray will never materialize.

Because of widespread concern about the threatening gestures being made abroad, I have elected to spend these few minutes in reviewing our state's position with regard to the defense of the civilian population. I know that the members of the Indiana Association of Chiefs of Police are vitally interested in the problems of Civil Defense.

The very existence of the threat is the main reason why Civil Defense is of such grave concern in the year 1959. Officials and citizens alike have a duty to work together in the development of protective measures. But keep this in mind: the primary leadership must come from public officials.

Preparedness would cause even the reckless to hesitate. The best protection, then, is to possess the ability to, No. 1—survive an attack, and No. 2—retaliate with annihilating force. Therefore, preparedness—both military and non-military—is the best deterrent to war.

Now, in thinking about counter measures, it is necessary to consider the situation we might face. What would an atomic, jet-propelled conflict mean to we who live and work here in Indiana? These points, I think, will provide some of the answers:

1) *Vulnerability*—The development of faster-than-sound airplanes and guided missiles have made the United States vulnerable to attack. The friendly Atlantic and Pacific Oceans, which once served as buffers to keep the enemy at bay and give us valuable time to organize our military strength, have been reduced to small puddles.

 Less than 10 years ago, it was estimated that Indiana was within 12 to 18 hours of a bombing run from Siberia, 3,400 miles distant, or Vladivostok, 6,000 miles away. Today a jet bomber can span those distances in seven hours or less. One of the new missiles, launched from a base in Russia, might conceivably strike in Indiana in a matter of 30 minutes after it was fired.

2) *Target Potential*—The Middle West, with its huge capacities for industrial and agricultural production, ranks high as a target. I'm advised that located in Indiana are

Continued on page 1364

* Given at the 37th Annual Convention of the Indiana Association of Chiefs of Police, Gary, Indiana, June 23, 1959.



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If a Bomb Drops

Continued from page 1360

nine of the 315 primary targets in the nation. These include, for example, the city of Gary, where we are meeting today, and the other closely-grouped industrialized cities which line the perimeter of Lake Michigan.

The others are South Bend, Fort Wayne, Terre Haute, Indianapolis, the Jeffersonville-New Albany area, the Anderson-Muncie area, Evansville, and the Air Force Base at Bunker Hill. There are still other military facilities, now dormant, which would be considered as objectives in wartime.

Yes, we may be sure that our state, with its tremendous potential to manufacture supplies on a large scale in an emergency, will be in one of the principal strike zones if the trigger is squeezed off.

3) *Atomic Aftermath*—The deadly effects of a nuclear explosion—called "radioactive fallout," which linger for varying periods —would endanger areas that escape the immediate blast, according to tests by scientific experts. The winds could be expected to distribute radiation-contaminated particles over long distances.

This means that few areas in the state, if any at all, would escape these secondary effects. Hoosier farm lands—growing and stored crops, animals and other rural produce—would be blighted. The smaller communities would suffer.

It can be seen that the next conflict would come suddenly, it would be in our own backyard, and it would test the ability of humans to survive under the worst possible disaster conditions. The last—human survival—concerns we policemen, as well as other officials.

A nuclear war, in the opinion of informed authorities, will not be won by the attacker, but will be won by the nation that can sustain itself *after* the attack. To repeat, then, a strong, effective Civil Defense program, organized and directed by constituted government, is imperative.

The mission of Civil Defense is: to protect life and property from attack and *major disasters* by preparing for and carrying out emergency functions to prevent, minimize and repair injury and damage.

Now, I hope you noted my reference to "major disasters," as separated from a war between nations. I wish to clear up this point before moving along. A strong Civil Defense setup is not limited to war, nor was it intended to be. It is an emergency organization of officials and citizens for use in protecting the civil population in any kind of peacetime catastrophe of major proportion. And that's exactly what it was intended to be.

There are two parallel roads by which this protective goal can be achieved:

1) Inform the public of disaster hazards and how to meet them.

2) Leadership at all governmental levels in creating, directing and executing plans for recovery after a disaster.

In view of the swiftness with which an air strike could be made on Indiana, the most logical course would be to convince the citizen that survival has become a *personal* matter. Individuals might have to depend upon their own knowledge and resourcefulness for extended periods after an attack. Thus, state and local officials—including the police—have the task of acquainting every citizen of these steps to safety:

1) Warning signals and what they mean.

2) Protection from radioactive fallout.

3) First aid and home emergency preparedness.

4) Use of CONELRAD to alert and give directions to the civilian population during an attack.

How are we to stimulate the necessary response by the citizens? I think that at this point we should review what have been done about organizing a national defense program, and what is being done by your state government. Finally, I'd like to touch briefly on some of the things that are yet unaccomplished.

I'm sure that you police chiefs are aware of the "early warning" radar system that extends far above us in the northern reaches of Canada. The first is known as the "dew line." These

Continued

If a Bomb Drops

Continued

United States outposts stretch from the Aleutians to Newfoundland, and probably will be extended to Greenland. Farther south there is the "mid-Canada line," maintained by the Canadian government. Then, 200 miles north of the U. S. border, there's the "pine tree line," which was also constructed and is manned by our military.

In addition, radar-equipped ships and planes are on roving patrol on the oceans, plus a scattering of fixed "platforms" in the sea on which are mounted radar detecting devices.

Information is flashed instantly from these points to the headquarters of the North American Defense Command at Colorado Springs, Colo., which controls all activites affecting military and civilian defense operations. Instructions from this command center are communicated to 276 regional centers of the national warning system. From there pertinent information is transmitted swiftly to the community level. I shall deal with this phase in greater detail in just a moment.

First, let me say, in passing, that our country is prepared to deal with any act of aggression, quickly and surely. The nation's defenses are in the hands of capable leaders whose constant attention to research and development has provided the armed might to strike down attackers, and to carry out retaliatory measures. These forces—the most moden conceived by man—are on guard night and day.

Moreover, we do not stand alone. Many other nations of the world are joined with us in our stand against human slavery.

Indiana has not been lagging in activating Civil Defense programming under the Office of Defense and Civilian Mobilization, which was established by President Dwight D. Eisenhower. We have been making sure, steady progress.

Just a few days ago, Governor Harold W. Handley assigned Maj. Gen. John W. McConnell, the adjutant general of Indiana, as director of state Civil Defense. This move in placing Civil Defense under a high-priority classification, to speed and strengthen the program, emphasizes the governor's concern.

About 15 state departments have made available the necessary personnel to operate the 21 divisions of the state-level Civil Defense organization, including coordination, planning, guidance and assistance to local units.

As an illustration of this continuing program, in July about 80 persons will attend a 5-day course to receive instruction in "radiological defense," which includes the effects of nuclear weapons, the measurement of radiation, and the technic of operating and maintaining radiological instruments. They will form the teams to instruct the thousands of other civilian defense workers in radiation control as the state-wide program progresses.

My department is cooperating with the county and city departments in relaying information from the military-civilian control center at Colorado Springs to the local level. As you know, the attack warning system is frequently tested by means of unannounced alerts, and the police of Indiana can point with pride to handling this assignment with dispatch.

It is to be expected that the state's law-enforcing agencies will be in the forefront of the Civil Defense effort. Emergency situations are our stock in trade. Under disaster conditions, we must be ready to police and direct evacuation traffic, prevent looting and re-entry into devastated or contaminated areas, and handle a variety of other problems. But our available, trained policemen are likely to be inadequate in numbers to cope with a major emergency.

It is here that an organization of auxiliary police officers may make the difference. However, it is my feeling that the recruiting of such an auxiliary force will depend upon—and this is most important—how active your community is in the over-all Civil Defense effort.

The record suggests that there is a critical need for arousing interest in many Hoosier communities. In one-third of the 92 counties there is no Civil Defense organization. In an estimated 20% of the ramaining two-thirds of the counties there is merely a paper organization. In but three counties—Lake, Marion and Allen —are full-time Civil Defense directors employed.

The elimination of public apathy is the first and greatest hurdle to be surmounted in attaining an active program. Citizens must be made to realize that adequate safeguards for them and their families require their active cooperation in the state and national defense mobilization program.

Unfortunately, some people think, fallaciously,

If a Bomb Drops

Continued

to be sure, that it can't happen here. Or if the bomb is dropped, they'll not be in range. Others, more fatalistic, contend there can be no defense against the destructive forces of the nuclear blast.

Just a year ago, the warning signals in an eastern city of 100,000 sounded accidentally one night. What happened was not good. For one thing, the mayor of the community turned over and went back to sleep. More appalling to defense authorities was the fact that those frightened enough to act, acted the wrong way. They jammed telephone lines, turned on lights, and even left the shelter of their homes to gather in the streets.

After a similar fiasco at Oakland, Calif., officials employed researchers to find out why people reacted as they did. The survey revealed that although 75% of the residents heard the Civil Defense alarm, only 10% took protective measures. Ten % attempted to get information by telephoning public officials or listening to their radios. Some 35% checked by looking out their windows and calling the newspapers or neighbors. An astounding 45% did nothing at all.



"Just where is this splinter you picked up from your broom?"

In an Indiana city, when sirens announced an attack test, one motorist did what he was supposed to do—abandon his car and ran for a shelter. He promptly received a ticket for improper parking from an officer who hadn't been told of the practice run.

These incidents point up the fact that much remains to be done if an effective, efficient Civil Defense force is to be established. There is no easy answer as to how to break down the barrier of apathy. I wish there were.

It is not a new situation to the police administrator, who each day faces a similar job of trying to arouse public interest in traffic accident and crime prevention.

This much is certain: the pace of any future full-scale war, employing hydrogen warheads deliverable by missile or jet bomber, will leave little or no time for mobilizing to protect the civilian population. This would also apply to peacetime disaster occurrences. These situations must be handled through "forces in being."

Another certainty is that the police administrator will figure prominently in the picture. Knowing that, it would be to his benefit to make an effort to stimulate his fellow officials and citizens to action.

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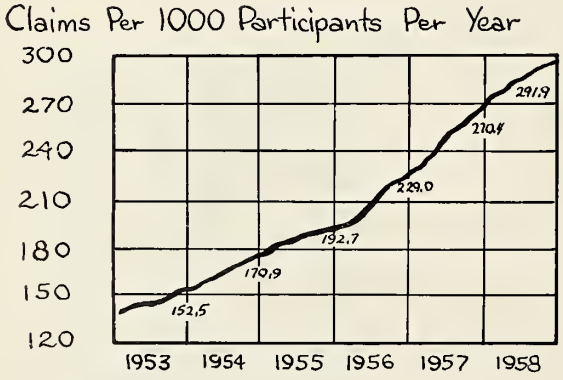
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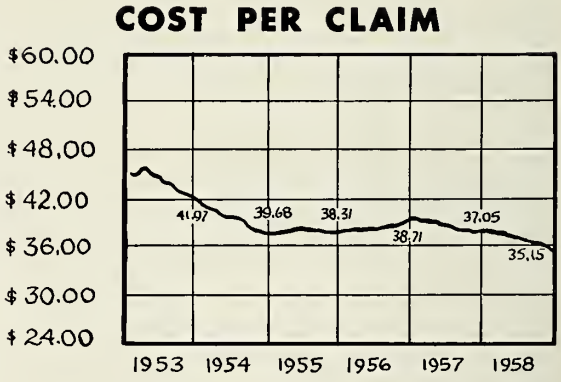
This article is the sixth in a series prepared by Blue Cross—Blue Shield dealing with trends in the financing of health care.

Blue Shield follows changes in medical practice and has the flexibility to match quickly the requirements of new situations. These are significant facts to be found behind the figures of the charts on this page.

One chart shows that usage increased steadily from 138.5 per 1000 participants at the beginning of 1953 to 291.9 at the end of 1958. Cost per claim during this same 6-year period decreased from $45.45 to $35.15.

There *was* a real increase in usage during these years and a decrease in cost per claim. But the full story is not that simple. There are other facts to be considered. One of the most important is the effect of other services added to the Blue Shield program. These include in-hospital medical, anesthesia, diagnostic and additional procedures covering minor surgery in doctors' offices. These have increased the number of claims submitted—and at the same time have reduced the average cost per claim.





Other factors that have enabled Blue Shield to operate through this period of change without increasing fees for the same coverage include simply the sheer volume of our operation, plus operating economy made possible by the use of modern methods and machines.

For example, administrative cost per claim has dropped from $2.07 in 1953 to $1.39 in 1958. Remove the cost of income taxes imposed recently by the state government and the cost per claim is now at a low point of approximately $1.00.

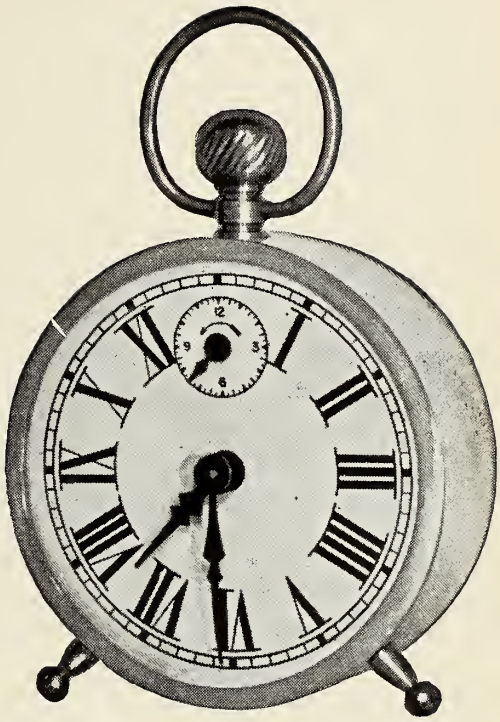
What about the future? Blue Shield will continue to adjust to the demands of our members —and changes in medical practice. Blue Shield will at the same time stress aggressive enrollment activity, seek further economies in operation and change with changing situations.

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NEWS NOTES—from State and Nation

Exhibit Shows Physicians as First Auto "Test Drivers"

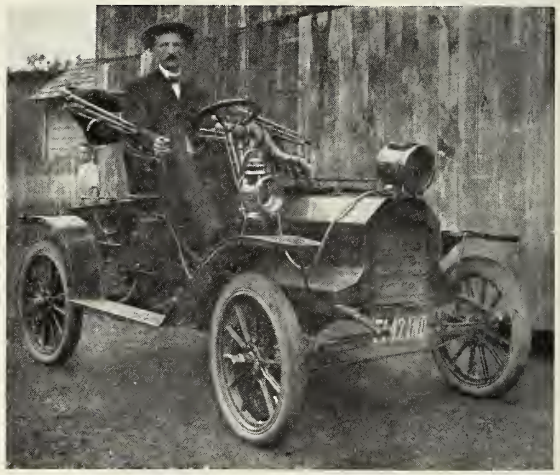
ATLANTIC CITY—Physicians at the turn of the century were the automobile industry's first "test drivers," according to an exhibit in Convention Hall in connection with the 1959 annual meeting of the American Medical Association.

Driving pioneer makes of cars under all weather and road conditions when other owners dared not to go out, studying the mechanics of the "horseless carriage" as thoroughly as they did the anatomy of the human body, and making their own repairs when road breakdowns occurred, physicians reported their experiences and recommendations in great mechanical detail in automobile sections of the *Journal of the AMA.*

The exhibit, prepared by Dr. Harold M. Camp of Monmouth, Ill., and Dr. Theodore R. Van Dellen of Chicago, editor and associate editor, respectively, of the *Illinois Medical Journal,* official publication of the Illinois State Medical Society, presented these reports. The exhibit was based on an article by John A. Mirt of Chicago, published in the *Illinois Medical Journal.* Photographs showed physicians at the wheels of automobiles of ancient vintage.

"The Indianapolis Motor Speedway as a test of stamina for automobile engines and accessories was not to come upon the scene until 1911," the exhibit pointed out. "There were no proving grounds in those early days. No group was in a better position than 100,000 physicians of the nation to give the automobile its needed, thorough workout, and to find its mechanical defects.

"To them, rapidity and certainty of transportation were material and practical considerations. The long time spent in travel was an economic waste. In some instances, the speed with which a physician reached his patient was a factor between life and death. So, he took up the new automobile not for pleasure but for professional reasons.



The late V. V. Cameron, M.D., who practiced medicine for nearly 40 years in Marion, Ind., was the first Marion doctor to drive a car, according to his family. He's pictured here in a 1907 1-cylinder model Reo.

"Manufacturers realized that there could be no greater testimonial for their products than to have the family physician make his calls in city and country by auto. Promotion was directed to the medical profession. Physicians led the way in switching from horses to automobiles.

" 'Doc' guided his automobile over city and country, on good roads and bad, through mud, snow, sand and clay, up hill and down, day and night, winter and summer under every weather and road condition imaginable.

"When the mechanical 'bugs' of his machine showed up—and this happened much too frequently—he had no one to turn to for help. Moreover, mechanics were of little help because of lack of standardization of parts and designs.

"Each model of car required a particular knowledge of its workings. So, the physician had to 'get out and get under.' With the aid of a few choice, non-medical words, he did the repairing himself.

"It became evident that medical and mechanical emergencies were Siamese twins. In order to deal with both, the physician learned the me-

chanics of an automobile the hard way. He pored over technical books dealing with the principles of gasoline and steam engines, electric motors, fuels, storage batteries and other accessories. He tinkered with a car in a stall in an old stable. In time, he came to know the anatomy of his automobile as well as that of his patients."

The interest of the medical profession in the developmental stage of the automobile was started with a letter that appeared in the *Journal of the AMA* in 1901. It was by Dr. Charles H. Mayo, one of the founders of the Mayo Clinic of Rochester, Minn. Dr. Mayo reported on the advantages and disadvantages of "steam buggies," gasoline-driven automobiles and electrically propelled machines.

This was the beginning of a chain reaction. The *Journal of the AMA* carried sporadic accounts by physicians of their experiences with automobiles. By 1906, the motor car was recognized as an important potential factor in better medical care. Yet, manufacturers were far from solving their mechanical problems.

The *Journal of the AMA* took cognizance of this situation and called for detailed reports and recommendations from its readers. On April 21, 1906, a 36-page section was devoted to accounts by physicians who pointed out the merits and demerits of every type of accessory that went into a motor car.

There was agreement on one point only—every physician should undergo training in gas engineering. Typical of the advice was that of Dr. C. P. Thomas of Spokane that every physician "should know the mechanics of his car as well as he knows his surgical instruments," and that of Dr. Rolandus G. Walker of Denver who said: "Learn to diagnose your trouble when it arises. Understand the physiology of your engine. Apply the treatment as when you prescribe drugs in your daily practice."

This brought demands for more information. On March 7, 1908, the *Journal of the AMA* carried a 27-page automobile section. A third special section of 34 pages was published a year later. Editorially, the *Journal* recommended that the automobile industry standardize parts to cut production and maintenance costs, put out a $500 car which Henry Ford did, provide reliability of performance, make parts easier to reach.

"From then on, the automobile industry grew

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'Tourists' at G-M



FIFTEEN ISMA physicians recently toured the Technical Center at General Motors' Detroit plant. Shown (l to r) are ISMA President Kenneth L. Olson; Dr. J. X. McCalla of Paoli (back to camera); R. J. Hulse, Delco-Remy (Anderson, Ind.) personnel director; Dr. Emmett B. Lamb, chairman, ISMA Public Health Commission; and Dr. R. C. Swan, medical director, Delco-Remy.



ARRIVING FOR the tour of G-M at Detroit, members of the ISMA Public Health Commission are assembled for a briefing of what they will see in the ultra-modern research plant. They spent a day inspecting work being carried out by G-M in automotive and industrial safety, especially in the fields of radiant heat and noise control.

A person remains immature, whatever his age, as long as he thinks of himself as an exception to the human race.—Harry A. Overstreet, *Think.*

"Test Drivers"

Continued

fast," the exhibit pointed out. "In 1911, the Indianapolis Motor Speedway staged its first 500-mile race, to put the automobile to a grueling test. This merely added speed to the earlier trials.

"But the physicians of the country had served as the first test drivers under actual road conditions."

Dr. Dollens Honored Again

Oolitic, Ind., honored Dr. Claude Dollens, Indiana State Medical Association's Doctor of the Year for 1958, at special "Dollens Day" celebration on May 12. The 78-year-old doctor was feted at "I'm a Dollens Baby" program and reception that evening in the high school gymnasium.

A teacher for five years, Dr. Dollens gave up that profession to enter medical school at Central College of Physicians and Surgeons, Indianapolis. He graduated from Purdue University with his M.D. in 1907.

Dr. Dollens served as president of the Lawrence County Medical Society and was a delegate to the State Association for several years. He is a former Lawrence County health officer, and was president of that county's Tuberculosis and Health Association at one time.

Kenny Foundation Scholarships to Continue

The Sister Elizabeth Kenney Foundation will continue its program of post doctoral scholarships in the field of neuromuscular diseases, it was announced in June. The scholarships, designed for scientists at or near the end of fellowship training in the fields of neuromuscular diseases, are given annually. Each grant provides a stipend for a 5-year period at rates of from $5,000 to $7,000 a year, depending on qualifications.

Candidates from United States and Canada medical schools are eligible. Dr. E. J. Huenekens, medical director of the foundation, is handling inquiries. The address is 2400 Foshay Tower, Minneapolis 2, Minn.

The modern Boy Scout helps an old lady across the street by slowing down his convertible.—Harold Coffin.



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stops vertigo



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Nicotinic acid (50 mg.) – the drug of choice for prompt vasodilation.[1,3]

Prescribe ANTIVERT for relief of Meniere's syndrome, arteriosclerotic vertigo, labyrinthitis, and streptomycin toxicity. Also effective in recurrent headache, including migraine.

Dosage: One tablet before each meal.

Supplied: In bottles of 100 blue-and-white scored tablets. Prescription only.

References: 1. Menger, H. C.: Clin. Med. 4:313 (March) 1957. 2. Charles, C. M.: Geriatrics 2:110 (March) 1956. 3. Shuster, B. H.: M. Clin. North America 40:1787 (Nov.) 1956. 4. Dolowitz, D. A.: Rocky Mountain M. J. 55:53 (Oct.) 1958.

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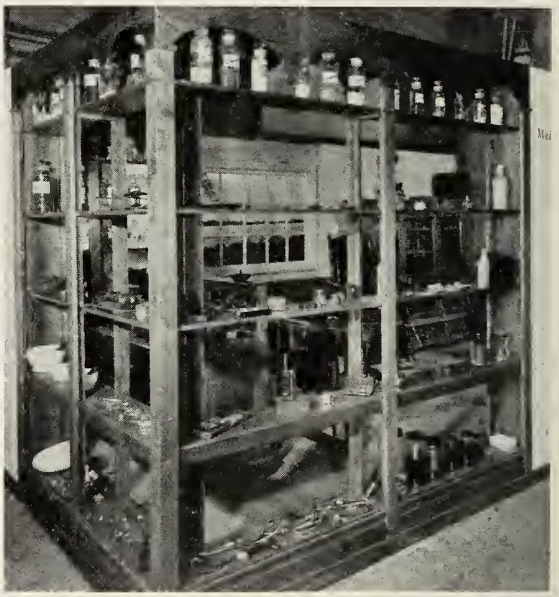
Medical Evansville in the Nineteenth Century

Brochure and exhibit of 19th century medicine is another milestone in Indiana Medicine

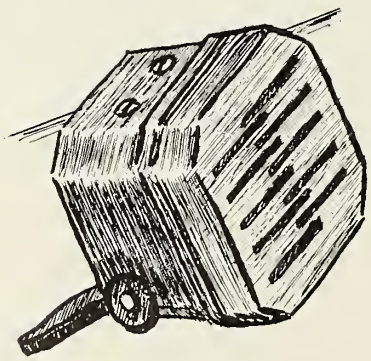
"For many of us, mention of the colorful nineteenth century, the years from 1800 to 1900, elicits visions of heartwarming Currier and Ives scenes . . . scenes of hunting in the virgin forests or riding across the broad prairies . . . wintertime vignettes of drifting snow, sleigh bells, and groaning, festive tables. . . .

"We are prone to forget the fear, often the horror, that was the ever-present accompaniment of disease during that century. . . ."

THESE EXCERPTS are from a unique (and what itself might be termed another milestone in medical history) brochure called *Medical Evansville in the Nineteenth Century*, published in cooperation by The Vanderburgh County Medical Society, The Evansville Museum of Arts and Science and Mead Johnson & Company, Evansville.



NEARLY 500 ARTIFACTS are included in the Medical Evansville exhibit, all of which were gathered in the Evansville area to represent medicine of the nineteenth century.



SCARIFICATOR

This instrument was used to lance the patient for bleeding. It is a small cubical, brass box, in which 10 small lancet points turn on a pivot. By flipping the spring, all the tiny blades shoot out. (Drawing and copy from Medical Evansville brochure.)

The title *Medical Evansville in the Nineteenth Century* first appeared in this *Journal* in March, 1958, Vol. 51, No. 3, pp. 337-350, as written by Dr. W. D. Snively, Jr., vice-president and medical director of Mead Johnson & Co.

Contained in the brochure, in addition to Dr. Snively's article, is a prologue which quotes Dr. James Newton Matthews' "Ballade of the Busy Doctor" (describing the horror and hardships of the nineteenth century medicalwise) and a series of sketches of nineteenth century instruments and other tools of early Evansville physicians.

The drawings are from items in an exhibit of a physician's office sometime in the middle of the past century. It also was a joint project



AN OVERALL VIEW of the Medical Evansville exhibit which was shown to thousands of physicians at the annual AMA meeting held in Atlantic City. At right is a wax likeness of Dr. William Elliott, an early Evansville physician.

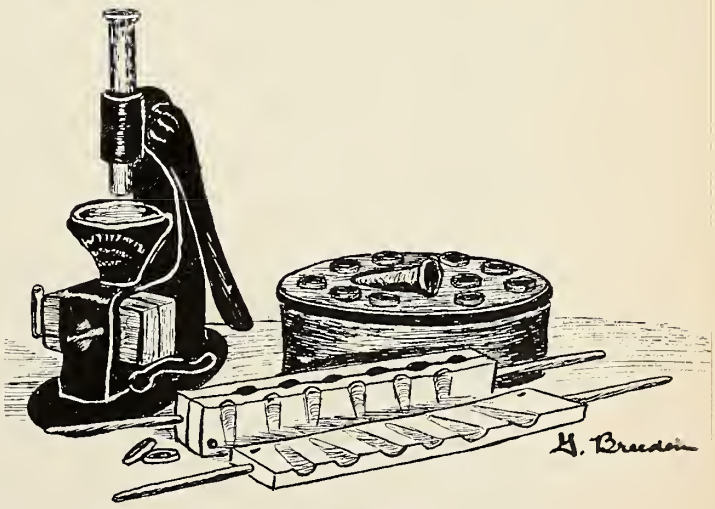
of the aforementioned three organizations, financed through a special grant from Mead Johnson & Co.

First shown at the annual meeting of the AMA in Atlantic City June 8-12 where it was seen by thousands of physicians, the exhibit is being moved to a permanent place in the beautiful new Evansville Museum of Arts and Science which will be completed later this year.

It consists of a full sized, completely furnished doctor's office of a century ago. Actually a composite of several representative physicians' offices of the period, it is 12′ x 20′ in size and contains nearly 500 medical artifacts, some up to 200 years old.

These items include an old-time surgical chair, work desk, drug mill, pill machine and the ornate bottles of 100 years ago, some containing the original compounds. There also are medical

Continued on page 1380



SUPPOSITORY MOLDS

These suppository molds were used by physicians and druggists during the nineteenth century. At one time, suppositories were not made available except as needed and the patients had to wait while they were specially made. (Drawing and copy from Medical Evansville brochure.)

NIAMID*

the mood brightener

Lifts the burden of depression... opens the way for a sunnier outlook

New areas of therapy

NIAMID is clinically effective in a broad range depressive states, including: involutional mel cholia, senile depression, postpartum depress reactive depression, the depressive stage of ma depressive disease, and schizophrenic depres reaction.

A wide variety of psychoneurotic depressions s in general practice also respond effectively NIAMID. Depression associated with the menopa and with postoperative states, and depression companying chronic or incurable diseases such gastrointestinal and cardiovascular disorders, thritis, and inoperable cancer, can now be trea successfully with NIAMID.

NIAMID is also strikingly effective for many c plaints, mild or severe, vague or well defined, w due to masked depression rather than to orga disease. This masked depression may take the f of guilt feelings, crying spells or sadness, difficu in concentration, loss of energy or drive, insom emotional fatigue, feelings of hopelessness or h lessness, loss of interest in normal activity, listl ness, apprehension or agitation, and loss of appe and weight.

While tranquilizers have had some measure effectiveness in many of these areas, NIAMID gives the practicing physician a new, safe drug the specific treatment of depression without risk of increasing the depressive symptoms.

New safety

The outstanding safety of NIAMID in extens clinical trials eliminates the hepatotoxic reacti observed with the first of the monoamine oxid inhibitors. These reactions have not been seen v NIAMID.

Acute and chronic toxicity studies show this distinctive freedom from toxicity. Moreover, du the extensive clinical trials of NIAMID by a la number of investigators, not only has no liver d age been reported, but only in a very few isol instances have hypotensive effects been seen.

The absence of toxicity may be the result of unique carboxamide group in the NIAMID molec This structure may explain why NIAMID is excr largely unchanged in the urine, with only insig cant quantities of potentially free hydrazine b formed. Previously, where a monoamine oxi inhibitor had been associated with hepatic toxi there was some evidence that substantial quant of free hydrazine were formed in the body.

Background of NIAMID

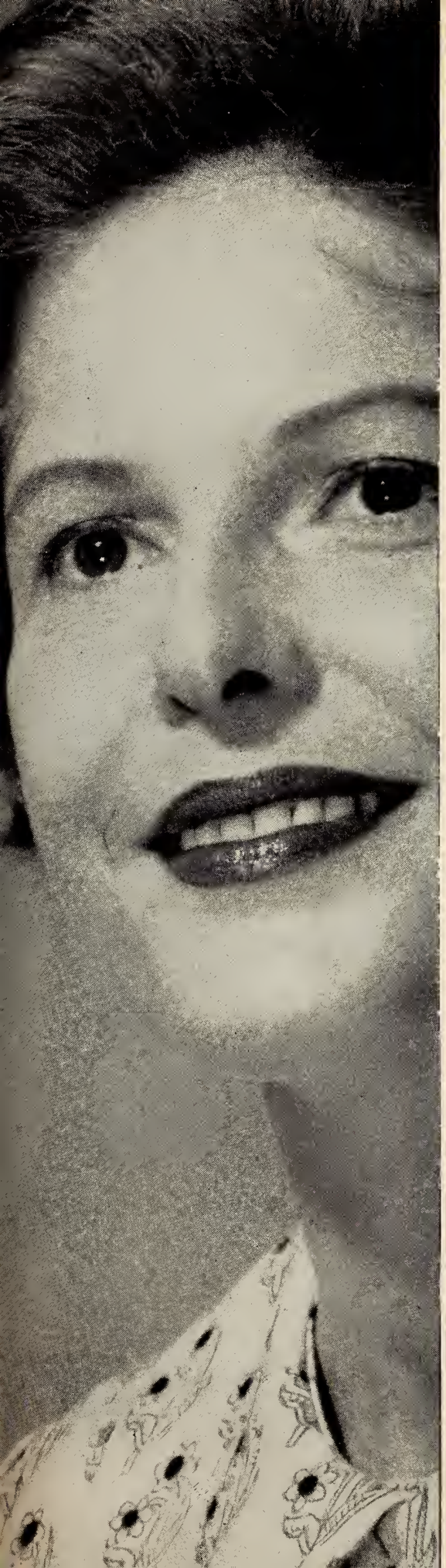
A major advance in the treatment of mental pression came with a newer understanding of influence of brain serotonin and norepinephrin the mood. Levels of both these neuro-hormones decreased in animals under experimental co tions analogous to depression; relief of these m depressions is seen with a rise in the levels of serotonin and norepinephrine.

A second advance came with the developmen monoamine oxidase inhibitors, substances w raise the cerebral level of both serotonin and epinephrine. The first of the amine oxidase in tors raised the cerebral level of serotonin, but not appear to raise that of norepinephrine l proportionately.

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Attention at Pfizer Research was then directed to a new drug that would overcome this disadvantage. NIAMID significantly raises the cerebral level of *both* serotonin and norepinephrine under experimental conditions.

The dramatic discovery of NIAMID now makes available an extremely effective, safe antidepressant for the successful treatment of a full range of depressive states.

Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance, in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.

The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

Supply

NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

References

Complete bibliography and Professional Information Booklet are available on request.

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NIAMID
the mood brightener

Medical Evansville

Continued from page 1377

instruments of the period and a library of 200 books.

Seated at the desk is a wax life-like figure of Dr. William Elliott, an early Evansville physician, whose diploma from the old Evansville Medical College hangs over the desk.

All of these items were obtained from the Evansville area. In one wall of the exhibit is a view projector which shows Evansville sites having medical historical significance. A sound track explains their connection with the exhibit.

The exhibit has not only brought the Vanderburgh County Medical Society national attention, but will serve as a permanent reminder of the significance of the society and its interest in the cultural and civic development of the community.



MORTAR AND PESTLE

The mortar and pestle were used by physicians and druggists for pulverizing and mixing drugs. The iron mortar (left) was used for pounding drugs which could not be ground in the porcelain or Wedgwood mortar (right). The iron mortar was tall and flat-bottomed and the end of the pestle was also flattened. (Drawing and copy from Medical Evansville brochure.)

In addition, it is a clear and definite demonstration of how medicine and the pharmaceutical industry can work together in creating good public relations.

Medical milestones need not all be in improved medical knowledge, technics and facilities; a milestone can be achieved in better understanding by lay people—potential patients—of the profession itself, of the dedication of physicians and the pharmaceutical industry to ever-growing knowledge and improved care of the ill.

Both the brochure and exhibit on Medical Evansville in the Nineteenth Century seem to have achieved this milestone in Indiana medicine.

(For additional information or copies of the brochure, write Miss Martha Wessner, project director, Medical Evansville in the Nineteenth Century, Medical Department, Mead Johnson & Company, Evansville 21.) ◄

Surgeons to Meet in Chicago

The 24th annual congress of the North American Federation, International College of Surgeons, will be held in the Palmer House, Chicago, September 13-17.

Surgical specialties to be represented are: coloproctologic, neurologic, obstetric and gynecologic, ophthalmologic, otorhinolaryngologic, orthopedic, plastic and reconstruction, trauma and rehabilitation, and urologic. There also will be surgical motion pictures, reports on advances in military medicine and a surgical nurses' program.

The North American Federation covers the United States, Canada, Mexico, Cuba, Haiti, Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica and Panama.

Dr. Karl A. Meyer of Chicago and Dr. W. Wayne Babcock of Philadelphia are honorary chairmen of the congress and Dr. Alexander Brunschwig of New York is general chairman.

Surgeons desiring to present papers should write to Dr. Peter A. Rosi, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10. For hotel reservations, write to the reservation secretary, care of the College.

The article entitled "Medical Guide for Physicians in Determining Fitness to Drive a Motor Vehicle" which was prepared by the Committee on Medical Aspects of Automobile Injuries and Deaths of the American Medical Association, and which was originally printed in the March 14, 1959, edition of the *Journal of the A. M. A.*, has been reproduced in the form of a pamphlet. The pamphlet is recommended for all physicians.

Ethel Gastineau ISMA's Favorite Daughter

The Indiana State Medical Association can now claim a "favorite daughter." Mrs. Ethel Gastineau, Indianapolis, installed in June as President of the Woman's Auxiliary of the AMA, is the first Hoosier to be elected to that office.

Mrs. Gastineau, who has been active in both state and national auxiliary work for many years, was named president-elect of the National Auxiliary at the AMA 1958 meeting in San Francisco. She has attended conventions since 1935, serving as the association's director in 1950-52, on AMEF 1952-6, and vice-president 1957-8.



Indianapolis Times Photo by Ben Lawrence

Marion County Medical Auxiliary members honored Mrs. Frank Gastineau at their annual luncheon in May. Mrs. Gastineau is pictured here (seated) with Mrs. Russell W. Lamb (center) and Mrs. Roy V. Myers, who took part in a humorous skit in Mrs. Gastineau's honor.

A charter member of the Indianapolis auxiliary, she has served as secretary, treasurer and president of that group during her membership of over 30 years. She was state president in 1944-6, and has been an active leader in organizing several other auxiliaries.

Mrs. Gastineau is a graduate of Indiana State Teachers College, and a former Indianapolis physical education teacher.

Deputy Surgeon General Named to Army SGO

Brig. Gen. Thomas J. Hartford, Army Medical Corps, has been appointed deputy surgeon general of the United States Army Medical Service in Washington, D. C. His predecessor, Maj. Gen. James P. Cooney, will become chief surgeon, U. S. Army, Europe.

General Hartford will coordinate Army Medical Service programs and assist the surgeon general in supervising Medical Service activities.

Prior to assuming his present duties, General Hartford was commanding general of Madigan Army Hospital, Tacoma, Wash. He was deputy commanding general of Walter Reed Army Medical Center, Washington, D. C., from July 1955 to April 1958.



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MARIE THEOBALD

Indianapolis

IN OCTOBER 1956, with the approval of the Indiana State Medical Association, the Indiana State Association of Medical Assistants was organized, and members held their first State Convention in Indianapolis in May, 1957. Membership has increased each year and we now have 310 members. In 1957 there were six constituent societies—Fort Wayne, Indianapolis, and Cass-Carroll, Shelby, Vanderburgh and Wayne-Union Counties. At our recent convention in Fort Wayne, charters were presented to three new societies—Delaware-Blackford, Bartholomew-Brown and St. Joseph Counties.

The purposes of this Association are to unite those engaged in any phase of medical assistants' work in a physician's office; to establish and maintain good fellowship among its members; to stimulate a high order of business, professional attainment, and acquaint the members with the problems in the medical field; to inspire loyalty, integrity and efficiency in their service to their physician-employer and to the public; and to further their knowledge of their work and its procedures, and to uphold the honor and dignity of their employment in connection with the medical service rendered to mankind.

A medical assistant is one who performs services in the aid of a medical doctor in carrying on his profession, such as: nurses, secretaries, receptionists, technicians and all others who aid medical doctors in their profession.

Our goal for the year 1959-1960 is 600 members, and we invite every medical assistant in Indiana to become one of us. Our membership committee headed by Miss Jeanne Woods, 5240 Clarendon Road, Indianapolis 8, will be happy to assist you. We urge one and all to come aboard!

During the past year many conferences have

Continued on page 1384



NEW OFFICERS of the Indiana Medical Assistants Association are (l to r): Mrs. Jean Blance, Fort Wayne, president-elect; Mrs. Trudy Cleckner, Fort Wayne, recording secretary; Evelyn Sommers, Logansport, president; Mrs. Evelyn Montgomery, Shelbyville, treasurer; and Jeanne Woods, Indianapolis, immediate past president.

Physicians Tell Why:

Reasons Stated for Active Support Given American Medical Assistants

*HALLIE CUMMINS, R.R.L.**

Michigan

MORE AND MORE doctors throughout the country are coming to know what the American Association of Medical Assistants is doing to assist with the education and know-how of their members, and more and more interest is being shown by the medical societies, both county and state.

A central office with an executive secretary has been opened in Chicago and members are offered a salary replacement insurance plan comparable to plans offered to the medical profession.

Plans are underway for educational courses which will be offered to those presently working in the field and to those interested in entering the field as medical assistants. The work in the doctor's office is highly specialized and trained medical assistants are necessary to assist the doctor and to relieve him of many of the details which are a part of the office routine.

The Third Annual Meeting of the association will be held in Philadelphia, October 16-18 at the Benjamin Franklin Hotel. Medical Assistants and doctors are invited to attend.

Here is what a representative group of doctors have to say:

Dr John W. Rice, Jackson, Mich.: "We in the Michigan State Medical Society are justly proud of the Michigan State Medical Assistants Society. This organization has come from a start in 1949 to an enthusiastic, ambitious, hard-working group of 1000 members at the present time.

"The State Medical Society in Michigan stands squarely behind the medical assistants and we want them to produce a standard for girls working in our offices that is so high that it will become a career program for high school graduates to shoot at.

"We hear seven reports at the opening of our annual meeting of the House of Delegates. One of these is from the president of the Michigan State Medical Assistants Society, along with the president and president-elect of the Michigan State Medical Society and the president of the State Woman's Auxiliary.

"Every county medical society has an Advisory Committee in counties where the girls are organized. These committees back the girls and help them with their problems. This year at our annual state meeting we are having our first state-wide meeting of county advisors. This is an effort to coordinate the thinking of the many advisory committees along with the officers of the Michigan State Medical Assistants Society.

"We in Michigan have come a long way from 1949, when the medical assistants were only an idea, to the present shoulder-to-shoulder attitude in support of medical progress in Michigan."

Dr. Fred Sternagel, West Des Moines, Iowa: "I have watched with a great deal of satisfaction the founding, growth and development of the American Association of Medical Assistants. From a small beginning a few years ago, the AAMA has won recognition from the American Medical Association and the state medical societies of 21 states where they have chapters.

"I have watched carefully the progress of this association and observed that the highest standards of ethics have governed its activities. Some few physicians who disapprove of the movement on the basis that it tends to create a union and may result in unreasonable demands

* Chairman, Public Relations Committee, and member, Board of Directors, American Association of Medical Assistants.

Physicians Tell Why

Continued

by assistants upon their employers have found nothing to substantiate their fears.

"One of the principal purposes of the association is to encourage girls engaged in this activity to become better educated, better trained, better qualified and more capable employees in their chosen vocation. The success of this program should eventually and inevitably lead to financial advancement and adequate compensation for work performed. However, it should be remembered that if members receive more benefits from their career it will not be because of any so-called union, but rather to the higher standards of performance as a result of better training and more requirements for those who seek employment in this field.

"Physicians should welcome increased standards of work requirements and give encouragement to the AAMA because better trained assistants free the physician for other and more important duties. The time lost by a physician interviewing applicants and training girls to assist him in his office is something which may eventually be eliminated entirely through the AAMA and adoption of rules and regulations governing preparation and training of girls for work. These many advantages for the physician, together with the dignity which comes to a doctor's office through the employment of a well-trained assistant who has met prescribed work requirements and who is a member of an accredited and recognized professional association should enlist the support of every physician in the work of the AAMA."

Dr. Robert L. Schaeffer, Allentown, Pa.: "The practice of medicine in recent years has become very complicated, and the work of the medical assistant employed in the physician's office has consequently become complex. There are many facets in medical practice and in the work of the doctor's assistant so that an efficient girl must be trained along many channels. In addition to the particular technical knowledge her doctor requires, she must know the principles of public relations, professional relations, insurance such as Blue Cross, Blue Shield, and the various commercial coverages, and she should understand taxes, federal, state and local.

"The American Medical Assoication and some state and county societies are aware of the need and have aided the medical assistants to form the American Association of Medical Assistants, with many component state and local groups. The association's major aim and purpose is to offer educational programs to better equip the assistant for her work in the physician's office. Attendance at association meetings and convention seminars and sharing ideas and special skills with girls of similar interests enriches the knowledge and capabilities of the doctors' assistants so that they will render superior service to the medical profession.

"The American Association of Medical Assistants is an infant who needs the support and *'The Assistant'* of every every physician in the AMA. With a strong organization, its program of education will go into high gear and ultimately it will be the doctor who will reap the greatest benefits—well-trained, efficient help for his office will be more readily available.

"DOCTOR—Help the American Association of Medical Assistants—help your assistant—to better serve YOU! Urge her to become a member of this dedicated organization."

Dr. M. E. Smernoff, Denver, Colo.: "It has come to my attention, since attending the na-

Indiana Assistants

Continued

been held with Mr. Virgil Hunt, director of the Indianapolis Extension Center of Indiana University, and Dr. Harry Pandolfo, chairman of the Public Relations Committee of the Indiana State Medical Association, on an "In-Service Educational Program." This program is to be initiated this fall in the extension centers throughout the state. As soon as all plans are completed and criteria can be printed, the information will be sent to all physicians throughout the State.

The American Association of Medical Assistants will hold their third convention in Philadelphia at the Benjamin Franklin Hotel. Dates—October 16, 17, 18. Program to include meeting of the General Assembly, meetings of the House of Delegates, educational sessions with excellent speakers, election of officers and installation ceremonies. Won't you plan to join the "Indiana Bandwagon" to Philadelphia, the city of brotherly love, in October? ◄

tional convention of medical assistants last October, that many doctors are skeptical and suspicious of the intentions of the organization we now so cherish. What is the advantage? This is a common question. Ideas of unionism, demands for higher salaries, prepaid insurance, sick leave and specialization have become rampant.

"I feel that the doctors have not been made totally aware of the reasons for existence of the organization so completely sponsored by all local and state medical societies as well as the American Medical Association.

"An organization which snow comprises over 6,000 dedicated women in 21 states are educating themselves at the expense of time and money to better serve the medical profession. They carry their own health and accident insurance. They are becoming more adept public relations servants. They are improving as bookkeepers and accountants to better serve the business office. They are improving their poise and personal effects to lure and retain the patient. Their code of ethics is that adopted by the medical profession.

"Further, the American Association of Medical Assistants is striving for a standard national educational program which will eventually offer certification and registration of flexible assistants who will become unmistakable assets to any professonal office regardless of the specialty.

"Let me assure the medical profession and reiterate that the advantage is solely yours. It behooves all doctors of medicine not only to accept but to propose for expansion an organization so dedicated."

Dr. Robert Allyn Royster, Evansville, Ind.: "It has been my pleasure to have been closely associated the past few years with medical assistants groups on a county, state and national level. The aims and ideals of these enthusiastic groups are outstanding and, in 1956, the American Medical Association passed a resolution at its clinical meeting in Seattle, Wash., commending the objectives of the American Association of Medical Assistants and its component chapters.

"Medical assistants associations in each state are organized under the supervision of the county and state medical societies to render educational services for the self-improvement of their members, and to stimulate a feeling of

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Physicians Tell Why

Continued

fellowship and cooperation with the medical profession in improving public relations. The high set of standards and ethics maintained by these groups inspire their members to render honest, loyal and more efficient service to the profession and to the public which they serve.

"Many of us doctors, recognizing the invaluable service of the American Association of Medical Assistants to the medical profession and the benefits to be derived by both medical assistants and their employers from membership in this worthwhile organization, have not only encouraged our office girls to belong to this group, but are also paying their dues in the county, state and national chapters."

Dr. Steward H. Smith, San Diego: "For several years I have been associated with the medical assistants group in San Diego County. More recently my experience has broadened into statewide and national scope. Because of these direct contacts, I feel as though I can speak from first-hand knowledge regarding the caliber of these organizations.

"The greatest asset of each of these groups is absolute sincerity of purpose. The basic reason for organization on all levels has been the desire of the members to further their education in this allied medical field. This desire and its fulfillment means that the medical assistant is trying to do a better job for her employer.

"There has never in the history of any chapter, never locally, state-wide or nationally—I repeat, there has never been any intent or even desire to organize for purposes of forming a union. This fact is not known by all medical doctors. The medical assistants are recognized and sponsored by the county, state and American Medical Associations.

"A great deal of spadework has to be done in recently organized state societies and the new national association. This work cannot see fruition without time, effort and money.

"The medical assistants have shown conclusively that they are willing to expand generously of time and effort for their organizations. Each has contributed to the best of her ability in monetary ways.

"My purpose in writing this article is to suggest, for your consideration, a way of assisting this worthwhile group. If each of the doctors were to pay the annual dues for his medical assistants—the amount varies, I believe, between $10 and $15 annually for local, state and national dues—this would aid a great deal in defraying necessary expenses. This item, of course, is deductible.

"This one stamp of endorsement by the physician would aid the medical assistant greatly in continuing the work she has so nobly begun. Won't you give the suggestion some thought and, if you approve, take the necessary steps to render this assistance?" ◄

Cancer Society Meets in October

The Annual Scientific Session of the American Cancer Society will be held at the Biltmore Hotel in New York City on October 26 and 27. The scientific program will be devoted to a symposium on "Evaluation of Early Diagnosis of Cancer." The program is approved by the American Academy of General Practice for 12 hours of Category II credit for its members.



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Separate buildings for boys and girls, each with round-the-clock supervision of skilled personnel.

Total enrollment 90.

G. H. Marquardt, M.D. *Medical Director*

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(near Chicago)

Psychosomatic Medical Meeting Planned

The sixth annual meeting of The Academy of Psychosomatic Medicine will be held October 15-17 at the Sheraton-Cleveland Hotel in Cleveland. It will be oriented and directed to fit the needs of non-psychiatric physicians.

Practical everyday office management of psychosomatic problems and emotional disturbances will be dealt with in formal papers, symposia, panel discussions and small study groups.

The meeting is open to all scientific disciplines, as well as psychologists, social workers and nurses. Information may be obtained from Dr. Bertram B. Moss, Suite 1035, 55 East Washington Street, Chicago 2, Ill.

Medical educators from 50 countries will take part in the Second World Conference on Medical Education, August 29 to Sept. 4 in Chicago.

Between 1,500 and 2,000 persons from all over the world will attend the conference, which is sponsored by the World Medical Association, World Health Organization, and Council for International Organizations of Medical Sciences and the International Association of Universities.

New Booklet Discusses Physical Ed Health Problems

Problems of parents when their children participate in school athletic programs and physical education are studied in a booklet entitled "Answers to Health Questions in Physical Education," published recently by the American Association for Health, Physical Education, and Recreation.

The 24 page report, prepared by the AMA and the National Education Association, gives advice on infection and spread of disease, first aid, exercise, injury precautions and other situations which arise as a result of a normal school athletic program.

The booklet is available for 50c per copy from the American Association for Physical Education and Recreation, 1201 16th St., N.W., Washington 6, D. C. Quantity discounts are available.

Frank Forry, M.D., Indianapolis, has been installed as president of the Indiana University Medical School Alumni Association.

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For the Diagnosis and Treatment of Psychiatric Disorders
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Dr. Nurnberger to Open North Shore Lectures

The Tenth Annual North Shore Hospital Lecture Series this year will be on the general subject of "Office Management of Emotional Disorders." The lectures are given at the hospital, 225 Sheridan Road, Winnetka, Ill., on the first Wednesday of each month from Oct. 1959 to June 1960, at 8 p.m. All members of the medical profession and allied professional personnel are cordially invited to attend the lectures. The program is approved for postgraduate training by the American Academy of General Practice.

The opening lecture, on Oct. 7, 1959, will be given by Dr. John I. Nurnberger, chairman of the Department of Psychiatry, Indiana University School of Medicine. The subject will be "Diagnostic Signs and Symptoms of Emotional Disorders." The program for the entire series is as follows:

Nov. 4, 1959. "Evaluation and Understanding of Emotional Disorders." C. Knight Aldrich, M.D., Department of Psychiatry, University of Chicago.

Dec. 2, 1959. "Drugs Useful in the Treatment of Emotional Disorders—Physiology, Indications, Contra-indications." Harold E. Himwich, M.D., Professorial Lecturer in Physiology, University of Illinois College of Medicine.

Jan. 6, 1960. "Management of Neuroses in the Office." Francis J. Gerty, M.D., Department of Psychiatry, University of Illinois College of Medicine.

Feb. 3, 1960. "Management of Psychoses in the Office." Benjamin Boshes, M.D., Department of Neurology and Psychiatry, Northwestern University Medical School.

Mar. 2, 1960. "Management of Psychosomatic Disorders in the Office." Jules H. Masserman, M.D., Professor of Neurology and Psychiatry, Northwestern University Medical School.

Apr. 6, 1960. "Management of the Alcoholic and the Drug Addict in the Office." H. H. Garner, M.D., Department of Psychiatry and Neurology, Chicago Medical School.

May 4, 1960. "Management of Behavior Problems in the Office." Henry H. Fineberg, M.D., Department of Psychiatry, Northwestern University Medical School.

June 1, 1960. "Management of the Psychiatric Patient Not Suited to Office Practice." Eugene S. Turrell, M.D., Department of Psychiatry, Marquette University School of Medicine.

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Maplecrest—

Restful, congenial homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.

Rhinologic Society Meets Oct. 7

The American Rhinologic Society will hold its fifth annual meeting in the Belmont Hotel, Chicago, October 10. This will be preceded by a surgical seminar in the Illinois Masonic Hospital, Chicago, October 7-9.

A special showing of scientific exhibits will open the hospital clinical program Wednesday. On Thursday and Friday the program will consist of lectures, surgical demonstrations, clinical reports with case presentations, and panels on osteotomies, implants and surgery of the lobular cartilages.

For further information write to Dr. Robert M. Hansen, secretary, 1735 N. Wheeler Avenue, Portland 12, Ore. Physicians and guests are invited. There is no registration fee.

Prize Offered For Goiter Paper

The Van Meter Prize award of $300.00 is again being offered by the American Goiter Association to the essayist submitting the best manuscript of original and unpublished work on "Goiter—especially its basic cause." The award will be made at the Fourth International Goiter Conference in London, England, July 5-9, 1960.

Essays may cover clinical or research investigations on any aspect of the thyroid gland and its functions in health or disease. They should not exceed 3,000 words, and must be presented in English. Duplicate typewritten copies, double spaced, are to be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Ave., Albany 10, New York, by January 1, 1960.

American abstracts for the Conference, to be considered for presentation, must be sent to J. E. Rall, M.D., National Institute of Arthritis and Metabolic Diseases, National Institutes of Health, Bethesda 14, Maryland, by December 1, 1959. They should not exceed 400 words, and should be submitted in quintuplicate.

Booklet to Help Youth Problems

"As Others See Us" is the title of a new 36-page booklet which offers suggestions for helping young people overcome some of their physical and psychological difficulties. Published by the Joint Committee on Health Problems in Education of the National Education Association and AMA, it covers such areas as appearance, poise, gracefulness and personal characteristics.

The booklet also discusses the effect of grooming, clothing, posture, manners, speech and physical defects problems which adolescents experience. Single copies, at 25c each, are available from the Order Department of AMA, 535 Dearborn Street, Chicago 10. Quantity discounts are also available.

Dr. Ambrose C. Estes, Bloomington, spoke in May at the first combined meeting of the Indiana and Kentucky chapters of the American College of Surgeons. His topic was "Surgical Bacteriology."

Dr. Mell B. Welborn, Evansville, was elected president of the Indiana chapter of the College of Surgeons at a May meeting.

Medical Writers to Meet

The American Medical Writers' Association will hold its 16th annual meeting at the Chase Hotel, St. Louis, Oct. 2 and 3. A 4-hour conference on Oct. 3 will include 3 sections: technical aspects of medical writing, contributions of other arts and sciences to medical writing, and technical aspects of publishing and editing.

Among more than 30 speakers listed on the program is Dr. W. D. Snively, Jr., Evansville, who is chairman of the Oct. 3 conference.

Hoosier Top Civil Servant

Dr. Roy H. Behnke, chief of medicine at Veterans Administration hospital in Indianapolis, received the 1959 Federal Civil Servant of the Year award in Indianapolis recently. Dr. Behnke is a former member of the Indiana University School of Medicine faculty.

Dr. John F. Rigg, Indianapolis, retired in July after 39 years of active practice in medicine in Indianapolis. He has moved to Miami Shores, Florida.



Surgeons Plan Congress

Atlantic City will be the meeting place for the 45th Annual Clinical Congress of the American College of Surgeons, Sept. 28 through Oct. 2, 1959. The program includes 9 postgraduate courses, panel discussions, symposia, research reports, motion pictures, color closed-circuit telecasts from Bellevue Hospital, New York, cine clinics, and scientific and industrial exhibits.

I.U. Gets Hill-Burton Grant

Two new Hill-Burton grants, totaling a Federal share of $135,077, were approved for Indiana University during April. Projects for the University Rehabilitation and Dental centers make a total of three projects approved but not under construction as of April 30. There were 35 projects under construction on that date, and 47 projects completed and in operation in Indiana.

Two Appointed To I.U. Faculty

President Herman B Wells of Indiana University has announced two new faculty appointments in the Indiana University School of Medicine in Indianapolis. Dr. Morton Alpert, formerly assistant professor of anatomy at Ohio State University, became associate professor of anatomy on August 1. Dr. Stuart Osborne Bondurant, formerly senior resident physician at Peter Bent Brigham Hospital in Boston, is now an assistant professor.



"Oh, you won't have any trouble finding my house, Doc. It's marked 'telephone' on the outside!"

Ultrasonic Medics to Meet

The American Institute of Ultrasonics in Medicine will hold their annual meeting September 2, at the Leamington Hotel, Minneapolis. Guest speaker at the luncheon meeting will be Russell Meyers, M.D., Professor of Surgery and chairman, Division of Neurosurgery, State University of Iowa Hospitals and College of Medicine, who will discuss "The Potentials of Ultrasonics in General Surgery and Surgical Specialties."

For any further information contact John H. Aldes, M.D., Secretary, 4833 Fountain Avenue, Los Angeles 29, Calif.

Business, church, civic and fraternal organizations of Fremont, Ind., joined forces in June to honor Dr. Blaine Blosser, who has practiced medicine for 50 years. Festivities included a parade, invitational dinner and a program and reception.

A graduate of Tri-State College and Bennett Medical School, Chicago, Dr. Blosser has also practiced in Fort Wayne and in Colorado Springs, where he did special work in tuberculosis.

A Chrisney, Ind., physician, Dr. Ivan L. Gailey, has been appointed medical director of the newly organized American Public Life Insurance Company. Dr. Gailey, a graduate of Washington and Jefferson College, is a member of Who's Who in the Midwest. The insurance firm was incorporated in March.

A Muncie, Ind., physician is the new vice-chairman of the Section of General Practice of the American Medical Association. Dr. Charles R. Alvey took office at the Atlantic City meeting of AMA in June.

Dr. J. W. Ricketts, Indianapolis, retired in June and has moved his residence to Florida.

Dr. Kenneth L. Craft, Indianapolis, was moderator of a panel discussion on "Nasal Polyps" at the annual meeting of the Southwest Forum on Allergy in Houston, Texas, last spring.

Dr. Robert F. Heimburger, Indianapolis neurological surgeon, spoke on "Steriotactic Brain Surgery" at a meeting of the board of United Cerebral Palsy of Central Indiana, in May.

Add 1

Hobby Show Is Your Show; Health Inspections: A Controversy

by corki

Hobby, Hobby, who's got a Hobby? Or, for that matter, is there an artist in the house?

According to the reliable old grapevine (or scuttlebutt if you are an ex-sea surgeon), there are a lot of doctors in this organization who are pretty outstanding with paints and canvass, some tops with cameras and many others who have hobbies in a big way.

To you in the above categories I speak!

Hopes are high that the Art and Hobby Show at the annual convention in October will be bigger and better this year. And this is your show, doctor! Only those of you who are artists and hobbiests can make it bigger and better.

Last year's show featured an excellent display of paintings, photos and hobbies and drew a great deal of fine comments (it was one of my favorite hiding places at the convention . . . if it can be considered hiding to be among a throng of people admiring displayed talent).

Dr. Philip T. Holland of Bloomington, who is making plans for the show, reports that there will be winners named in the following classes:

Black and white photography
Color photography
Oils
Pastels or water color (also includes black and white drawings)
Sculptures
Other crafts and hobbies

Special consideration will be given to those who have been working at their art or hobby two years or less.

First, second and third place ribbons will be given in each class. Judges will be experts in the field of arts and crafts.

In order to aid in planning the exhibit, Dr. Holland requests that those who plan to enter notify ISMA headquarters office, 1021 Hume Mansur Bldg., Indianapolis 4, **right away.** He needs name of exhibitor and what he (or she) will be exhibiting.

So don't miss out on being a part of this show. Get your name into the ISMA office RA'T NOW! You hear?



"Have those tranquilizers been relaxing you, Mabel? Mabel . . . OH, MABEL!"

Basis for Modern Prosperity. A California friend sent me the January cover of *The New Yorker* and it intrigues me.

A Steinberg cartoon, it shows Uncle Sam and Uncle Tom shaking hands at the very base. To the left is an "Unemployment" lion with an arrow piercing through him and a "Semantics" fish. At right an arrow with a "Statistics" flag pierces through an "Inflation" bird.

Above a "Happiness" 'gater hangs onto a yellow snake-like creature with a 'gater mouth tabbed "The Pursuit of." Each hangs onto the other's tail with sawteeth.

Then, to left and right, and upper left and right are eight little men who appear to be in

Add 1

Continued

grey flannel suits. "Vice & Virtue" shake hands; "Labor & Leisure" shake hands; "Art and Industry" shake hands; and "Science and Commerce" shake hands.

At left on a special pedestal is Santa Claus and at right Sigmund Freud. Topping it all off, standing on the whole conglomeration, is "Prosperity," symbolized by a short, squat man in brown suit with top hat, and manacled to chains that hang down.

Now interpreting this is interesting. Each symbol in itself can be cause not only for comment, but for a downright pitched battle. Put them all together and they spell a "discussion" that could go far into the night over whatever you are drinking. If anyone cares to pick up the discussion, I can begin philosophising at 4:30 p.m. DST any weekday!

Health Inspections??? Under the "Fourth Estate" section in this *Journal* issue, page 1246, you will find an editorial from the *Chicago Tribune*, dated May 5, on the controversial subject of the 5-to-4 decision of the Supreme Court upholding a Baltimore sanitary inspection ordinance . . .

To wit: a duly authorized health inspector can enter a private dwelling to inspect for health-endangering conditions without a formal search warrant.

A hue and cry has gone up over this decision . . . and it is one that vitally affects the medical profession from two sides . . . from that of private citizens and that of protectors of health.



"At the party tonight stop telling everyone that your husband practices infernal medicine!"

On the one hand:

The *Chicago Tribune* upholds the Supreme Court, giving as evidence both the Baltimore ordinance, which has been in effect 150 years without it being used against a private citizen for more than the protection of public health; and the Chicago health service which, it says, has been operating without warrants for 50 years. . . . And, it continues to say that in Chicago, as in scores of other cities, this procedure has been used without it becoming a wedge to entry without warrant on anything except sanitary inspection.

I have a few questions: If the vast majority of our citizenry operated under the belief there were NO exceptions to the "enter without warrant" rule, was illegal use of its demise ever really tested (as I interpret this claim by the Hurst paper)? Even if the health "waiver" *could never* be used as a wedge for other legal entries without warrant, couldn't dishonest officials make use of this one to impose on private citizens? (Maybe Baltimore and Chicago *have* all honest officials . . . but human nature being what it is, how long can this go on?) AND, wouldn't it be easier to forge a health officer's credential than a court warrant?

There are many more questions on this issue; but I always believe in bringing such an issue down to the basic values as much as possible. To me, the basis is in the individual home. Suppose, doctor, your wife is home alone and a stranger comes to the door flashing a "health inspector credential." Is she to let him in on the supposition that his credentials are real? What's to keep any number of con men, improper law officials, etc., et cetera, et cetera, from utilizing this "new" law to victimize the private citizen . . . your wife, or single women like me . . . or even you, yourself?

This just for the sake of argument! (Must be my day to argue!)

On the other hand (still for the sake of argument):

As a protector of health, you might argue that such a law is necessary. I'd really like to hear more of the arguments to back up this conten-

tion; for, as yet, I've seen no examples showing the dire necessity for such tremendous speed in protecting public health from unhealthy conditions existing in private homes that couldn't wait a few more hours for the necessary court warrant.

Thus far, the issue is generalization and theory as far as I can see (or perhaps I need an opthalmologist) . . . for, since the Supreme Court decision, there's been little enough time for individual testing of the act or law or what-have-you.

However, maybe I'm a bit bullheaded and one of those who are deterring progress, but it would take a lot of good, sound facts to convince me that it is better to give *any* official the right to enter at his own discretion, rather than keep what we've traditionally believed to be protection by legal court from unwarranted entry.

It would take a lot of convincing to make me believe that every citizen shouldn't join in a hue and cry against this deprivation of traditional protection of the individual citizen!

Anyone care to discuss this one?

Dr. William J. Stangle, Bloomington radiologist, took over the presidency of that city's Rotary Club on July 1. Dr. Stangle is a senior member of Stangle, Edmonds and McIntire, radiology firm.

Two northern Indiana doctors have been elected to offices in the Northern Tri-State Medical Association. Dr. Donald G. Mason, Angola, is the new president, and Dr. John C. Richter, Laporte, will serve as the secretary-treasurer.

Indiana physicians recently certified by the American Board of Obstetrics and Gynecology are Dr. Lewis H. Knight, Fort Wayne, and Drs. William M. Huse and John R. Melin, Indianapolis.

Certificates of Fellowship in the American College of Chest Physicians were awarded to Drs. Pasquale D. Genovese, Indianapolis, and William C. von der Lieth, Vincennes, at the annual meeting, June 4 in Atlantic City.

don't miss

next month's

JOURNAL

★ Final Convention Program

★ ISMA Officers' Photos

★ Convention Information

★ Convention Business

and

★ Pre-convention Registration Forms

and

★ A full Scientific Section on Rabies

★ A paper on Brainwashing in Korean POW Camps

Deaths . . .

Lehman M. Dunning, M.D.

Dr. Lehman M. Dunning, 75, a general practitioner for over 50 years, died June 3 in his Indianapolis office.

A native of South Bend, he had lived in Indianapolis for 65 years. Dr. Dunning was a graduate of Princeton University and obtained his M.D. from Indiana University School of Medicine in 1908. He interned at Indianapolis City Hospital. He was a faculty member of the I. U. School of Medicine before he entered the Army Medical Corps during World War I.

Dr. Dunning was a 50-Year Club member of ISMA. He also belonged to AMA and All Souls Unitarian Church.

Freeman E. Keith, M.D.

Dr. Freeman E. Keith, 86, a senior and 50-Year Club ISMA member, died June 6 in his St. Bernice home.

Dr. Keith, who was born in Ontario, Canada, came to the United States at the age of 16. He graduated from the Medical College of Indiana at Indianapolis in 1897 and practiced at Richmond prior to establishing an office at Clinton in 1944. Recently, he had been in semi-retirement and practiced only from his St. Bernice home.

Dr. Keith was a member of AMA and the First Church of the Nazarene in St. Bernice.

Maynard F. Poland, M.D.

Dr. Maynard F. Poland, well-known Indianapolis surgeon and medical instructor, died June 11 at Veterans Administration Hospital in Indianapolis.

A native of Fairland, Ind., Dr. Poland received his A.B. degree from Indiana University in 1923, after which he became a teacher in the Bloomington schools. He enrolled in medicine at I. U. and received his M.D. degree in 1931.

Dr. Poland was a veteran of both world wars. He practiced medicine in Bloomington from 1935-42, then moved to Indianapolis, where he did cancer research at Eli Lilly Co., was surgical consultant for Veterans Administration and was a Butler University instructor.

He is a former instructor at Indiana University, Montreal University (Canada), Marion County General Hospital and the Indiana College of Embalming. Dr. Poland had been staff resident at Methodist, St. Vincent's and St. Francis hospitals in Indianapolis.

He was a member of the Indiana Council of Family Relations, National Congress of Parent-Teacher Associations, Board of Weekday Religious Activities, American Academy of Political and Social Sciences, Butler University Faculty Club, I.U. Alumni Association, and an elder at Northwood Christian Church, Indianapolis.

Will A. Thompson, M.D.

Dr. Will A. Thompson, 81, Union County health officer for nearly 50 years, and former president of the Union-Wayne Medical Society, died June 5 in Reid Memorial Hospital at Richmond.

Dr. Thompson attended Wabash College, and graduated from the Indiana University School of Medicine in 1909, after which he began practice which lasted nearly 50 years in Liberty. He was appointed health officer two years after beginning his practice.

Dr. Thompson was a delegate to ISMA, representing Union and Wayne counties for 16 years. He was to receive his 50-Year Club pin this fall.

Dr. Thompson was active in political and civic circles, a member of the Memorial Methodist Church, Liberty Masonic Lodge, Elks Lodge at Richmond and Liberty Commercial Club. He was on the state medical licensing board for a 4-year term.

Lemon Randle Young, M.D.

Dr. Lemon Randle Young, Jr., general practitioner for 25 years, died May 28 in his Indianapolis home. He was 50.

A native of Meridian, Miss., Dr. Young had lived in Indianapolis since 1922. He was a graduate of Lincoln University, Lincoln, Pa., attended the University of Michigan, and received his M.D. from Indiana University in 1934. He interned at Provident Hospital, Boston.

Dr. Young was a member of Mt. Zion Church, Omega Psi Phi Fraternity, Y.M.C.A., AMA and Aesculapian Medical Society.

Association Reports

EXECUTIVE COMMITTEE

June 3, 1959

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; O. W. Sicks, M.D.

Statement from the Wolf Management Engineering Company in the amount of $3,864.32 was approved for payment on motion of Drs. Owsley and Covalt.

A combined profit and loss statement from Wolf Management Company was approved by consent and comment made that this was one of the best organized statements that the Committee had seen.

Membership Report

Number of members as of May 31, 1958		4,112
1959 members as of June 1, 1959:		
Full dues paying	3,530	
Residents and interns	204	
Council remitted	38	
Senior	385	
Military	43	
Honorary	1	
Total members as of June 1, 1959		4,201
Gain over last year		89
Number of members December 31, 1958		4,201
Delinquent members as of June 1, 1959		44
Number of AMA members as of May 31, 1958		3,980

1959 AMA members:

Dues paying	3,359	
Exempt, but active	715	
Total 1959 AMA members as of June 1, 1959		4,074
Gain over last year		94
Number of AMA members as of December 31, 1958		4,054
Delinquent AMA members as of May 31, 1959		188*

Headquarters Office

The report of the Building Committee, directed to the Executive Committee, was read.

Letters from architects concerning proposals for working with the Association in preparing drawings and designs for consideration were read, and upon motion of Drs. Mericle and Covalt the chairman, Dr. Wood, was authorized to negotiate with the architects in accordance with the recommendations of the Building Committee.

Employers application from Blue Cross-Blue Shield covering the headquarters office group was authorized to be signed by the executive secretary on motion of Drs. Mericle and Owsley.

Treasurer's Office

The report of the treasurer was approved on motion of Drs. Mericle and Covalt.

Legislative Matters
National

A bulletin from the Valparaiso Chamber of Commerce requesting the Association to lend its support by contacting the members of Congress concerning the establishment of an Indiana port was read and upon motion of Drs. Owsley and Mericle the secretary was authorized to take appropriate steps to support this program.

Participation in the Republican Congressional Dinner at Washington, D. C., on June 8, 1959, for which it was suggested that the Association buy plates at $100.00 each and give the tickets to the Indiana delegation was turned down by consent.

1959 Annual Convention, Indianapolis, October 6 to 9, 1959

The selection of a member of the Fifty-Year Club to make the response for the Club at the annual banquet was considered, and it was agreed by consent that Dr. Will Thompson and Dr. J. W. Ricketts should be contacted.

Organization Matters

A letter from Thomas A. Troeger, secretary of the Indiana Chapter of the Student AMA, was read in which he reported the names of those who attended and participated in the Student AMA meeting in Chicago, and returning $90.00 of unused money. By consent it was agreed that the Student AMA Indiana Chapter is to be requested to give a five-minute report on its activities before the House of Delegates at the first meeting in October.

A letter from Mrs. J. M. Black, president of the Woman's Auxiliary to the Indiana State Medical Association, was read in which she proposed that the Auxiliary undertake a program of making an annual award to some individual who made an outstanding contribution to the advancement of public health, and it was noted that the selection of the recipient would not be finally made until counsel had been held with the Executive Committee. On the basis of this, the request of the Auxiliary was approved, on motion of Drs. Owsley and Covalt.

The question concerning what type of program

* 125 of these have paid state dues but have not paid AMA dues.

the Auxiliary might develop for the first night of the convention was also discussed and the Auxiliary is to be informed that it may design any type program the members might desire.

Letter from Mr. K. L. Kaufman, general chairman of the 1960 National Science Fair, in which he requested the Association to financially support the 1960 Science Fair, was read, and by consent it was agreed that the Commission on Public Information be requested to appropriate $1,000.00 of its funds for this purpose.

Letters of appreciation from several participants in the 1959 Science Fair were read in which the Association was thanked for making the trip to the National Science Fair possible.

A letter from the North Central District Blood Bank Clearing House calling attention to the fact that Indiana should appoint a member to the Board of Directors was read, and upon motion of Drs. Owsley and Covalt, Dr. Jene R. Bennett, of South Bend, is to be reappointed.

A letter from William S. Kroger, M.D., of Chicago, requesting permission to conduct courses in Clinical Hypnosis and Psychosomatics was read, and by consent it was the opinion of the Committee that there would be no objection to offering these courses.

A letter from Dr. A. C. Offutt asking the Association to recommend two members to serve on the Vision Advisory Committee as created by the 1959 State Legislature was read, and by consent the names of Dr. Richard P. Good, Kokomo, and Dr. James V. Cassady, South Bend, were to be submitted.

Letter from Dr. John Ray Frank was read and upon motion of Dr. Mericle and taken by consent the letter is to be answered by Mr. Hollowell inasmuch as there is no action the Association can take in this matter.

A request from Dr. A. C. Offutt for a recommendation by the Association of a physician for membership on the Commission for the Handicapped was presented to the Committee. On motion of Dr. Owsley, taken by consent, the name of Dr. Neal E. Baxter is to be submitted.

Request for participation by the Association in an amount not to exceed $25.00 in the Farm-City Week program was turned down by consent.

Letter from the National Society for Medical Research requesting a contribution from the Association was turned down by consent.

Statement from the Joint Committee on Improvement of Patient Care in Indiana in the amount of $25.00 was approved for payment by consent.

A $50.00 membership in the United States Chamber of Commerce was approved on motion of Dr. Mericle, taken by consent.

Letter from Mr. Hollowell regarding the civil defense program was referred by consent to the Commission on Legislation.

New Business

Upon motion of Drs. Owsley and Mericle the Executive Committee is to recommend to the Program Committee that plans be made for a time for a Blue Shield panel program to be held during the 1959 annual convention, at which time the members of the Board of Directors of Blue Shield would be available for an open discussion of Blue Shield plans and policies.

Dr. Owsley brought up the question of the over-65 age group, and upon motion of Dr. Owsley, taken by consent, the Auxiliary is to be encouraged to pursue a survey of the 65 and over group in Indiana, and the Commission on Public Health is to be requested to work with the Auxiliary on this program.

The Committee expressed its appreciation to Dr. Forrest E. Keeling and the management of the Portland Country Club for the splendid arrangements which had been made for the Executive Committee meeting.

There being no further business, the Committee adjourned to meet again at 6 p.m. on Saturday, July 11, 1959, at the Student Union Building, I. U. Medical Center, Indianapolis.

Lighter Vein—

Parents: People who bear infants, bore teenagers and board newlyweds.—Paul V. Hale.

Sound Barrier: What you should have between the rumpus room and the rest of the house.—Francis O. Walsh.

Whatever happened to that wonderful type of woman who couldn't stand a man underfoot when she was doing the housework?—Ken Kraft.

The only culture many children are exposed to is bacteria.—Bert Kruse.

The main difference between Russia and the U. S. is in the former the state owns everything and in the latter the finance companies do.—George N. Hall.

From a report of the American Psychological Association: "Women who are co-operative and good sports are more likely to have big families."—*Journal of the American Medical Association.*

The new football stadium at West Texas State College is provided with outlets for spectators' electric blankets.—*Quote.*

One should no longer sing, "If I had the wings of an angel," but "If I had the thrust of a satellite's rockets."—*Nuggets,* Barnes-Ross Co.

Summer brings the urge to hit the open road—which you usually find closed for repairs.—*Lake Mills* (Iowa) *Graphic.*



"I thought I'd never make it to work this morning, doctor; I missed a bus!"



"Perhaps it's a slipped gallstone!"

The reason loudmouths usually are bigheaded is because hot air has a tendency to expand.—George N. Hall.

Those who think radio is old-fashioned should remember it's never yet been accused of showing an old movie.—Lester D. Klimek.

Another advantage of owning a midget car is that it can double as a golf cart.—Vesta M. Kelly.

Considering the way girls dress in summer, it is hard to believe that they really love clothes.—Vesta M. Kelly.

One of the teacher's constant tasks is to take a roomful of live wires and see that they are grounded.—*Wisconsin Journal of Education.*

We see fewer wallflowers at parties these days—and a lot more of the potted variety.—D. O. Flynn.

America has drive-in theatres, drive-in supermarkets, drive-in restaurants and drive-in banks. What it needs now is more drive-in parking places.—Dan Bennett.

Two nights a week I attend night school at a local college where most of the students are hard-working business men trying hard to get their degrees. An English prof, complimenting us on our excellent scholastic record, said: "I hold you up to my day students, telling them how you family men work all day and still get better grades than they do."

"Oh, I wouldn't be hard on them," one business man commented: "After all, they take their report cards home to understanding parents. We have to face our kids!"—Ernest Blevins.

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The JOURNAL is interested in full-length scientific papers and case reports for early publication. This is an open invitation to you to submit such work. Each paper is given careful consideration.

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*Barrett, C. D., Jr., *et al.*: *J.A.M.A.* 167:1103, 1958; *Id.*; Am. J. Pub. Health 49:644, 1959.

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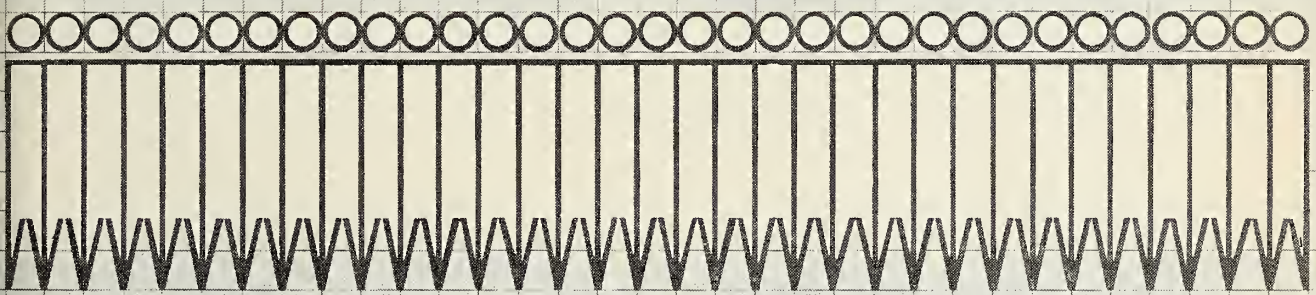
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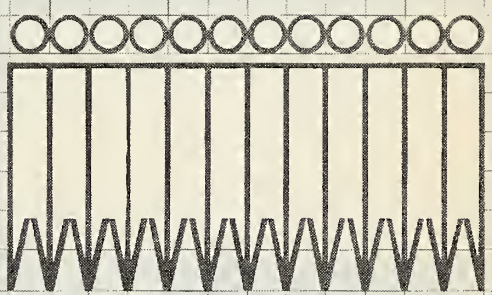
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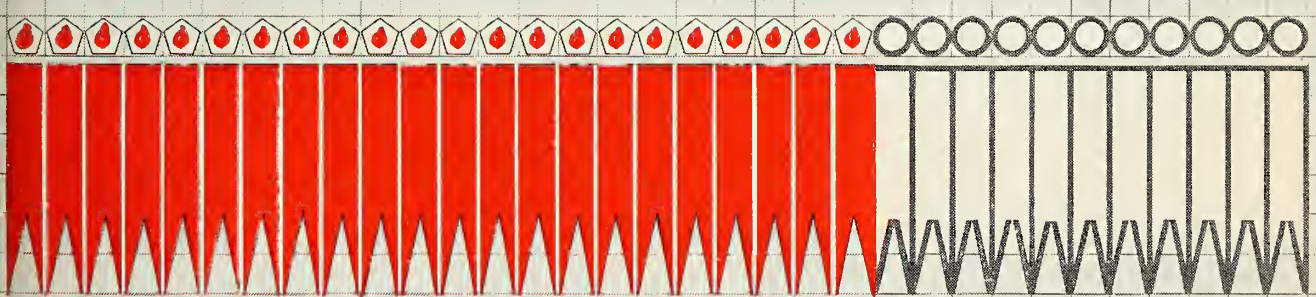
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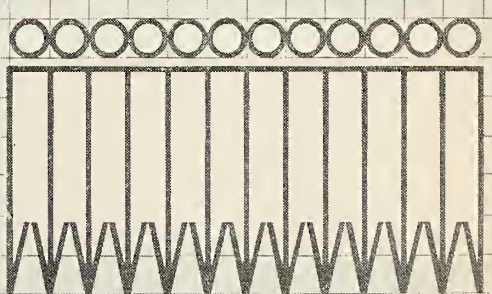
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2.	Herbert O. Chattin, M.D., Vincennes	J. S. Brown, M.D., Carlisle	1960
3.	P. T. Hodgin, M.D., Orleans	(to be appointed)	Fench Lick, 1960
4.	Robert M. Reid, M.D., Columbus	David L. Adler, M.D., Columbus	Columbus, May 11, 1960
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7.	Leon Gray, M.D., Martinsville	Herbert L. Egbert, M.D., Indianapolis	Fall, 1959
8.	Richard C. Swan, M.D., Anderson	M. P. Benoit, M.D., Anderson	Anderson, June 8, 1960
9.	Harry E. Klepinger, M.D., Lafayette	Forrest J. Babb, M.D., Stockwell	Lafayette, May 18, 1960
10.	Martin O'Neill, M.D., Valparaiso	John R. Frank, M.D., Valparaiso	1960
11.	Eugene Cook, M.D., North Manchester	C. L. Wise, M.D., Camden	Monticello, Sept. 16, 1959
12.	Harold F. Zwick, M.D., Decatur	Stephen C. Michaelis, M.D., Fort Wayne	1960
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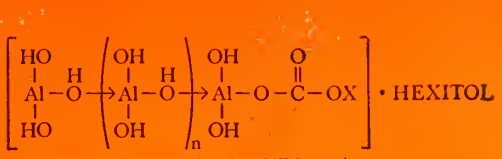
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Perry	John M. James, Tell City	Noel L. Neifert, 515 Main St., Tell City
Pike	M. H. Omstead, Petersburg	M. H. Omstead
Porter	F. J. Kleinman, Valparaiso	Ralph C. Eades, 6 Napoleon St., Valparaiso
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Starke	J. R. Matthew, North Judson	Earl R. Leinbach, Hamlet
Steuben	Robert Barton, Angola	M. M. Crum, Angola
Sullivan	Joe E. Dukes, M.D., Dugger	J. S. Brown, M.D., Carlisle
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Tipton	R. K. Kincaid, Tipton	R. T. Belding, Kempton
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Vigo	William O. Baldridge, Terre Haute	Hubert T. Goodman, 410 Rose Dispensary Bldg., Terre Haute
Wabash	Robert A. Rauh, Wabash	Robert M. LaSalle, Jr., 55 W. Market St., Wabash
Warrick	Arthur R. Rogers, Newburgh	Robert Colvin, Newburgh
Washington	I. E. Huckleberry, Salem	H. G. Coleman, Salem
Wayne-Union	Paul Dingle, Richmond	Morris Wertenberger, Reid Memorial Hospital, Richmond
Wells	Robert G. Cook, Bluffton	Charles E. Jackson, Bluffton
White	Stanley E. McClure, Monon	David C. Beck, Monticello
Whitley	L. J. Minick, Churubusco	D. B. Reid, Columbia City

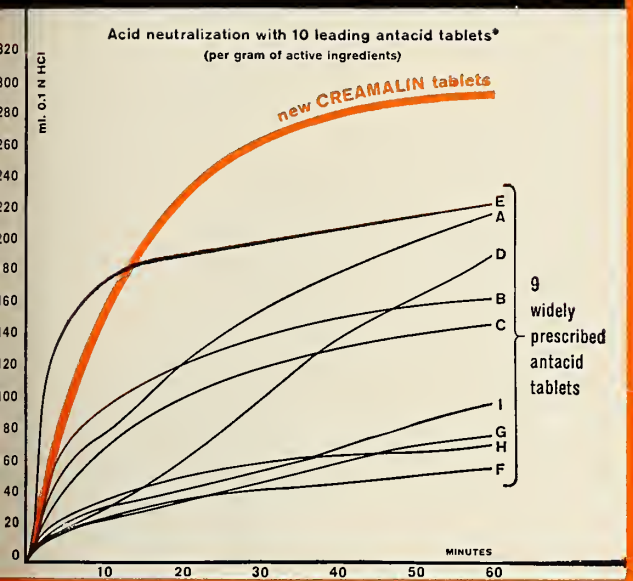
a new high in effectiveness and palatability



n is at least 1 and averages less than 6. X is a cation.

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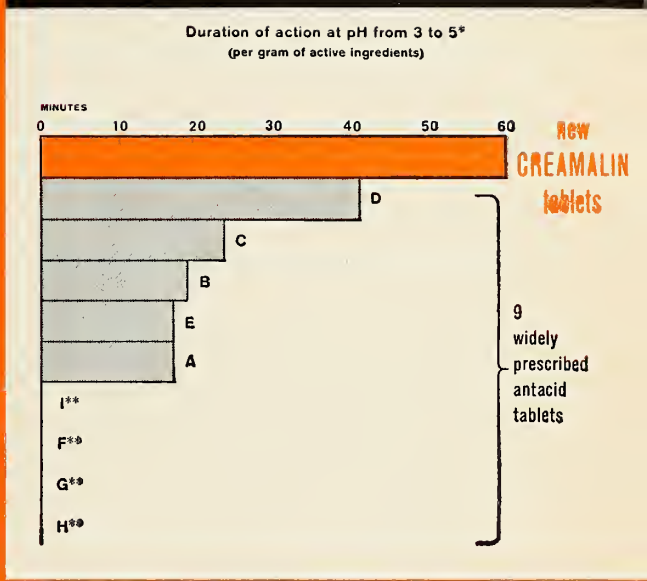
Quicker Relief • Greater Relief



tablets were powdered and suspended in distilled water in a constant temperature bath at 37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour.

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More Lasting Relief



*Hinkel, E. T., Jr., Fisher, and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.

**pH stayed below 3.





No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

• NO ACID REBOUND • NO CONSTIPATION
• NO SYSTEMIC EFFECT

Adult Dosage: Gastric hyperacidity: 2 to 4 tablets as necessary. Peptic ulcer or gastritis: 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

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This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and airmailed to THE JOURNAL on the ninth of each month preceding month of issue.

THE MONTH IN WASHINGTON

Washington, D.C. -- The House Ways and Means Committee has put aside until next year the so-called Forand bill which is opposed vigorously by the medical profession.

But supporters of the legislation have made clear that they will press for action by Congress next year when politics will be paramount because of the presidential and Congressional elections in November.

The Ways and Means Committee took no action on the legislation after five days of hearings highlighted by the Eisenhower Administration lining up with the medical profession in opposition to it.

Arthur S. Flemming, Secretary of Health, Education and Welfare, told the committee that "it would be very unwise" to enact such a bill. He warned of "far-reaching and irrevocable consequences." It would freeze health coverage of the aged "in a vast and uniform government system" and would mark the beginning of the end of voluntary health insurance for old persons, he said.

Secretary Flemming later promised to report to Congress early next year on possible alternatives, including Federal subsidies to private carriers of health insurance for the aged. But he took no position on any of the alternatives for the time being.

Summing up the hearings, Dr. F.J.L. Blasingame, executive vice president of the AMA, said:

"It was shown that it would be most unfortunate for the federal government to move in for political reasons and attempt in a compulsory fashion to solve by legislation problems which are being thoughtfully considered at the state and local level by the medical profession and other dedicated members of the health team."

Main support for the bill, which was sponsored by Rep. Aime J. Forand (D.,R.I.), comes from organized labor. The legislation would increase Federal Social Security taxes to finance hospital, surgical and nursing home care for Social Security beneficiaries.

Although this bill has been shelved for the time being by the House Committee, the problems of the aged are being studied by a Senate subcommittee headed by Sen. Pat McNamara (D.,Mich.). The Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare has held public hearings intermittently in Washington. It also planned to hold hearings in various other cities.

In his second appearance before the Senate Subcommittee, Dr. Fred-

Continued on page 1428



now...a new way to relieve pain and stiffness in muscles and joints

- Exhibits unusual analgesic properties, different from those of any other drug
- Specific and superior for relief of SOMAtic pain
- Modifies central perception of pain without abolishing natural defense reflexes
- Relaxes abnormal tension of skeletal muscle

SOMA™

N-Isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

In back pain, bursitis, sprains, strains, and bruises, whiplash and other traumatic injuries, inflammatory and degenerative muscle and joint complaints.

Many patients report they feel better and sleep better with SOMA than with any previously used analgesic or relaxant drug.

SOMA often makes possible reduction or elimination of steroids, salicylates, sedatives and narcotics.

RAPID ACTING. Pain-relieving and relaxant effects start within 30 minutes and last for at least 6 hours.

NOTABLY SAFE. Toxicity is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy on higher than recommended dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white sugar-coated 350 mg. tablets.

Literature and samples on request.

WALLACE LABORATORIES, NEW BRUNSWICK, N. J.

Continued

erick C. Swartz, chairman of the AMA's Committee on Aging, reported that state and local medical associations "have moved promptly" to make the AMA's six-point "positive health program" for the aged "an effective and workable instrument."

Dr. Swartz said that the problem of financing health services for the aged is "a temporary, not a permanent one" because "each year, more and more of the Americans who are reaching 65 are covered" by voluntary insurance.

*** ***

Democrats in Congress cut back their housing program further after President Eisenhower vetoed a $1.4 billion bill. Starting with a $2.1 billion program, Democrats came down to the $1.4 billion figure in an effort to avoid a veto although it was a more expensive program than Mr. Eisenhower wanted.

After the President vetoed this bill anyway, Democrats came up with $1 billion bill which retained three provisions of interest to the medical profession.

They would:

1) provide construction loan guarantees by the Federal Housing Administration of up to 75% of the cost of proprietary nursing homes; 2) authorize $25 million in direct loans for construction of housing for interns and nurses, and 3) authorize a $50 million revolving fund for direct loans to help private nonprofit corporations build rental housin for the elderly.

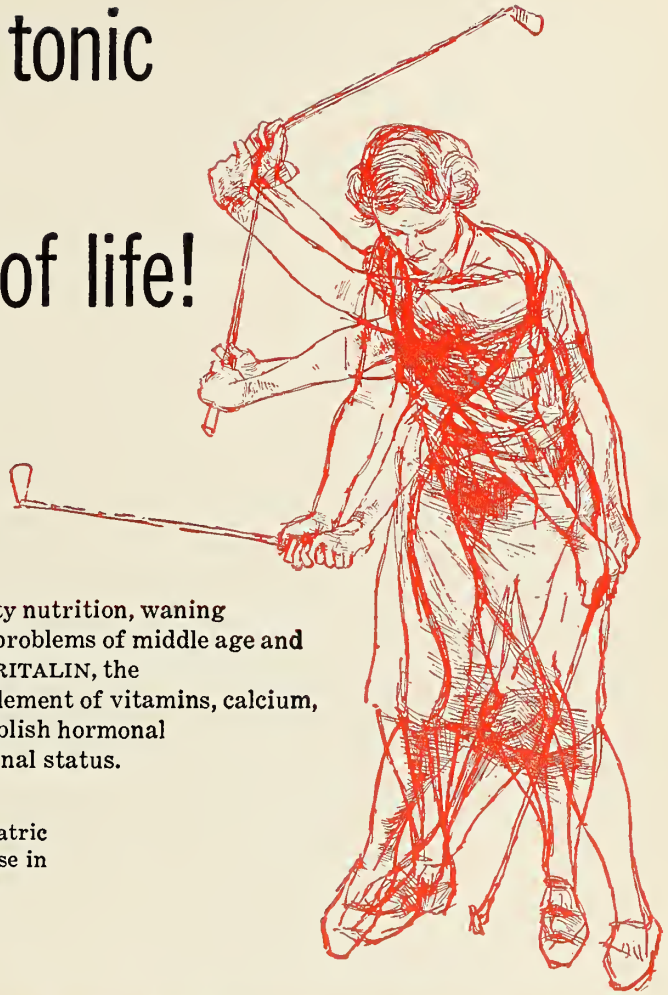
*** ***

Congress voted a compromise $400 million appropriation for medical research. The amount was about $80 million less than approved by the Senate, but was more than $100 million above the Eisenhower Administration's request for the National Institutes of Health.

The allotments for research in specific fields included: cancer, $91 million; mental health, $68 million; heart, $62 million; arthritis, $47 million; neurology, $41 million; allergy, $34 million.

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A sense of frustration and inadequacy, faulty nutrition, waning gonadal function—RITONIC meets all these problems of middle age and senile let-down. The unique combination of RITALIN, the *safe* central stimulant, with a balanced complement of vitamins, calcium, and hormones acts to renew vitality, re-establish hormonal and anabolic benefits, and improve nutritional status.

"We found Ritonic to be a safe, effective geriatric supplement . . ."[1] "Patients reported an increase in alertness, vitality and sense of well being."[2]

PRESCRIBE RITONIC

for your geriatric patients, your middle-aged patients and your postmenopausal patients.

Each Ritonic Capsule contains:

Ritalin® hydrochloride	5 mg.
methyltestosterone	1.25 mg.
ethinyl estradiol	5 micrograms
thiamin (vitamin B_1)	5 mg.
riboflavin (vitamin B_2)	1 mg.
pyridoxin (vitamin B_6)	2 mg.
vitamin B_{12} activity	2 micrograms
nicotinamide	25 mg.
dicalcium phosphate	250 mg.

Remember
SERPASIL®
(reserpine CIBA)
for the anxious hypertensive with or without tachycardia

Dosage: One Ritonic Capsule in mid-morning and one in mid-afternoon.
Supplied: Ritonic CAPSULES; bottles of 100.
References: 1. Natenshon, A. L.: J. Am. Geriatrics Soc. *6*:534 (July) 1958.
2. Bachrach, S.: To be published.
RITALIN® hydrochloride (methylphenidate hydrochloride CIBA)

C I B A SUMMIT, N. J.

The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Rabies in Indiana . . .

A four-year-old Sullivan county boy died of rabies, based on preliminary laboratory tests reported last week by the state board of health.

While this was the first human death from rabies reported in Indiana since 1957, the danger to people is practically continuous because of the greater incidence of rabies in animals which may transmit the disease to humans.

The state health department's report for the week ending July 4 showed 77 cases of animal rabies had been discovered in this state for 1959 to date.

These included: Dog, 58; fox, 7; cow, 5; cat, 1; horse, 1; opossum, 1; rabbit, 1; skunk, 1.

Incidentally, a health authority tells us that the fox is believed to be the "chief wildlife rabies reservoir in Indiana." It is easy to see how rabies can be spread when a fox bites a stray dog, of which we have so many.

As for animal bites, the state health department had reports of 3,440 in the state for 1959 up to July 4. This is a big increase over the 2,005 reported for the same period in 1958.

Here in the city of Elkhart, 137 bites had been reported up to Monday of this week, compared to 229 for the whole year of 1958.

Thus the "bite rate" is also higher in Elkhart, and considering the large number of strays in our area we may be lucky the number is not higher.

Reported dog bites, of course, are not a reliable index as to actual bites.

It can be assumed that a number of bites occur which are not reported, though they should be, in the interests of protection against rabies.

R.W.S.
The Elkhart Truth
July 15

Eisenhower Sticks Needle into Nation's Doctors

Hospital Costs Have Risen 20 Per Cent in 20 Years

By JAMES MARLOW
Associated Press News Analyst

Washington (AP) — President Eisenhower, making a 1959 crusade against inflation, this week stuck a needle in the nation's doctors.

He told them in effect medical services should be kept within reason.

The government's figures show that living costs in general have gone up 108.6 per cent since 1939. Which means: What you could buy for $1 in 1939 would cost you $2.08 today.

In that same 20-year period the rise in hospital costs eclipsed almost everything else in the various categories which make up the government's total picture of living costs. They went up around 300 per cent.

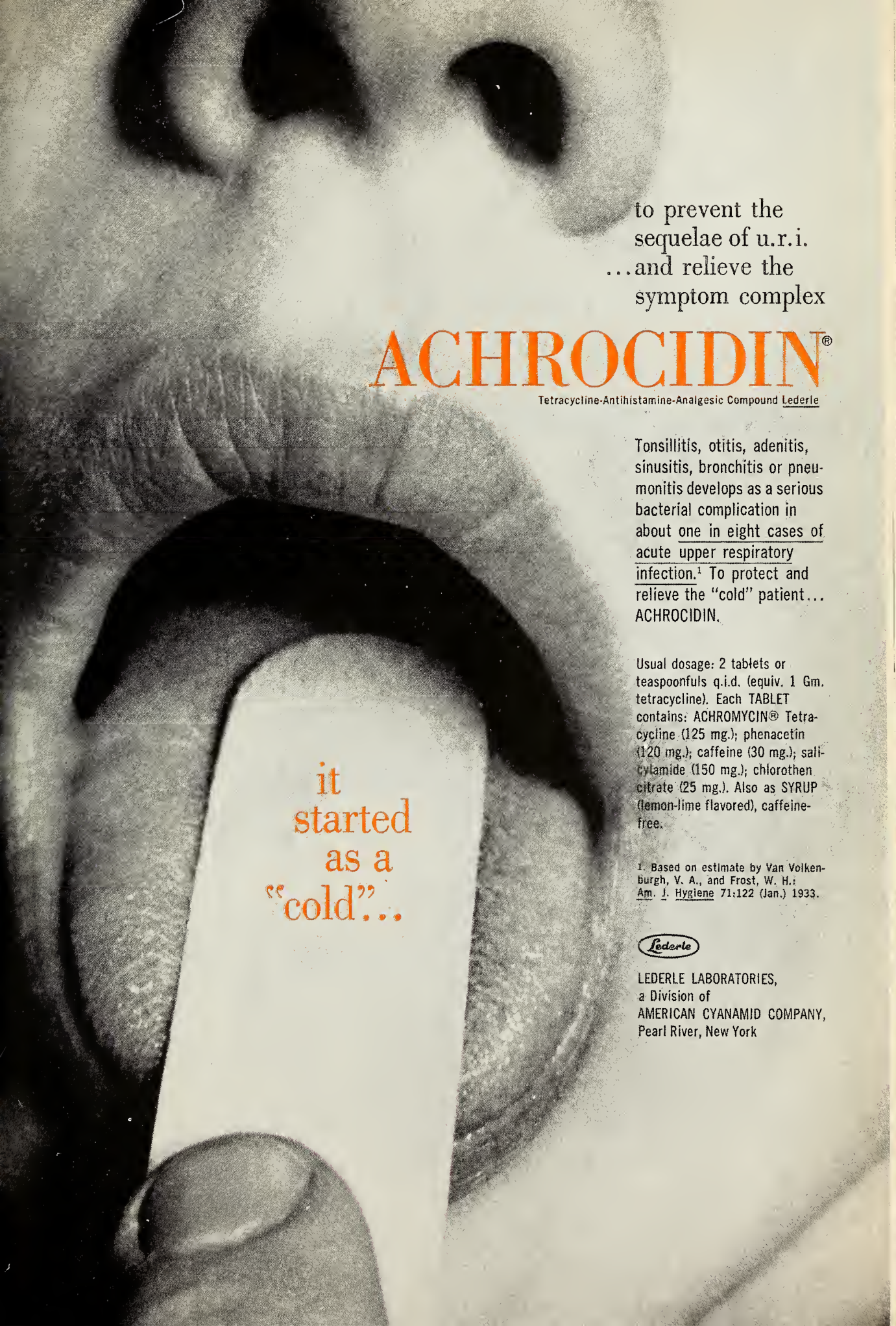
In those 20 years doctors' fees have climbed 84 per cent. Some of the items in other categories were much higher—in their rise—than doctors' fees, some were lower.

Eisenhower, using his speech to the American Medical Assn. convention in Atlantic City Tuesday night to support the practice of private medicine as against a government medical care program, told the doctors:

"The medical profession, as much as any other, has a vital interest in preventing inflation. Certainly it wants to provide its services for a fee within range of what people can reasonably pay.

"If the time ever comes when large numbers of our citizens turn primarily to the government for assistance in what ought to remain a private arrangement between doctor and patient, then we shall all have suffered a great loss."

Although in the 20 years since 1939 the government's broad category of "medical care" rose just a little less than the general cost of living—106.1 per cent as compared with 108.6 per cent—



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...and relieve the
symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Tonsillitis, otitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

Lederle

LEDERLE LABORATORIES,
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AMERICAN CYANAMID COMPANY,
Pearl River, New York

Fourth Estate

Continued

there is a big variation in the cost of the items which go into that category.

Here are some other examples of how living costs have risen in the 20 years since 1939:

In that period food costs—as a whole—have zoomed up 149.7 per cent, the biggest single jump in all the major categories which make up the government's living cost index.

The cost of housing has gone up 69.1 per cent, and this figure includes house purchase, interest, taxes, insurance and upkeep; rent up 60.9 per cent; gas and electricity, 12.7 per cent; solid fuels and oil, 145.9 per cent; house furnishings, 94.4 per cent.

Here are some other 20-year increases in various things people pay for under the head of living costs:

New cars went up around 125 per cent; men's haircuts, 206 per cent; gasoline, 69 per cent; household appliances, 33 per cent; newspapers, 124 per cent; and movie admissions, 120 per cent.

Kokomo Tribune
June 11

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE

INTENSIVE POSTGRADUATE COURSES
STARTING DATES — FALL, 1959

SURGERY—
Surgical Technic, Two Weeks, Octobr 19, November 30
Surgery of the Colon & Rectum, One Week, October 26
Gallbladder Surgery, Three Days, November 2
Surgery of Hernia, Three Days, November 5
General Surgery, One Week, October 26, Two Weeks, December 7
Board of Surgery Review Course, Part I, Two Weeks, October 5
Blood Vessel Surgery, One Week, November 30
Fractures & Traumatic Surgery, Two Weeks, October 12

GYNECOLOGY & OBSTETRICS—
Office & Operative Gynecology, Two Weeks, September 28
Vaginal Approach to Pelvic Surgery, One Week, October 12
General & Surgical Obstetrics, Two Weeks, November 2

MEDICINE—
Electrocardiography, Two-Week Basic Course, October 5
Gastroscopy & Gastroenterology, Two Weeks, November 3
Internal Medicine, Two Weeks, October 19

UROLOGY—
Two-Week Intensive Course, October 26
Ten-Day Practical Course in Cystoscopy, by appointment.

RADIOLOGY
Diagnostic Radiology, Two Weeks, November 30

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address:
REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

The Doctor's Bill

Doctor's fees, sometimes a source of some mystery and considerable pain to the patients, may become more comprehensible before long in Minnesota. It is hoped that the few physicians whose bills have been far above average will adjust their figuring to more reasonable levels, thus contributing to the peace of mind of their patients, as well as their health.

In an important statement of new policy, the house of delegates of the Minnesota State Medical Association has approved a system of charging for typical medical and surgical services. This is not a fixed schedule of fees; rather it is a definition of relative values for various services, to be based on a fee-unit to be set by each physician for himself. Thus, for example, a house call might cost the patient 2 units, a night visit 2½ units, a tonsil operation 15 units.

The plan will be voluntary, but the medical association will urge its members to use it as a guide. It is aimed chiefly at the few whose rates are exorbitant or erratic, not at the majority who consider their fees already proper and fair. But for any doctor it will have the advantage of being easy to explain to questioning clients, and the patients are more likely to be satisfied if they know the basis of the system.

Such a plan for more uniform fees is already in use by medical societies in California, Iowa and Kansas, and physicians in several other states are studying possible systems.

Minnesotans will applaud their doctors for their effort to develop a plan of fair costs for the public which depends on them.

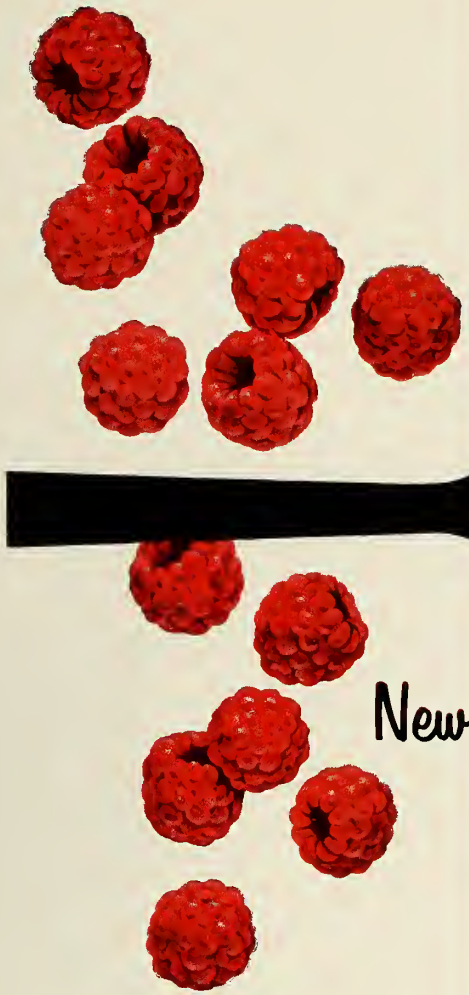
Minneapolis Sunday Tribune
May 31

The Air Around Us

As one who possesses both a nose and an adequate pair of lungs, we're grateful to note that General Motors is considering financing a study of the relation, if any, between auto exhaust fumes and lung cancer.

The Sloan-Kettering Institute for Cancer Research will conduct the experiments with burned gasoline fumes, suspected by some scientists of contributing to respiratory ills and eye ailments as well as skin and lung cancer.

Indeed, it must have struck many people that it was high time auto manufacturers did something about the fumes that pester so many peo-



Prompt 4 way check of DIARRHEA

POMALIN TRADEMARK Liquid

New **RASPBERRY FLAVOR**

and pink color make POMALIN pleasant to take and appealing to both children and adults.

- ✓ Curbs excessive peristalsis
- ✓ Adsorbs toxins and gases
- ✓ Soothes inflamed mucosa
- ✓ Provides intestinal antisepsis

FORMULA:

Each 15 cc. (tablespoon) contains:

Sulfaguanidine	2 Gm.
Pectin	225 mg.
Kaolin	3 Gm.
Opium tincture	0.08 cc.
(equivalent to 2 cc. paregoric)	

SUPPLIED:

Bottles of 16 fl. oz.
Exempt Narcotic.
Available on Prescription Only.

DOSAGE:

ADULTS: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

CHILDREN: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

Winthrop LABORATORIES
New York 18, N. Y.

Continued

ple. The designers have arranged air-conditioned cars, button-controls that roll up and down at will windows and cartops. If released for a time from their fascination with flares and fins, we have no doubt that the same engineers could do something about the control of fumes.

In a related move to this study of auto fumes and cancer, General Motors is also reported developing a new filter to cut all noxious exhaust gases to a minimum—a project the Automobile Manufacturers Association has been studying for some time. But as the Air Pollution Control Association has pointed out recently, nothing much has been done; in fact, the clean air people accused the manufacturers of "dragging their feet" on the research.

Nobody knows, of course, whether there is any tie-in between lung cancer and auto exhaust fumes. But it would be a very foolish man indeed who would say that the fumes have no effect at all. Every newspaper reader knows what is likely to happen if a man remains in a closed garage too long with a car engine running. What is likely to happen is that the man's friends send flowers.

The city streets are, admittedly, not a closed garage; all the same in a fair-sized place there are thousands of cars pouring out their lethal fumes all day long and half the night.

And anybody with a nose and a pair of lungs who happens to be caught in a mid-day traffic jam knows what's happening to the air around us.

Wall Street Journal
August 6

Why Risk Polio?

In Des Moines, they had special clinics to give polio shots. Health officials there urged parents to take their children to their own doctors or, if they could not afford it, to take them to the special clinics for free shots of Salk serum.

The story is headline news across the country today because the parents failed to heed this advice. A polio epidemic is raging in Des Moines.

Now, the parents there are responding. But already it is too late for so many.

There is no reason why parents should fail their children in Indianapolis—or anywhere else.

Every private doctor is equipped to administer the Salk serum.

If parents cannot afford to pay a private doctor, we have in Indianapolis the "Dollar Clinics" which are going from neighborhood to neighborhood.

These "Dollar Clinics" are sponsored by the Marion County Chapter of the National Foundation (March of Dimes) in co-operation with volunteer physicians, city-county public health officials, Red Cross and the Visiting Nurses Association.

The Times will publish from time to time lists of where the neighborhood clinics will be established. Or you may call polio office, MElrose 8-4518, for further information.

We are now in the beginning of the annual polio season.

Don't be too late. Don't be sorry.

Act now to wipe out this crippling disease. No family can afford the tragedy, suffering and cost of polio.

Take your children to get polio shots as soon as possible. Today, if possible.

Don't be like the sorrowing parents in Des Moines.

Indianapolis Times
July 20

Hospitals in State Need 5,000 Beds

Indiana general hospitals need 5,000 new beds and should replace 2,500 others, a state survey showed today.

Dr. Andrew C. Offutt, state health commissioner, said:

"We also know that we are doing little more than keeping pace with the growth in population."

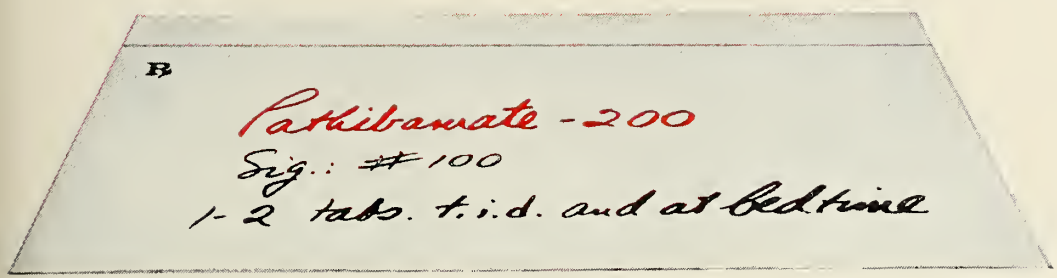
Dr. Offutt said the 1959 state hospital, medical facilities and health center plan shows that a considerable number of additional beds are needed for mental patients.

The number of beds now available for tuberculosis patients apparently is sufficient, he said, although a "great percentage" are in unsuitable buildings.

There now are available in the state 14,159 general hospital beds, he said, 1,390 tuberculosis beds, 9,291 beds for the mentally ill and 421 chronic disease beds.

Continued on page 1438

NEW! for greater flexibility in the control of tension and G.I. trauma... now you can write:



In the management of such gastrointestinal dysfunctions as duodenal or gastric ulcer, intestinal colic, spastic and irritable colon, ileitis, esophageal spasm, gastric hypermotility and anxiety neurosis with G. I. symptoms, nearly two years' experience has confirmed the clinical advantages derived from the combination of the two agents in PATHIBAMATE.

New PATHIBAMATE-200 Tablets combine Meprobamate at one-half strength, with PATHILON at full established potency.

With PATHIBAMATE-200, further individualization of treatment is facilitated in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: PATHIBAMATE-400 — Each tablet (yellow, ½ scored) contains Meprobamate, 400 mg.; PATHILON Tridihexethyl Chloride, 25 mg.
PATHIBAMATE-200 — Each tablet (white, coated) contains Meprobamate, 200 mg.; PATHILON Tridihexethyl Chloride, 25 mg.

Administration and dosage: PATHIBAMATE-400 — 1 tablet three times a day and 2 tablets at bedtime.
PATHIBAMATE-200 — 1-2 tablets three times a day and at bedtime. Adjust dosage to patient response.

AMATE® 400 200

Meprobamate with PATHILON® Tridihexethyl Chloride* LEDERLE

*PATHILON is now offered as tridihexethyl chloride instead of the iodide, since the latter may interfere with the results of certain thyroid function tests.

MERICAN CYANAMID COMPANY, Pearl River, New York

Fourth Estate

Continued

The figures include beds which soon will be available in new hospitals now under construction at Kokomo, Brook, Paoli and Scottsburg and additions to existing hospitals including Boone, Clay, Huntington, Wabash and Bartholomew County hospitals; Protestant Deaconess Hospital at Evansville and St. Joseph Hospital at Logansport.

More people are using hospitals, he said, but studies show the time required for hospitalization per individual is only about half as great as it formerly was.

The 1959 plan establishes priorities for the various communities in the state.

Indianapolis News
July 22

The New Caste

The various arguments over the Forand bill, which would provide medical care to the aged through Social Security, seem to us to miss the real point.

Some opponents argue that the measure would wreck the Social Security system because it would inevitably boost total Social Security taxes too high for either employees or employers to tolerate. Others say it would amount to a form of national compulsory health insurance.

The bill's advocates, for their part, contend that the problem is serious. They say less than half of the people over 65 have health insurance although persons in this age group use two and a half times more medical care than those under 65. Behind this assertion is the unquestioned fact that an increasing proportion of the population consists of older people. And for many of us getting old is no fun whether we are comfortably off or poor, healthy or ill.

But why, it ought to be asked, should the medical care of the aged be considered a Federal responsibility? Plainly planning for old age is the responsibility of the individual long before he gets old, and never were there so many ways of it doing it even on modest income—through insurance (including health insurance), investments, savings, and private and public pension plans.

For those who would not or could not make provision for sickness in old age, the responsibility rests on their families if they are able. For those who have nothing and no one to turn to, the responsibility rests on the local community, assisted as always by private charity. Ironically, the bill could do nothing for the indigent aged who were neither receiving nor eligible for Society Security benefits.

In short, quite apart from the other serious objections, it cannot possibly be sound public policy to assess the whole working nation to pay for the medical care of all old people except those who surely need it most.

That suggests what this bill really portends: The beginning of a major political effort to capture the votes of those of us who are or soon will be "senior citizens," that creepy euphemism employed by the politicians. Make no mistake about it, there are men in Congress who are convinced that this is the big new area for vote-getting political largess in the future—to make the aged a class apart on which subsidies can be showered.

And this cynical notion of creating a new caste of wards of Government is an insult both to today's old people and to those now trying to provide for a dignified old age. It is even more cynical when you consider that one real way for Congress to help is to see to it that the people's dollars are not eaten away by inflation by the time they get old.

Wall Street Journal
July 28

"Listen, Captain," said the perspiring police officer. "We've been giving that ventriloquist the third degree for over an hour and a half, and a plainclothesman, three cops, and a detective have all confessed the crime—Shall we go on?"—*Supervision.*

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 52 — September 1959 — Number 9

Symposium on Rabies

Papers Presented Before the Central Indiana Veterinary Medical Association

Opening Remarks

PETER JOHNSON JR., D.V.M.

President, C.I.V.M.A.

THIS EVENING'S symposium on rabies has been brought about because of the extremely high incidence of this disease in Indianapolis and Marion County.

In 1958, Marion County had 196 clinical cases of rabies in animals as diagnosed by the State Board of Health. By having almost 200 cases in our area, we have the highest incidence of Rabies in the country!

Noting the marked increase in the disease in 1958, it was felt that a more positive approach to this problem was necessary. In October 1958, in cooperation with the State Livestock Sanitary Board, the State Board of Health, and city and county health and law enforcement agencies, clinics were established and the members of our association vaccinated over 10,000 dogs and cats, which represented about 15% of animals in the county. Despite this vaccination program, we have already had 16 cases of rabies in 1959.

Our program this evening is an effort to present some of the conditions that rabies imposes, when it is endemic in a community, and the measures that are necessary to control the disease. We can see from the continued incidence of rabies in Marion County that the mass immunization of animals alone cannot accomplish desirable results.

It is our hope that this symposium will permit an interchange of ideas between doctors and veterinarians which will prove beneficial to all; and that, with additional knowledge on both sides, we may be able to remove the constant threat of rabies from our community.

Rabies in Animals

*V. B. ROBINSON, D.V.M., Ph.D.**

Zionsville

HISTORICALLY rabies is one of the oldest known diseases. Aristotle described it with considerable accuracy in 322 B.C., while in 100 A.D. Celsus recognized the relationship of animal bites to rabies in man, and recommended wound cauterization as a preventive measure. In 1804 Zinke produced rabies experimentally by inoculating normal dogs with infective saliva obtained from a dog in which the disease occurred naturally proving that saliva contained the causative agent of rabies. The reservoir of rabies is known to be in dogs, cats, foxes, wolves, bats and other similar species. An excellent description of rabies is given by Hagen and Bruner.[1]

Rabies is one of the most feared of all known diseases. Its transmission by savage animal bites, the violent clinical symptoms and its 100% mortality probably account for this universal fear.

Geographic Distribution

Rabies is essentially worldwide except for certain islands such as Hawaii, Great Britain and Australia. Strict quarantine regulations have enabled these islands to remain rabies free.

In the United States, the incidence is nationwide except for a few states in the Intermountain West and upper New England where its occurrence is extremely rare.

Causative Agent

Rabies is caused by a neurotropic, filtrable virus. This agent is easily killed by heat, disinfectants, drying and other adverse conditions. Rabies virus was modified by Pasteur thru passages of the same strain in dogs until a fixed strain was produced. This fixed virus is consistent in its incubation period, clinical symptoms and other characteristics. In 1947 Koprowski and Cox[2] were able to adapt a strain of rabies virus which could be carried by continuous passage in eggs. Rabies virus has been grown in tissue culture containing neurons, but success here has not been notable.[5]

Clinical Symptoms

Paralytic or "dumb" rabies and furious rabies are the two clinical types usually described in dogs. Due to damage to the trigeminal nerve, the "dumb" form may be manifested by relaxation of the mandible and drooling as a result of pharyngeal paralysis. This similarity to symptoms seen in throat obstruction may lead to exposure of human beings as a result of attempts to remove suspected foreign objects. Otherwise, the animal may attempt to eat and drink, and show a nearly normal response to its environment.

In the furious type of rabies, personality changes such as increased restlessness, irritability, excitability and viciousness often occur. Loud noises and sudden motions often incite vicious attacks on anything at hand. Death may follow a period of paralysis or occur during a convulsive seizure.

Incubation Period

The incubation period varies widely in all species of animals. In dogs, the disease may develop from three weeks to four months, or longer after exposure. In the human being, symptoms may develop as early as 10 days or as late as six months after exposure.

Transmission

The rabies virus is almost always transmitted by contamination of penetrating bite wounds

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with infective saliva. The saliva of approximately 75% of dogs and 87% of foxes contains virus at the time that clinical symptoms develop. The fixed rabies virus is not found in saliva of infected animals.

Diagnosis

All dogs suspected of having rabies should be carefully examined and observed by a competent veterinarian. In many cases a differential diagnosis can be made and other diseases identified by thorough clinical examination. A complete postmortem examination should be made of animals that die. Under no circumstances should the animal be killed.

Diagnosis from examination of stained impression smears from the brain for Negri bodies is considered to be about 87% accurate, while even greater accuracy can be obtained with stained tissue sections.

The intracranial inoculation of young mice, though time consuming, is essentially 100% accurate. Inoculated mice may show paralysis in five to 20 days with an average of 10 days.

The fluorescein antibody technic for identifying virus particles is now being adapted to the diagnosis of rabies and shows considerable promise in this field.

Pathogenesis

The virus apparently travels from the wound via nerve fibers to the spinal cord and brain to produce death. There is some evidence in the literature to indicate that the virus may occasionally be present in the blood stream,[4] but this work has been most difficult to substantiate. The extremely variable incubation period suggests temporary localizations of virus in nerve tissue rather than continuous movement from the site of entrance to the brain.

The itching that sometimes occurs in horses at the wound site usually develops several weeks or months after exposure, and may be due to irritation of the brain rather than the nerve endings.

Histopathology

In view of the severity of symptoms in rabies, the histopathologic lesions are modest. A mild to moderate deterioration of neurons often attracts microglia around their periphery. Infiltration of perivascular spaces and the formation of foci with small round cells are not uncommon. Intracytoplasmic inclusion bodies develop in the cytoplasm of neurons in the hippocampus, gasserian ganglia, cerebellum and other areas. These inclusion bodies are well demonstrated by special stains, the most popular of which is basic fuchsin. These bodies were first described by Negri[3] in 1903 and still bear his name. Fixed virus of rabies does not produce inclusion bodies.

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Statistical Incidence of Rabies In Marion County and Indiana

*JOSEPH D. SALISBURY, D.V.M., M. Sc.**

Indianapolis

A TITLE of this nature always bothers me and I'm afraid may be very boring. As a consequence of my own personal feelings in this regard, I have had three charts or bar graphs prepared to illustrate but a very few facts regarding the rabies situation in Indiana and our own area of residence, Marion County. It has been said a picture is worth a thousand words—hence the charts.

The graph titled "Rabies in Indiana—1958" (Figure 1) depicts the situation with regard to the species of animals infected in Indiana last year. Obviously, the main source of human exposure to rabies is by dogs, and in our canine friend we have the highest number of cases. All other species including wildlife amount to only that portion represented by the bar on the right side. The proportions represented here hold true for more than the last decade during which 88.7% of all cases of rabies in animals in Indiana have been in dogs.

In the second graph (Figure 2) the left hand column portrays the total number of cases in the state. The second and third columns added together would equal column one. The middle column represents Marion County's contribution to this total in 1958. The third column is the total for the remaining 91 counties in the state. Of the 196 cases in Marion County, 193 were dogs, two were cats and one was a cow. I should like to point out that the proportions on the graph are by no means constant. A few years ago some other counties would have occupied the position of Marion County on such a graph.

To complete the picture for Marion County, I have had prepared a line graph (Figure 3) of the actual number of cases in animals which have occurred in the last 10 years. This disease is cyclic in nature with the occurrence of epizootic waves. This cyclic wave is adequately demonstrated on this line graph. That these cyclic waves do not occur uniformly over the state at the same time could be illustrated by superimposing a line graph for Lake County over this one for Marion County. In Lake County the low years would be about 1950 and again in 1958 with a peak occurrence in 1953 and 1954. It is just about the reverse of Marion County. Because of the out

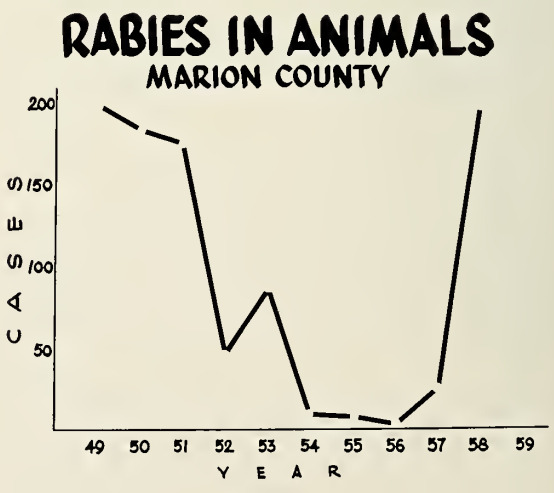


Figure 1

* Public health veterinarian, Indiana State Board of Health.



Figure 2

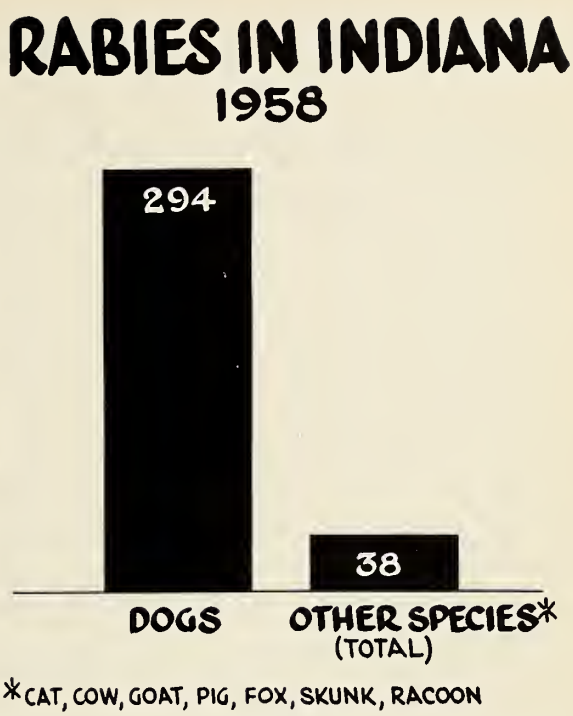


Figure 3

of phase waves the average number of cases of animal rabies has given Indiana a dubious distinction of remaining each year among the first eight states in the incidence of animal rabies. In 1958 this state ranked *first* in the number of cases in dogs.

Although four Hoosiers have died of rabies since 1950, there were no human deaths in Indiana in 1958 from rabies.

I should like to leave these few points with you. First, the dog is the principle source of human exposure and is the animal most frequently the victim of the disease in Indiana. Second, we presently have a very serious problem in Central Indiana. Third, have your dog vaccinated to "Protect Your Family and Your Dog Against Rabies."

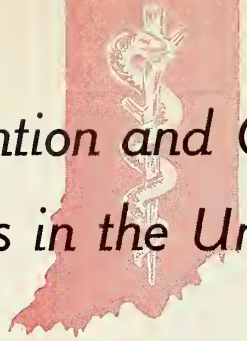
Diabetes Symposium Planned for October

The Chicago Diabetes Association will conduct its third annual symposium on diabetes on Thursday, Oct. 1, 1959, at Thorne Hall of Northwestern University 740 N. Lake Shore Drive, Chicago.

The program will consist of lectures during the morning and afternoon and discussion groups during the lunch hour. Dr. Richard C. de Bodo will talk on "Regulatory Effects of Pituitary and Adrenal Glands on Carbohydrate Metabolism." Dr. Rachmiel Levine will speak on "Hepatic Mechanisms in Carbohydrate Metabolism."

"Current Concepts of Insulin Antagonists" will be discussed by Dr. James B. Field. The Woodyatt Memorial Lecture on "Recent Work on Glucagon" will be given by Dr. Charles H. Best. Dr. George F. Cahill will discuss "Interrelationship of Lipid and Carbohydrate Metabolism." Dr. Francis D. W. Lukens will speak on "Interrelationship of Protein and Carbohydrate Metabolism."

A fee of $25.00 is charged for the course. Members of the American Diabetes Association, medical students, interns and resident physicians are exempt from the fee but are required to register. Inquiries may be addressed to the Chicago Diabetes Association, 5 S. Wabash Ave., Chicago, 3.



Prevention and Control of Rabies in the United States

*ERNEST S. TIERKEL, A.B., V.M.D., M.P.H.**

Atlanta, Ga.

DURING 1958, the last complete calendar year, 4,814 laboratory confirmed cases of animal rabies were reported in the United States. Of the total cases, 1,643 were in dogs, 2,075 in wildlife, 353 in cats and 737 in farm livestock. The states contributing most cases were Texas, Kentucky, Indiana, Georgia, Alabama, Virginia, Minnesota, Wisconsin and Iowa. The sizable increase in Indiana, from 120 in 1957 to 338 in 1958 is largely due to an epizootic of dog rabies in Marion County — Indianapolis. Skunk rabies continues to be the major portion of the problem in the North Central States. Reported number of cases dropped in Florida from 117 to 61, South Carolina from 202 to 120, Ohio from 288 to 166 and Louisiana from 179 to 31. The States in New England, upper Rocky Mountains and Pacific Northwest remain essentially rabies free.

Six human rabies deaths were reported during 1958 (Table 1). Two of the six fatalities contracted the infection from stray dogs. One case was caused by fox bite, one by bat bite and one by skunk bite. In one case the vector is unknown. Three of the cases received no specific antirabies treatment. In two cases, 14 daily doses of antirabies vaccine were administered and the patients succumbed to rabies after very short incubation periods. In the case reported from California the patient received antirabies serum as well as 14 doses of antirabies vaccine begun four days after the bite. This is the first completely proven case of human rabies caused by bat bite in the U. S. The patient was bitten by a silver-haired bat *(Lasionycteris noctivagans)* which was positive for rabies by both microscopic and the animal inoculation tests. The bitten woman developed rabies two months after exposure. (Two other human deaths were previously attributed to bat exposures, one in 1952 and the other in 1956; in neither of these episodes was the biting bat examined.)

Examination of the epidemiology of rabies reveals that it is ubiquitous in character. Climate and season have no influence on its occurrence. It is found in the arctic regions as well as the tropical countries of the Old and New Worlds. By the same token, it may be present during any season of the year. The disease, in nature, is characterized by variable incubation periods. Transmission occurs by the entrance of virus-laden saliva into a wound generally caused by the bite of a rabid animal. The probability of human infection is dependent upon the concentration of the virus in the saliva of the biting animal, the site of the bite on the body (bites on the head, neck, and face are most dangerous; the hands, feet, arms, and legs are next in importance, and on the trunk least dangerous), the depth of the bite, the multiplicity of the bite and the possible interposition of clothing. The rabies virus is a rather labile organism and loses its virulence rapidly when exposed to light, heat and drying. Thus, fomites or indirect exposure by contaminated objects are of no real significance because the virus is destroyed so easily in the atmosphere.

Over the years, one of the very real problems in the specific biological therapy of exposed persons was the ineffectiveness of vaccine in severe bite cases, especially in those involving the region

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Table 1

REPORTED HUMAN RABIES DEATHS

United States—1958

Locality	*Date Died*	*Age*	*Sex*	*Nature of exposure*	*Incubation period*	*Length of illness*	*Treatment*	*Biting animal*
1) Lawrence County Ohio	2/1/58	4	F	Bite on forehead	36 days	3 days	None	Stray dog
2) Clarendon County South Carolina	3/4/58	60	F	Multiple bites on fingers	22 days	3 days	Local cleansing, 14 doses vaccine	Fox, confirmed rabid
3) Athens Ohio	9/20/58	10	M	Unknown	Unknown	4 days	None	Unknown
4) South Dakota	10/6/58	2	M	Bite	16 days	10 days	14 doses vaccine	Skunk, confirmed rabid
5) Atlanta Georgia	10/8/58	55	M	Severe bite, nose	14 days	11 days	None	Stray dog
6) Butte County California	11/4/58	53	F	2 bites fingers	57 days	8 days	Serum systemically, 14 doses vaccine, 4 days after bite	Bat, confirmed rabid

of the head when the incubation period was too short to allow for the development of immunospecific protection. This problem has now largely been overcome by the production of hyperimmune rabies antiserum which can be administered to confer sufficient passive immunity in that critical early period of time before the vaccine can stimulate active protection. Convincing experimental evidence in challenge tested laboratory animals and in antibody studies in man has established its value when followed by the usual course of vaccine. One serum injection with 0.5 ml./kg. of body weight is given within 72 hours of the bite or sooner. As with all serum therapy, the usual precautions should be taken to test for sensitivity of the patient.

There can be no question that the ultimate solution to the rabies problem is predicated on the control and eventual elimination of the disease from animal populations. This may be accomplished by the setting up of transmission barriers, such as animal immunization, elimination of stray dogs and the reduction of excessive numbers of wildlife vectors. Extensive laboratory research and field projects have proved that these technics may be applied successfully to eradicate the disease from a given area if integrated into a carefully planned and well executed program. Dramatic demonstrations of the effectiveness of such programs have been displayed in recent years in many parts of the United States. It remains for us now to muster the forces of the rest of the country to set similar machinery in motion for an all-out fight against rabies.

It is an established premise that coordination of control activities is the keynote of a successful state-wide rabies control program. For this reason it is advisable that the complete administration of such a program be delegated to a qualified public health veterinarian at state level. The development of such a program under the health

department veterinarian can insure effective uniformity of control practices among the various health jurisdictions.

Local rabies control works best on a countywide basis and sound programs should include the following basic activities:

(1) *Mass immunization of dogs.* This should be carried out intensively on a schedule that aims at the vaccination of all owned dogs within the shortest possible time. In the face of a serious outbreak, at least 70% of the entire dog population of the county should be vaccinated within a one-week period.

(2) *Elimination of all stray dogs.* Mass immunization will not reach the stray or ownerless dog, which remains as a potential threat in transmission of rabies. An efficiently conducted program requires the operation of a local pound or humane shelter where stray animals may be kept for a few days and, if unclaimed at the end of that period, destroyed humanely. Collection of strays should be carried out by teams of dog wardens and assistants in properly equipped trucks. Licensing or registration of all dogs often is a valuable adjunct. If properly enforced, it identifies the ownerless strays, helps to defray the expense of control activities and may serve as the basis of a reasonably accurate dog census.

(3) *Reduction of excessive numbers of wildlife vectors.* Outbreaks of rabies in wild animals, such as foxes and skunks, occur generally when the population of the species becomes particularly dense in an area. Organized countywide trapping programs are the most effective means of reducing this overpopulation to a safe level in areas menaced by wildlife rabies.

Other important measures are restraint of dogs while the control campaign is under way and pursuit of a continual and energetic publicity campaign. Essential to the success of the program is good organization under health department and veterinary medical auspices with the fullest use of all technical resources in the community.

Perhaps the most significant advance in the field of rabies control in recent years has been the development of a modified living virus vaccine (Flury strain) produced in chicken embryos. Compartive duration of immunity experiments in dogs at the Communicable Disease Center have shown that this vaccine is significantly superior to the older type inactivated virus nerve tissue vaccines for periods of at least three and one-fourth years between vaccination and experimental exposure. Field experience with this vaccine has thus far corroborated the results of the controlled tests. The WHO Expert Committee on Rabies in its recent report "recognizes that the chicken-embryo vaccine (Flury strain) produces excellent immunity in dogs for at least three years following a single intramuscular injection (posterior thigh muscles) and recommends the use of this vaccine in mass immunization programs."

Further studies at CDC have shown that pups can be immunized successfully as early as three months of age, although most of these animals were challenged after relatively short postvaccination periods. For this reason, it is recommended that dogs vaccinated under six months of age should be revaccinated within the first year of life. Thus, in areas which have successfully eliminated the disease, but are faced with the constant danger of its reintroduction, we can visualize a prophylactic regime somewhat similar to smallpox vaccination in human populations by vaccinating dogs with chicken embryo (Flury strain) vaccine at three months and one year of age, followed by a booster vaccination three to four years later. It should be emphasized, however, that this procedure by no means precludes the necessity of carrying out intensified mass canine immunization campaigns in areas of enzootic or epizootic rabies.

During the past 12 years 33 state health departments have established veterinary public health programs with the development of organized rabies control activities. Progess achieved in control during these past 12 years is reflected in the annual nationwide reported cases. The total number of cases in 1946 was 10,872. This declined steadily to 4,814 cases for 1958, a decrease of more than one half. Similarly, the human deaths have dropped from 22 in 1946 to 6 in 1958, a decrease of 73%. Although the dog still accounts for most of the cases and remains the most important vector of the disease, the striking decline in canine cases from 8,384 in 1946 to 1,643 in 1958 (80%), in spite of a greatly increased dog population, is eloquent testimony to the success of organized control programs throughout the country during this 12-year period. In sharp contrast to the decrease

in canine rabies, the reported number of wildlife cases has doubled.

Success with the control of dog rabies has focused attention on what seems to be an increase in the spread of the disease among various species of wild fauna. Besides the very obvious effect of wild animal rabies from huge livestock losses, there are also the public health aspects of the sylvatic rabies problem. Of primary significance are the reported direct exposures of man to rabid wild animals. During the past several years, 20% of the human rabies deaths in the United States have been caused by the bites of rabid wild animals, principally foxes and skunks. Observations of rabies in these wild species indicate that sooner or later the disease spills over into canine populations where the hazard is greater because of man's closer association with dogs. There is general agreement that if rabies is to be eventually eradicated or brought down to a controllable minimum, the reservoir of the virus in the the country's wild fauna must necessarily be included in scientifically devised control operations.

In the United States, the principal wildlife vectors of rabies at the present time are the grey fox (genus *Urocyon*), the red fox (genus *Vulpes*), the small spotted skunk (genus *Spilogale*) and the large striped skunk (genus *Mephitis*). The fox rabies areas can be found along the Appalachian Range southward from New York State to Georgia and southern Florida and westward along the southern tier of states to western Texas. Contiguous with this is the fox rabies area which lies roughly between the Ohio River and the Great Lakes. Skunk rabies is active in an area which extends from Oklahoma and Missouri northward into the states of the upper Mississippi and Missouri River Valleys. There is also a sizable enzootic skunk rabies area in the central valley of California. In 1958 there has been evidence of an eastward spread of the great plains states skunk rabies areas causing an overlapping of skunk and fox rabies in Illinois, Indiana, Ohio and Kentucky.

The coyote has not been incriminated in the current national rabies picture to any appreciable extent, although coyote rabies raged through the mountains and prairies of the far west several decades ago. The only important focus of raccoon rabies in recent years has been reported from Florida.

Antibody studies by the Communicable Disease Center suggest the possibility of subclinical infection in wildlife vectors in nature. There seems to be some indication of a relationship of positive titers with history of infection in the areas studied. Large surveys of small wild rodents in high enzootic areas have produced negative results confirming suggestions that these species do not serve as reservoirs or vectors of the disease in nature. Definitive studies in foxes have indicated that this species is not capable of transmitting the disease as a symptomless carrier. The transmitting potential of foxes, however, is a great one as evidenced by the isolation of rabies virus from saliva of infected animals for as long as 17 days.

One of the important new developments in the epidemiology of rabies has been the discovery of the disease in insectivorous bats. Since the first reported case in Florida in June, 1953, there have been over 250 cases of bat rabies diagnosed from 19 states in widely diverse geographic areas of the country. Four species of tree-dwelling or solitary bats and 14 species of colonial or cave dwelling bats have been implicated thus far. All are the insectivorous variety. In studies by CDC on one cave colony, infection rates in normal bats collected in flight have ranged from 0.5% to 1.5% as contrasted with a rate of 5.1% in dead and moribund bats collected during a die-off. Antibody rates have been noted to increase from 14.7% early in the season to 28.2% late in the season of colonization in the cave.



Background and Development of Duck Embryo Rabies Vaccine

*CLYDE G. CULBERTSON, M.D.**

Indianapolis

IN APRIL of 1933, without any advance notice, I was told that, in addition to my duties as director of clinical laboratories at the medical school, I was to assume direction of the Indiana State Board of Health laboratory. Soon I learned that one of the main activities to be carried on was the Pasteur Laboratory, which had been conducted in an unusual fashion since Dr. Hurty took a legislative committee to see a boy with rabies who, as I understand, had been shipped to Indianapolis by Railway Express.

By present day standards, the law was an unbelievable one to have been enacted at that time. Treatment by the Pasteur method was done at that time only by preparing the vaccine from fresh rabbit spinal cords from rabbits paralyzed by fixed virus and dried for various lengths of time over sulphuric acid to attenuate the virus to various degrees, and thus only one place in the state, the "Pasteur Laboratory," provided opportunity for treatment. This necessitated patients coming to Indianapolis for the period of treatment. I presume that at first, at least, all comers were treated, but the expense depended upon whether or not the family had "visible means to pay." Patients fitting this category, as determined by the township trustee, which, to my certain knowledge, included farmers with 500-acre farms, were brought to Indianapolis, transportation paid, and put up at a hotel, usually the old Roosevelt Hotel at the corner of Ohio Street and Capitol Avenue, where their bills were fully paid. Sometimes when it was necessary to have a parent, or both of them, come to bring a child, all were accommodated free of charge, even, according to Dr. Thurman B. Rice, to procurement of suitable clothes in some cases. All this was financed by a provision that each county paid in to the state each year its surplus dog tax, which meant that after all the livestock killed by dogs or rabies were paid for by the county, the remainder of the money came to the state for the purpose of giving Pasteur treatments.

When I inherited this responsibility, the laboratory was located in the State House Annex at Market Street and Senate Avenue, on the second floor.

In April 1933 I assumed charge and was indoctrinated by a fine gentleman, Dr. C. C. Adams. Dr. Adams had a couch and a small table in a bleak, bare, poorly-lighted room with a tall ceiling where his weary and worried clientele trudged in each day, either at 11 a.m. or 4 p.m., to receive their daily dose of rabies vaccine. As you can imagine, it was a motley spectacle which I well remember. A Methodist Hospital nurse, Doris Asher, turned laboratory technician, was our assistant and she handled all problems; but I gave all injections, traveling each morning and evening from 1040 West Michigan Street. I had good advice for my teacher and colleague, Dr. Thurman B. Rice, had done all those chores some years before, so I had a ready and willing source of information and counsel; for he, like me, was sent from the medical school to serve the Board of Health by being in charge of epidemiology and vital statistics.

During this period we treated sometimes as many as 100 patients per day and conferred with

* Director, Biological Research Division, Eli Lilly and Company, Indianapolis.

many more. Dr. Verne Harvey, the health commissioner, Dr. Rice, and I spent much of our time listening to patients tell of their experience and it was common to have a patient tell his story to two of us independently for an unbiased comparison of opinion. Often we decided no treatment should be given, only to find that the family physician insisted upon treatment and advised the patient to appear in the line for treatment. We deplored this since we knew that the danger from the treatment in such cases was more than from rabies.

We also had dog heads and all sorts of animal heads to examine for Negri bodies. In this I had the able assistance of Mr. Kurner, who still is employed at the State Board of Health. We subsequently began the inoculation of mice for all cases negative for Negri bodies, but this was several years later.

At this time the Pasteur treatment was being given not by grinding to order Pasteur's rabbit cords but by using bulk packaged vaccine manufactured by Lilly's, using the Harris method. This was a live fixed virus made from rabbit brain which was supplied to doctors for about 40 years. Dr. Harris prepared the vaccine by freezing the brain and cord tissue and drying it to a degree which reduced its virulence for animals. It was soon obvious that several changes were needed and we began to make them as we could. It wasn't until many years later that the opportunity came to help improve the vaccine.

The first change was to get the Board of Health out of the business of treating patients; this was no longer necessary since the vaccine was on the market and anyone who could not pay for treatment could be treated under the "free antitoxin law." Before this could be accomplished, we moved the treatment site to the admitting room of the medical center where I supervised the treatments. The Legislature repealed the 1911 law and placed all treatment cost of indigent patients on the county, city or town governments in order to make them aware of their rabid dog problems, and to save the travel to Indianapolis.

The use of vaccine made from rabbit brain was accompanied by complications in the form of severe paralysis, sometimes fatal but always dangerous and crippling, which was apparently due to the myelin or other factors which were shown by several investigators to be demonstrable in appropriate laboratory tests using guinea pigs. Many attempts were made to remove this so-called paralytic factor from the brain vaccine without success. In one summer I had three patients I treated suffer this complication.

One morning in 1952, Dr. Horace M. Powell, my associate, who was attempting to grow poliovirus on egg embryos from a variety of fowl, reptiles and birds, came in and told me of his having grown rabies virus in duck egg embryos. From what I have said, you can realize what Dr. Powell and I talked about on this occasion, and we began further work. My role was minor, but Dr. Powell's labor was most intense and sustained. We needed to prove to ourselves and others that the paralytic factor was not present in the duck embryo. This was done first when Dr. John MacFarlane, of our biological development group, injected a large number of guinea pigs with the duck egg material and found that it did not, as we had hoped it would not, produce paralysis. This gave us encouragement.

We worked in a state of frustration for several years due to two main difficulties. One was the difficulties of the problem itself because there were many obstacles to overcome plus the knowledge that the problem we were spending a considerable effort on didn't compare in importance, at least in number, to many of the others we had in the mill. Dr. Powell is a research advisor to the organization and I am director of the division, so the worries could be somewhat shared—he worried about the details of the problem and I worried about how to justify the effort, so together we finally got the vaccine to the stage where Dr. Peck began to try it in patients.

A few necessary steps along the way may be of interest. We planned at first to supply a killed virus vaccine but after numerous attempts were unable to inactivate it with ultraviolet light and keep its potency. We thought at this point that we probably could develop a live virus vaccine similar to the Harris vaccine but this was second choice. By the use of a special technic in drying, finally we began to produce a stable, dried live virus rabies vaccine. We injected it into monkeys —some received injection into the brain, others only into the muscles. Those injected into the brain died with an extensive fixed virus rabies, as expected. Those injected into the muscle got no symptoms but developed good immunity.

Thus at this point we went forward with tests on a live vaccine which Dr. Peck will describe.

Then came the discussion with the National Institutes of Health about licensing this product. The N.I.H. had just been through trouble with polio vaccine and their view of live virus vaccines took a great decline toward the negative and they declined to accept the vaccine. This dismayed us for a short while, but since we really wanted a killed virus vaccine for several reasons, we didn't as much as argue the point but began again, for about the tenth time, to explore how we could get out of this particular predicament. About this time, Dr. LoGrippo and my friend Dr. Frank Hartman reported their studies on killing rabies virus in rabbit brain suspension with a compound called beta propiolactone, thereby producing an effective killed vaccine. This was what we needed to make further progress and Dr. Powell and his faithful associates, Miss Myers and Miss McKay, labored on to produce enough inactivated vaccine for the clinical trials. Dr. Peck again began his trials, about which he is to report later this evening.

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Rabies Vaccine Experience During the Recent Marion County Epizootic

*F. BRUCE PECK, JR., M.D.**

Indianapolis

I GREATLY appreciate the opportunity to speak to you tonight about some of the work that has been done with the problem of prophylaxis of rabies in humans. My discussion will deal with two facets of the use of rabies vaccines. The first is the experience of the Marion County General Hospital dog bite clinic during 1958, and the second is the problem of prophylactic primary immunization of the population at risk.

Marion County Rabies Clinic

For the past four years we have had the opportunity at the Marion County General Hospital to follow a large group of individuals who have been bitten or otherwise exposed to rabid or stray animals. During this time we have elected to use rabies vaccine of duck embryo origin as our vaccine treatment. As of January 1959, over 600 patients have received therapy with the duck embryo vaccine at the General Hospital. For convenience I have compiled a table showing only the admissions to our dog bite clinic for the years January 1957 to February 1959, which includes the period of the dog rabies epizootic here in Marion County (Table I).

As you can see, in 1957 there was a cyclic variation in the number of patients who received rabies vaccine at the Marion County General Hospital. When the weather became warmer, our incidence of treatments increased, reaching a maximum in June and then gradually falling off to the end of the year. Although I have not shown the figures for 1956 and 1955, the curve roughly parallels that seen for 1957. You will note that we had one case each in February, October, and December of 1957 and two cases in May of 1957 which were due to bites of proven rabid animals. This again is approximately par for the course.

Epidemic Proportion

In January 1958 the situation changed drastically, when we had 14 patients begin treatments for dog bites. Five of these were bitten or had intimate contact with laboratory proven rabid animals. This marked the beginning of the epidemic from the clinical standpoint. In February four more patients were treated because of contact or bites with rabid animals. Then in March the situation became much more serious, when 21 individuals began treatment because of exposure to laboratory proven rabid animals. This incidence continued for most of the rest of the year. For instance, we gave vaccine injections to 40 patients on the fourth of July. Our peak month in 1958 was October when from a total of 58 patients, we had 33 begin treatment because of exposure to known rabid animals.

So far in the first two months of 1959, the incidence of exposure to positive animals has greatly decreased although, of course, we do not know whether the situation will again repeat itself as it did in 1958, when the weather changed and the incidence of positive bites rose remarkably.

I believe you might be interested in some statistics on the magnitude of the problem as far as human prophylaxis was concerned in 1958. According to figures obtained from Dr. Nester's office, a total of 2,800 animal bites were reported in Marion County during 1958. Approximately 900 of these bites registered at the emergency

* Lilly Laboratory for Clinical Research, Marion County General Hospital, Indianapolis 7.

ward of the Marion County General Hospital for treatment. Of these 900 bites 435 received varying amounts of rabies vaccine as part of their therapy for the animal bites.

In the way of explanation of who does or does not get rabies vaccine for treatment—we treat every patient bitten by a proven rabid animal, a clinically suspicious rabid animal, and those bitten by animals that escape from observation, such as stray dogs, wild animals such as foxes, raccoons and rats. We also begin treating patients receiving face and neck bites or severe bites of the extremities but discontinue treatment if the animal remains healthy for from four to eight days. These animals are kept under observation for 10 to 14 days. If they remain healthy, the remainder of the rabies vaccine inoculations are not given. We have also elected to treat those individuals whom we feel have had very close contact with laboratory proven rabid animals. By this we mean that there is fairly good evidence that the patient has had mucous membrane or abraded skin exposure to the saliva of rabid animals. The classic example of this type of contact is the animal who becomes ill and appears to be choking, and who is examined by mother, father and one or two children to see if they can remove the bone from the throat of the animal. The animal then dies and is found to be rabid.

Patients Immunized in 1958

As noted previously, 435 patients were started on rabies vaccine at Marion County General Hospital in 1958. One hundred ninty-five of these individuals, or 45%, were treated for bites or close contact with laboratory proven rabid animals. The remaining 240 patients were treated because of bites from stray or wild animals.

Further breakdown of the 195 patients treated for exposure to rabid animals shows that 40% of these patients were treated because of actual bites and 60% because of mucous membrane or abraded skin contact.

The 435 vaccine-treated patients were also studied as to the offending animal. Three hundred forty-one patients (80%) were treated because of exposure to dogs, 68 (15%) due to rat bites, 20 (4%) due to cat bites, and there were four squirrel bites and one bite each from an oppossum, weasel and raccoon. We rountinely treat rat bites at the Marion County General Hospital with rabies vaccine since we consider the rat as a susceptible mammal and, thus, they fall under the classification of a wild animal which is unable to be observed. You may be interested in knowing that the incidence of rat bites in 1958 (68) was the same as that in 1957 (71 bites).

As far as vaccine dosage is concerned, we gave over 5,000 individual doses of duck embryo rabies vaccine in 1958 to the 435 patients in the vaccine group. Seventy patients received from 1 to 4 doses, 32 patients received from 5 to 9 doses, and 333 patients received a full course of 14 doses of rabies vaccine.

The age of our patients follows the national incidence quite closely, in that 60% of the patients were under the age of 10 years. Also, most of the face, neck, and arm bites were in children.

Reactions to Vaccine

We did not see any serious reactions to the use of duck embryo rabies vaccine. Typical local reactions, consisting of erythema and induration, occurred in some of the patients. This usually occurred during the middle third of therapy, in that the incidence of local reactions at the injection sites tended to occur more frequently between the sixth and the ninth day than at other times during therapy. We saw no neurological complications of any type. One patient developed urticaria, probably due to sensitivity to duck embryo protein and was switched to Semple vaccine. Thirteen of our patients developed typical mild serum sickness between the ninth and twelfth day of vaccine treatment. It is of interest that no case of serum sickness developed in anyone who had not received either tetanus antitoxin or rabies antiserum. All of these 13 patients were able to complete their course of 14 doses of rabies vaccine without further untoward side-effects. The serum sickness for the most part was treated with adequate antihistamine therapy and resolved quickly.

In regard to the outcome of all of these rabies treatments, I am happy to report at this time that no one, to our knowledge, has developed rabies in Marion County. Of course, we still have not passed the incubation period for rabies in many of these patients, but we would not expect to see any cases, at least in the vaccinated group. I am sure that everyone agrees that the big problem is not in the vaccinated group but is the person that is bitten and does not seek medical attention.

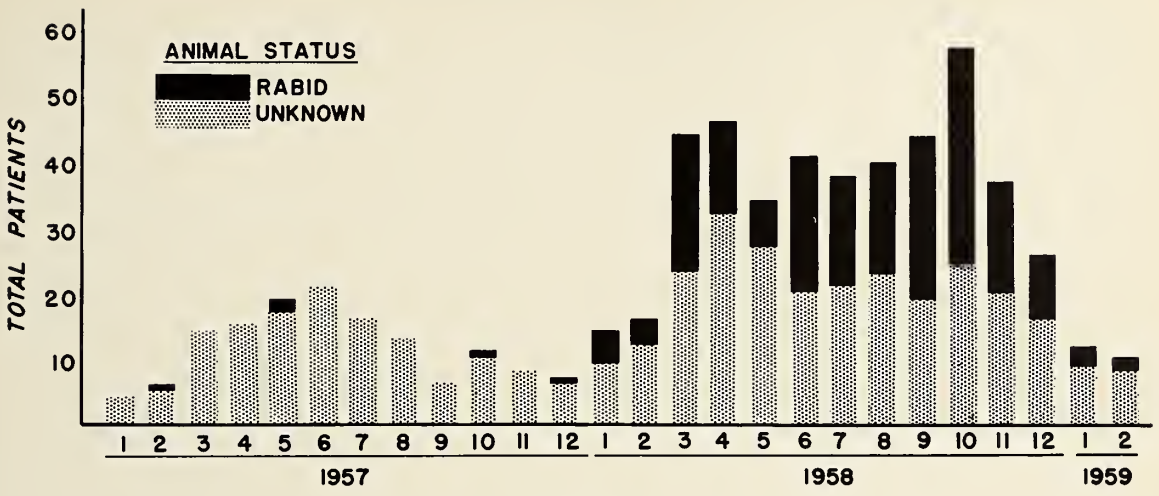


TABLE 1

To briefly recapitulate, the 1958 rabies epidemic resulted in a tremendous increase in the total number of patients receiving rabies vaccine at the Marion County General Hospital rabies vaccine clinic. Part of this was due to an absolute increase in the number of persons reporting for treatment who were bitten by stray animals but most significantly, there was a 3,900% increase in the number of patients receiving treatment for exposure to proven rabid animals compared to 1957. I think we have indeed been fortunate not to have a case of human rabies develop in Marion County.

Immunologic Response

The second portion of my discussion tonight deals with the immunologic response to rabies vaccine in the population at risk. Naturally, in post-exposure treatment, one must be reasonably certain of prompt antibody response in all patients who are exposed to rabies and who receive rabies vaccine. As we have reported elsewhere,[1, 2] immunologic studies in volunteers receiving 7 to 14 doses of rabies vaccine indicate that when subcutaneous doses of 1 cc. each are given at daily intervals, antibody makes its appearance between the seventh and tenth day and is present in practically 100% of the individuals by the tenth day of therapy. If seven daily doses are given, however, only about half of the patients show circulating antibody by day ten. This would indicate that at least 10 doses are necessary to be reasonably certain that circulating antibody is present in the individual being treated.

There is another group of patients in which rabies vaccine frequently must be used. This group comprises those individuals, usually veterinarians and dog handlers, who have previously been exposed to rabies and have received at sometime in the past at least one course of 14 doses of potent rabies vaccine. The question of whether or not to give booster doses to these individuals has been of great interest to us as well as to other workers in the field.[3] It now seems quite clear that if at least one 14-dose course of rabies vaccine therapy has been given sometime within the last five to 10 years, probably all that is needed is one or two booster doses of potent rabies vaccine. When this is done, a typical anamnestic response is noted similar to the booster response seen following recall immunization with tetanus toxoid or other biological products. It would seem reasonable then to state that if one is certain he has received a potent vaccine in the past, and that he has had at least 14 doses, he probably needs only to have 1 or 2 doses at weekly intervals in order to assure a good antibody response.

One of the most interesting possibilities as far as rabies immunization is concerned, is the possibility of giving routine primary immunization to those individuals who will be at risk due to their occupation. There has been a good deal

of work done by investigators in this country as well as by the group at the World Health Organization, and I am sure that you are all familiar with the results of these studies performed with chick embryo vaccine. Suffice to say that a great deal of information is being rapidly obtained as to the feasibility of performing primary immunization by a 3 to 5 dose immunization schedule, so that a basic antibody pattern can be established in the population at risk prior to exposure. As of now, there is increasing evidence that the proper use of elective vaccine immunization procedures results in what appears to be a good antibody response. This, of course, is not a flat recommendation for primary immunization against rabies since we still do not know the optimum amount of material to inject nor do we actually know what an adequate antibody level is. As far as I know now, however, there have been no reports of individuals developing rabies upon re-exposure, providing they have had, sometime in the past, an adequate course of rabies vaccine for a previous exposure. This, of course, is negative evidence but it may be of some value in assessing the practicality of primary immunization against rabies.

Summary

To summarize the present status of primary immunization against rabies, there is mounting evidence that satisfactory antibody responses can be obtained in humans following a 3 to 5-dose schedule. However, the optimal spacing and amount of vaccine inoculum, as well as the method of injection, has yet to be finally determined. It would appear that we are rapidly approaching a solution, but it is still too early to make any concrete recommendations.

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Experimental Medical Education Program Inaugurated at Indiana University

Indiana University has announced the appointment of Dr. Douglas A. MacFadyen of the University of Illinois College of Medicine to direct its new experimental program in medical education to be inaugurated in September.

The new program, which is a departure and extension of traditional medical training, has attracted national interest since it was announced early this year coincident with the University's receipt of a pilot grant of $173,000 by the Commonwealth Fund.

Starting this fall with a limit of ten students, selected from the approximately 180 to be admitted to the School of Medicine, the program will draw on the resources of the College of Arts and Sciences and Graduate School and will be administered by the medical school at Indianapolis under Dean John VanNuys. Eventually, 30 students at the end of their junior year in arts and sciences will be selected.

The new program has been described as having these objectives: a thorough training in polytechnical and cultural subjects, preparation of medical students whose paramount interests are in research and teaching, and an increase in the number of broadly qualified physicians.

Dr. MacFadyen, the newly appointed program director, also will be professor of pathology in the School of Medicine. A native of Canada, he is a graduate with A.M. and M.D. degrees from the University of Toronto. He has been a member of the staffs of the Rockefeller and Alfred I. DuPont institutes, chief of chemistry and physics of the Army Medical School, and since 1946 has been chairman of the department of biochemistry of Presbyterian-St. Luke's hospital in Chicago and professor of biochemistry in the Illinois College of Medicine.

Rabies Symposium, Question and Answer Session

The panel consisted of Virgil Robinson, D.V.M.; Jos. Salisbury, D.V.M.; Ernest Tierkel, V.M.D.; Clyde Culbertson, M.D.; Bruce Peck, M.D.

QUESTION to Dr. Tierkel: Is it true that bats develop some immunity to rabies and carry it indefinitely?

ANSWER: We know that it is true of vampire bats. We do not know whether it is true of the insectivorous bats that are found in this country. Vampires, as you know, are the blood-lapping bats that require blood for their existence and in this way transmit the virus through their saliva. We know the vampire bats are capable of transmitting the disease for as long as 8 or 9 months before coming down with any signs of illness and dying. It is thought that some are able to do it indefinitely. We now have some clue that this may be true of the insectivorous bats which are found in this country—we do not have vampires in this country—because we have found evidence of natural occurring serum neutralizing antibodies and in several instances, we have found evidence of virus in salivary glands without finding evidence of virus or pathological lesions in central nervous systems. These are animals that have been caught in normal flight, apparently behaving normally. These are the clues that we have. The definitive test for demonstrating virus in saliva continuously for long periods of time without signs of illness has yet to be done.

QUESTION to Dr. Peck: A veterinarian who has had one or more series and is exposed to a known rabid animal: do you recommend (1) a new series, (2) booster, (3) run a titer first. How long does it take to run a titer?

ANSWER: Well, I don't think I would wait to run a titer. It take about two weeks from the time the test is started until the time the last animal dies; and routinely, I think Dr. Powell reports back to me on titers that we do run prophylactically in about two weeks. Now Dr. John Fox at Tulane feels that anyone that has received at least one course of at least 14 doses of the potent vaccine within the past 10 years probably would only need one or two booster doses of vaccine. He has published a large series of follow-up studies on veterinarians and volunteers who have received vaccine and I do not think there is any question but that antibodies persist in those individuals that have received at least one course of the potent vaccine in the past several years. And he feels, and I do not see any reason to feel any different, that one or two doses would be perfectly adequate, especially for someone who has had 2, 3 or 5 of these series.

QUESTION to Dr. Culbertson: Has there ever been a neuroparalytic reaction reported in humans due to injection of duck embryo vaccine?

ANSWER: I do not know of any.

QUESTION to Dr. Robinson: Is a dog infectious during the incubation period?

ANSWER: Dogs are known to emit virus in the saliva in the latter part of the incubation period, say two or three days before actual symptoms are obvious, but only then.

QUESTION to Dr. Peck: How long does it take to tell antibody levels in an individual? How accurate is the test and what level is significant?

ANSWER: That's a loaded question. Well, as I said before, it takes two weeks to tell an antibody level if you are lucky and hit it the first time. Essentially, what you do is this. You get a group of six mice and give each group of six a mixture which consists of varying dilutions of serum incubated with 100 LD 50 of challenge virus and inject it intracerebrally. Then by determining the number of mice living, you arrive at a calculated figure of say 32, which would mean that a 1 to 32 dilution of the original serum protected 50% of the mice against 100 LD 50 of the challenge virus. It takes about two weeks and if you missed the endpoint, you

Tape recorded by Dr. W. A. Tornes, Chairman, Rabies Committee; transcribed by Mrs. W. A. Tornes.

have to put it on test again at higher dilutions and it takes a couple of weeks longer.

How accurate is the test? How accurate is any biological test—certainly not 100% by any means. It is a biological test. You cannot get exactly the same titrations from the same serum time after time, but they will fall in a rather narrow range so that I think you can say that a 1 to 32 dilution is certainly higher than a 1 to 40, or probably a 1 to 80. And whether the 1 to 32 is different than the 1 to 24, I do not know—it may not be. What levels are significant?—again, is a good question. I do not think anybody whom I have ever heard of or read about has ever received a 14 dose course of potent vaccine and who has been reexposed has ever died of rabies. It has been handed down by Dr. Fox and Dr. Horace Powell and several others—the higher the titer, the better off you are undoubtedly.

Question to Dr. Tierkel: Exactly what is the relationship between serum titers and actual protection against rabies?

Answer: As Dr. Peck has explained, a mixture of serum and virus is incubated and then inoculated into mice in a series of dilutions. What we are measuring here is the ability of serum antibody to neutralize given amounts of virus *in vitro* as indicated by the pathogenic effects of the mixture *in vivo* (in mice). We have no actual or experimental proof that serum antibody titer and actual protection are the same. Indirective assumptions are made on the basis of immunological principles. This is true in man. On the other hand, we do have good evidence that in certain species of animals, presence of antibody titers indicates actual protection to challenge with virus. Experiments have shown that this is true of cattle where relationship between antibody level and protection to challenge is fairly complete. In the dog we find this relationship on one side but not on the other. That is to say, whenever you can demonstrate antibodies you cannot bring these animals down by challenge. On the other side, some dogs without appreciable titers will likewise resist challenge.

At least we have a positive picture there. When we demonstrate antibodies we know we are in good shape. In essence we are applying these results in lower animals to human beings; it is rational to assume that there is some relationship between actual protection and the serum antibody picture in this test and that is as far as we can go.

Question to Dr. Culbertson: Where can one obtain a fluorescein test in Indianapolis?

Answer: I do not believe that anyone here or in the CDC—Dr. Tierkel can confirm it—is now using this test as a routine test in everyday practice. This is a new application of technic developed by Dr. Koons at Harvard University. I would expect that in the future this method would be increasingly valuable in many fields. I do not think we are quite ready yet to use it routinely.

Question to Dr. Tierkel: What is the incidence of rabies in rodents such as rats, etc.? Are there known exposure from these to humans?

Answer: I am sorry I cannot recall the exact incidence of rabies in rodents but I am able to tell you unequivocally that rodents do not play an important role in the transmission of rabies. There is an occasional rat and mouse that is reported in the national figures every year; not more than half a dozen out of 5,000 in all species. Sometimes we hear of so-called "outbreaks" of rat or squirrel rabies reported. Invariably, when we investigate them we find out that they are dying of another disease, that there are inclusion bodies found in the brain which are sometimes confused with Negri bodies and this is usually when the bubble breaks. They are not important vectors in the perpetuation of the disease. There never has been a known case of human rabies due to transmission from a rodent. As with all warm blooded animals they are susceptible to the disease and it is possible that bonafide cases could occur, but this possibility is quite remote.

Question to Dr. Robinson: Why observe an animal from 10 to 14 days when he is infectious for only 3 days prior to onset of symptoms?

Answer: I did not say to observe him for 10 or 14 days but that is the usual period recommended. I do not know what the upper or lower limit is before a dog has some symptoms with which the virus has been isolated from the saliva. Maybe Dr. Tierkel does. But the figure 2 or 3 is the one usually given. I think to rationalize

this is to keep a dog around to see if he does have symptoms or is going to develop symptoms and die. I doubt seriously if it is necessary to keep him that long if he is entirely healthy.

Dr. Tierkel: This is a very important point and I concur with Dr. Robinson and feel very strongly that there is no reason in the world to keep the animal under observation for 14 days. All regulations which still have this are badly dated because in no instance can you recover virus from the saliva of the dog except as Dr. Robinson says you would possibly 2 or 3 days before recognizable signs of the disease. The chances are that the prodromal stage of the disease has already begun; this stage is difficult to recognize unless definitive clinical examination is made. The disease is not recognized by most persons until rank classical signs occur later in the course. Ten days is certainly the longest that one should keep the biting animal for clinical observation. We are recommending 7 to 10 days now and this affords a reasonable margin of safety.

Question to Dr. Tierkel: Suppose we tell them to keep them for 10, 11 or 14 days and then on the 15th day the dog becomes sick and is diagnosed as rabies—then what do you do?

Answer: In the light of present knowledge, even though the animal becomes ill on the 15th day, one can safely assume the animal was not infectious at the time of the bite.

Dr. Salisbury: Regardless of the statement which just preceded, our Indiana regulation requires, nevertheless, a 14-day observation period and is presently in effect.

Question to Dr. Peck: Will you discuss antirabies serum?

Answer: I think you picked on the wrong man. Dr. Tierkel knows a lot more about it than I do. I think the rationale behind it was very well shown in the studies by the World Health Organization in Iran, where, as you know, they have a rabid wolf problem; and, in spite of 14 to 21 doses of presumed potent vaccine, there was still a 20% mortality rate in humans bitten by these wolves. It can definitely be shown that in these extremely severe bites that one or two doses of the proper amount of a hyper-immune serum at the beginning of therapy followed by complete treatment has dropped the mortality rate to zero. I think it does have definite indications, especially where you have a short incubation period and you need passive antibody protection for 3 to 4 months or whatever it is going to take. Erne, what about mortality from it?

Dr. Tierkel: I think you covered it very well in a nutshell. The indications of serum are in those cases where the exposure is such that you will associate it with an extremely short incubation period. In other words, you cannot protect an exposed patient with vaccine if the incubation period is going to be 16 to 22 days like some of the cases that we saw on the chart. In that instance you need already manufactured antibodies. Passive immunization has to be pumped into these people. Generally speaking, severe exposures particularly in the head, neck and face region, are usually associated with a short incubation period. In those instances one uses serum. Serum should be administered in doses given in the literature or on the package which is about ¼ ml per pound body weight which is a walloping dose, as you know. It is usually given intramuscularly in the butt. The average dose is about 50 ml in the average person. It is rather expensive. Serum sickness reactions have been reported at the rate of 50 to 75% in recent years. This is a delayed reaction which occurs 9 - 12 days afterwards. You should always, of course, test for sensitivity to preclude anaphylactic shock. There has been one fatality due to anaphylactic shock reported from Maryland two years ago in a child where the physician failed to test the child. Dr. Peck gave you the background of the Iran studies of the World Health Organization which were very dramatic—but not statistically significant. There is no question from corollary antibody studies that it does have very definite and real value.

Question to Dr. Tierkel: In one of Dr. Tierkel's cases and some of my own experiences, I am reminded of a question which I would like to ask him. The question is: where one of you gentlemen in veterinary medicine get a very severe bite on the hand (I've seen a couple of treatment failures in veterinarians that had a hand all chewed to pieces by mad dogs), and I cannot but feel myself, if I were to recommend

treatment that I would want to treat those with serum. I wonder if he agrees with that?

ANSWER: We know now that the attack rate is very high around head, neck and face. The hands are very important too. I agree.

QUESTION to Dr. Tierkel: Is there any kind of program of dog vaccination now in effect in Memphis and Dallas since their recent decline in rabies?

ANSWER: In Memphis they have annual mass immunication clinics, as I recall. I spoke with Dr. Luther Frederickson, who is the state public health veterinarian for Tennessee, and to Dr. Graves, who is the city health officer in Memphis, and they are quite interested and have been getting together with the local veterinary society in changing their program. They have not had rabies there since the old days, which is an excellent record, and they want to keep it that way. They are quite interested in going over to a modified plan; instead of having mass immunization clinics all the time, they consider themselves now a rabies-free area which is in constant danger of it coming back. They feel that a program for keeping up the immunization level of the dog population with less frequent vaccinations using Flury vaccine is the best bet now.

QUESTION to Dr. Tierkel: Discuss briefly the interference phenomenon with multiple injection hyper-immune antirabies serum in conjunction with vaccine.

ANSWER: In antibody studies it has been found if you give more than one therapeutic dose of serum plus the regular 14 daily doses of vaccine, there is some chance that the serum will interfere with the active immunization. By the same token, if you give one therapeutic dose of serum and less than 14 daily doses of vaccine you may also get interference. So the optimum is to give one therapeutic dose (not two!) plus at least 14 daily doses of vaccine.

QUESTION to Dr. Tierkel: How does the bat get rabies?

ANSWER: We have not been able to observe an actual transmission of bat rabies in nature, but we fully assume that bats get rabies like all other animals get rabies and that is by the bite, i.e., by inoculation of infected saliva through a bite wound. We know that bats are very effective biters through laboratory work which we have done. And we have been able to bring these creatures down by inoculating known strains of virus in them. So we assume that this is the way it occurs in nature. A great deal more work has got to be done on bat rabies and we are tackling it now at one of our stations in New Mexico.

QUESTION to Dr. Tierkel: In wild rabbits, cottontails have tularemia. Do you think this is confused clinicly with true rabies?

ANSWER: I do not recall having seen any reports of rabies in cottontails, and they fall pretty much in the same category as the other noncarnivorous animals. We have done large surveys in rodents and rabbits and in highly enzootic skunk and fox rabies areas and have never found any rabies in these animals. Between 1000 and 1500 animals have been screened in these known infected areas. I do not see any reason for difficulty in distinguishing clinical rabies from tularemia—but perhaps this is possible. Maybe Dr. Robinson has something to say about this.

DR. ROBINSON: I have never seen rabies in a cottontail. While I have the mike I would like to comment on the question of fluorescein antibodies that Dr. Culbertson mentioned. We are doing a little work in fluorescein antibody technics in virus diseases other than rabies but none on rabies. It was on TV, newspapers, etc.—I guess the work was done in Florida by the State Health Department. I checked with Miller of our own state laboratory and he didn't know much more about this particular work but apparently the technic is far from perfected from a practical application yet; but I feel like Dr. Culbertson, that it will be a matter of a year or two and it will be a practical contribution. Technic is being improved all the time by various agencies and it is interesting—apparently the salivary gland was used as an impression. The impression of the salivary gland rather than the brain for the fluorescein recovered virus.

QUESTION to Dr. Tierkel: What are your recommendations for cleanup of premises following death of a rabid dog?

ANSWER: Under ordinary circumstances in

a home, there is really nothing to be concerned about at all. The virus is extremely fragile. Exposure to ordinary atmospheric conditions will kill it in a matter of 5 to 10 minutes. We get many calls like that—"a dog died and slobbered on furniture; is it safe to keep the children in here?—should we disinfect the room?," etc. Nothing like that is necessary—just ordinary cleanup, ordinary atmospheric drying will render contaminated objects innocuous. On veterinary hospital examination tables, etc., you can use bichloride of mercury, Wescolyne or any strong disinfectants.

QUESTION to Dr. Tierkel: What is your origin of serum; is it equine serum?

ANSWER: Yes it is.

QUESTION to Dr. Tierkel: How long after an exposure to the bite, when a patient comes to you, how many days after that do you still consider use of serum in a severe bite?

ANSWER: Experimentally at least, with work that has been done in guinea pigs and in dogs, serum is of little or no value the longer you wait. The longer you wait the less value it is. Experiments in guinea pigs and dogs have shown it is of little or no value 72 hours after the exposure. But if there is a severe exposure and the patient does not get to you until later than that, do not preclude serum; give it anyhow. Give one therapeutic dose of serum and go on with your vaccine. At least you can hope that the serum antibody will ventralize the virus which has begun to multiply.

Technical Bulletin

INDIANA STATE BOARD OF HEALTH

1330 WEST MICHIGAN STREET, INDIANAPOLIS 7, INDIANA

A. C. OFFUTT, M.D., State Health Commissioner

No. 5 July 16, 1959

TO: All Physicians

SUBJECT: Processing Claims for Rabies Vaccine

In treating patients bitten by various animals the question often arises as to whether rabies vaccine may be obtained through use of tax funds. The Indiana State Board of Health does not treat patients with rabies vaccine nor does it provide or pay for vaccine. Two current statutes to provide for the furnishing of Pasteur vaccine providing the following circumstances prevail.

1. *IF A PERSON IS BITTEN OR OTHERWISE EXPOSED BY A RABID DOG*: Chapter 113 of the Acts of 1943 as amended by Chapter 152 of the Acts of 1959, Indiana General Assembly applies. "—the expense of taking the Pasteur treatment for hydrophobia incurred by *any person being bitten by, or exposed to,* a dog known to have hydrophobia, within any township of the State of Indiana. Any person requiring such treatment may select his own physician." The 1943 law was amended by the 1959 legislature by adding the words "exposed to."

PROCEDURE TO FOLLOW:

(a) Patient must have a *positive laboratory report* from the State Board of Health Laboratory or some other laboratory maintained by state, county or municipal funds, *or the affidavit* of an attending legally qualified graduate *veterinarian* stating that the dog that *bit or exposed* the patient was rabid.

(b) Physician forwards his bill for services and cost of vaccine, *with a copy of the positive laboratory report or veterinarian's affidavit* to the *township trustee* of the township in which the patient resides.

(c) The patient's ability to pay need not be considered under this law since the positive laboratory report or the veterinarian's affidavit makes the individual eligible under the provisions of this act.

(d) If the patient was not bitten by the dog, then the physician must judge from the facts presented to him the possible hazard of infection and necessity for the Pasteur treatment. Most authorities hold contact with the saliva of the infected animal to be "exposure" as used in this act.

2. *IF, HOWEVER, THE PATIENT IS INDIGENT AND IS BITTEN OR OTHERWISE EXPOSED BY ANY ANIMAL, THEN SECTION 1000, CHAPTER 157, OF THE ACTS OF 1949 APPLIES:* The physician can obtain rabies vaccine for his *indigent patient, bitten or otherwise exposed by any animal,* if, in the physician's opinion, treatment is warranted. Proof under this act that animal was rabid is not required. This law is of particular value when any *indigent patient* is bitten or exposed by *any* animal and the animal is not apprehended for surveillance.

PROCEDURE:

(a) Physician completes "Antitoxin and Vaccine Application Blank" (form SBH 2-18-24), obtainable from any local health officer or the State Board of Health.

(b) Patient's residence is indicated by writing his town, city or county of residence.

(c) Physician *must* sign the affirmation "I solemnly affirm that the free biologicals applied for will be administered to the person named above, and it is my belief after inquiry that the person is financially unable to pay for them."

(d) The completed signed application blank is surrendered to the dealer for the vaccine. The dealer signs the form indicating he has supplied the vaccine.

(e) The dealer forwards the completed form to the health officer having jurisdiction of the patient's place of residence.

(f) The local health officer certifies the form by writing "approved," entering the date and signing as health officer of the city, town or county indicated.

(g) The local health officer forwards the form to the proper city, town or county financial officer. *This blank is not to be sent to the township trustee.* Trustee is only obligated to pay for services under the 1943 act.

(h) The costs incurred in furnishing the biological shall be paid by the appropriate county, city or town against which the blank is issued from general funds not otherwise appropriated without appropriations. (Section 1005, Chapter 157, Acts 1949, Indiana General Assembly.) No provision exists for the payment of the physician's fees under this act. This act merely provides for furnishing the biological for the *indigent* patient under the noted circumstances.

SUMMARY:

(a) A non-indigent patient can qualify for the use of tax supported funds if bitten or exposed to the saliva of a *known rabid dog.* The non-indigent *cannot* qualify for treatment for bites or saliva exposures of animals other than dogs or where the offending dog is not captured and proven rabid.

(b) An indigent patient bitten or exposed to saliva of a known rabid dog can qualify (1) and (2) as described above. Under (1) the physician can be reimbursed for his services, but under (2) only the vaccine is provided.

(c) There is no provision in any law to pay for hyperimmune (anti-rabies) serum, human.

Rabies

INDICATIONS FOR SPECIFIC POST-EXPOSURE TREATMENT

NATURE OF EXPOSURE	CONDITION OF BITING ANIMALS AT TIME OF EXPOSURE	CONDITION OF BITING ANIMALS DURING OBSERVATION PERIOD OF 10 DAYS	RECOMMENDED TREATMENT
I. No lesions: indirect contact only (handling of food utensils, toys, bedding, etc.)	rabid		none*
II. Licks:			
(1) Unabraded skin; pre-existing wounds known to be more than 24 hours old and covered with an unbroken scab.	rabid		none*
(2) Abraded skin and abraded or unabraded mucosa	(a) healthy	healthy	none
	(b) healthy	clinical signs of rabies or proven rabid	*start vaccine at first signs of rabies in animal*
	(c) signs suggestive of rabies	healthy	*start vaccine immediately; stop treatment if animal is normal on 5th day after exposure***
	(d) rabid, escaped, killed, or unknown		*start vaccine immediately*
III. Bites:			
(1) Skin unbroken or wound protected from saliva by adequate clothing*	(a) healthy	healthy	none
	(b) healthy	clinical signs of rabies or proven rabid	*start vaccine at first signs of rabies in animal*
	(c) signs suggestive of rabies	healthy	*start vaccine immediately; stop treatment if animal is normal on 5th day after exposure***
	(d) rabid, escaped, killed, or unknown; or any bite by wolf, jackal, fox, or other wild animal		*start vaccine immediately*
(2) Lacerations and puncture wounds*	(a) healthy	healthy	*hyperimmune serum immediately; no vaccine as long as animal remains normal*
	(b) healthy	clinical signs of rabies or proven rabid	*hyperimmune serum immediately; start vaccine at first sign of rabies*
	(c) signs suggestive of rabies	healthy	*hyperimmune serum immediately followed by vaccine; vaccine may be stopped if animal is normal on 5th day after exposure*
	(d) rabid, escaped, killed, or unknown. Any bite by wild animal		*hyperimmune serum immediately followed by vaccine*

*Start vaccine immediately in young children and in patients where a reliable history cannot be obtained.

**An alternative treatment would be to give hyperimmune serum and not start vaccine as long as the animal remained normal.

NOTE: While desirable to administer hyperimmune serum early after exposure, there is no time limit on its use. Dose: 0.5 ml per kg of body weight at start of treatment, followed by course of not less than 14 doses of vaccine. Sensitivity to serum should be tested before serum is used.

These indications apply equally well whether or not the biting animal has been previously vaccinated.

Condensed Cardiology:

Treatment of Atrial Fibrillation:

Interrelation Between Digitalis, Vagus and the Myocardium

CHARLES FISCH, M.D.

Indianapolis

ATRIAL fibrillation is a common manifestation of heart disease, and although every effort should be made to diagnose the type of heart disease underlying the arrhythmia, not uncommonly and through no choice of our own the first therapeutic attack must be directed against the arrhythmia *per se* without regard for the type of underlying heart disease.

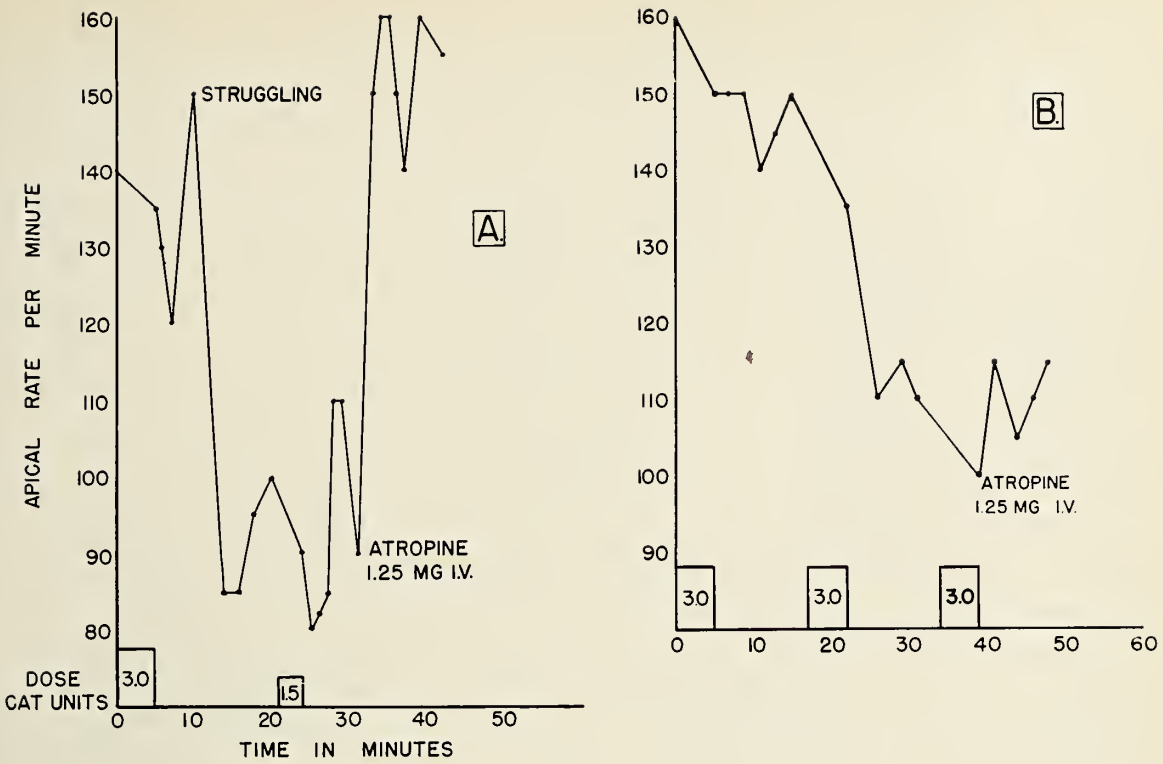
Since the adverse effects of fibrillation are usually due to a rapid ventricular rate, the initial effort should be directed toward the control of the ventricular rate. This is usually accomplished with digitalis. Digitalis, by depressing conduction via the atrio-ventricular (AV)node, decreases the number of impulses reaching the ventricles and thus slows the ventricular rate. The depression of conduction is a result of (1) stimulation of the vagus and (2) the direct effect on the conduction tissue. Only the latter effect results in a consistent control of conduction and thus the ventricular rate. The vagal effect is easily abolished by exercise, excitement or atropine. The recognition of this deceiving vagal slowing is extremely important for the proper management of atrial fibrillation.

The ventricular rate in atrial fibrillation, *if determined at the apex,* is a very reliable guide to the status of digitalis therapy. There is, however, a definite exception to this time honored "end point" of digitalization in cases of atrial fibrillation. It is well known that (1) rest alone will slow the ventricular rate and (2) that digitalis in amounts insufficient for complete digitalization will accomplish the same by its vagotonic effect. In neither case is the patient properly digitalized despite a satisfactory slow ventricular rate. This state of affairs may first become evident to the anesthetist who blocks the vagus with atropine and finds to his horror that this "well digitalized" patient has a ventricular rate of 150 and a tendency to "hypotension." Similarly an individual with a slow heart rate during early morning ward rounds when sent home may, with moderate exertion, have a ventricular rate of 150 and be quite uncomfortable. To avoid this "vagotonic" trap the ventricular rate should be determined after brief exercise or after subcutaneous administration of 1/100 or 1/50 grains of atropine before the individual is to be considered properly digitalized. The vagal and myocardial effect of digitalis and the value of atropine test in differentiating between the two is demonstrated in figure 1.

In our attempt to treat atrial fibrillation we are faced with two distinctly different clinical situations. In the vast majority, the patient presents himself with atrial fibrillation, with a moderately rapid ventricular rate (100-160 beats per minute), with or without overt congestive failure but not critically ill. Such patients should be digitalized with oral preparations of digitalis. We use digitoxin in all previously non-digitalized patients and occasionally resort to digoxin if the state of digitalization is in question. The initial dose of digitoxin is .6 mg followed in 6-8 hours by .4 mg. Subsequent doses of .2-.4 mg are given once or twice daily depending on the urgency of the situation until the apical rate is about 70 beats per minute.

The above outlined schedule may vary but could be described as representative of "moderately rapid" digitalization. In our opinion, once digitalization is decided upon, there seems

From the Robert M. Moore Heart Clinic, Marion County General Hospital, Indianapolis.



This figure shows the effect of atropine after administration of "non-digitalizing" and "digitalizing" doses of acetyl strophanthidin to two patients with atrial fibrillation. In figure A the ventricular rate was slowed from 150 to 80 with 4.5 cat units of the drug. However, blocking of vagus with 1.25 mg of atropine caused an immediate rise of the rate to 160, indicating that the acetyl strophanthidin exerted its effect purely through the vagus. In figure B, after 9 cat units the same dose of atropine caused a very slight rise of ventricular rate, suggesting that the slowing of ventricular rate was due to direct effect of the drug on the conduction tissue.

to be little reason to drag out the procedure for days. Naturally if the degree of digitalization is in question at the time the individual is first seen, extreme caution may be necessary. In such cases it has been our policy to give .2 mg digitoxin or .5 mg digitoxin twice daily, always watching for signs of digitalis intoxication, until the desired ventricular rate is achieved. One must remember, however, that in presence of fever, embolization, active carditis, thyrotoxicosis, beri beri, anemia and myocarditis it may be difficult, if not impossible, to achieve the optimum ventricular rate. In such cases persistent effort to reach the desired apical rate by giving more and more digitalis will result in severe digitalis intoxication in face of a persistent rapid ventricular rate.

Approximately 10% of the patients with atrial fibrillation present themselves with rapid ventricular rates superimposed on severe heart disease with resultant shock, "coronary" pain and/or progressive heart failure. Such patients require emergency care and are treated with norepinephrine and digitalis. The latter is given intravenously in form of lanatoside C. The initial dose is .6 mg and is repeated every 30-40 minutes until the desired ventricular slowing, sufficient to raise the blood pressure, without support of norepinephrine. At that point digitalization with digitoxin is started. One must remember that lanatoside C dissipates rapidly and full digitalization with digitoxin will be required.

In this brief presentation an effort was made to outline the management of atrial fibrillation. The problem of conversion of atrial fibrillation to sinus rhythm is beyond the scope of this paper.

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1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

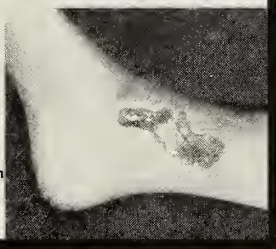
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. . . swelling
. . . cleared
by fifth day[2]





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. . . resolved with
VARIDASE[1]





INFLAMMATORY DERMATOSIS
rapidly spreading
rhus dermatitis
healed within
a week[1]





INFECTED LACERATION
marked reversal
in 3 days. . .
returned
to school. . .
osure advanced[1]





THROMBOPHLEBITIS
back on his feet
in a week after
recurrent episode[1]





REFRACTORY CELLULITIS
normal routine
resumed after 4 days
of VARIDASE[1]

The Journal of the Indiana State Medical Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year of 1959-60 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of $100.00, a second prize of $75.00 and a third prize of $50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1960.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.



The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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'ONE WORLD' OF TRANSMISSABLE DISEASE

IT'S A SMALL WORLD—and getting smaller all the time.

By jet aircraft Americans are less than a day's travel from any other country on earth. Very convenient if one desires to travel someplace, but we are now entering an era in which some inconveniences of fast air travel must be reckoned with. The same jet planes that get us there so fast may also serve to transport the vectors of disease or human carriers of disease.

Just as the voyages of Magellan and Columbus and the explorers after them spread disease from the old world to the new world and vice versa, the rapid transit of today will undoubtedly tend to universalize the world's transmissable ailments.

No disease has ever been treated out of existence. All the great plagues are still represented by a focus of active and virulent disease some place in the world, and probably in several places. Slow travel, immunization, inspection and sanitation of carriers, and quarantine have all served to protect us in the past, but now we are living in what has been called the "One World" of transmissable disease.

Sanitation and spraying of airplanes to rid them of insect vectors is now the custom in localities where such preventives are needed. Another element of the problem, however, is not so easy to deal with. A person may become infected with disease several thousand miles away, fly home during the incubation period, and actually expose others to the infection before he is clinically sick or in a diagnosable stage.

All of which reminds us that strange and exotic diseases are now or may be with us, and

should be considered in the diagnosis of any unusual malady.

Questioning the patient about his travels will not always rule out such foreign diseases, since the patient may be one of those who hasn't been out of his own locality, but has contracted the disease from some traveler whom he does not know.

It may be that the interest and knowledge of tropical disease which was propagated by military service in World War II will be of use in the peace time United States.

INDIANA LEADS IN MARRIAGE DECREASE

MARRIAGES in the United States have decreased during the past two years. The Statistical Bulletin of the Metropolitan Life Insurance Company announces that there were approximately 1,585,000 marriages in 1956, 1,518,000 in 1957 and 1,456,000 in 1958, a decline of about 4% in each of the last two years.

The marriage rate in 1958 was 8.4 per 1000 population. This figure includes the Armed Forces overseas, and even at that is the lowest rate recorded since 1932.

The early returns for 1959 indicate a slight increase over similar months in 1958. Since the depression in marriages was most marked in the period from September 1957 to March 1958, it is thought that the depression in finances was the main reason.

The number of persons attaining marriageable age during the past few years has been under standard figures due to the marriage depression in the early 1930's. The country is now approaching a period in which the number of people of proper age will be relatively larger. This together with the present recovery from the business recession and its attendant financial worries is expected to restore the marriage rate to its accustomed place.

The overall 4% decrease in marriages from 1957 to 1958, when tabulated by states, is found to be an average of a remarkable amount of variation. Marriages decreased in only 26 states and increased in 22 states and the District of Columbia. States varied all the way between minus 45% and plus 23.3%.

Indiana recorded the largest decrease of all, a drop of 45%. This is said to be due to the new law which requires a waiting period. This was effective in January 1958 and during that year only 41,226 marriages were solemnized in our state as compared to 74,891 in 1957.

The state of Mississippi raised the age for marriage on July 1, 1958 and hence, during the second half of that year recorded marriages at a rate about two-thirds below that for the preceding half year.

As would be expected the states bordering on the ones with new legal requirements enjoyed an upswing. The largest gains were in Kentucky and Ohio, and in Alabama, Tennessee and Arkansas.

In addition Oklahoma with a yearly increase since 1952 and Florida with a rise which dates back for six consecutive years are entered in the record as marriage boom states without any ready explanation.

All the cities of the U. S. of 100,000 population and over, as a class, had a decline in marriages of 2%, half of the general decline. Again Indiana led the list with the three such cities with the largest decreases in the nation; Evansville—less by 25%, South Bend down 18% and Gary down 17%. The nearness of these population centers to other states would reinforce the theory that the change in legal requirements moved the marriage business elsewhere.

The statisticians await the two new states with anticipation. However, as territories, the record was a bit contrary to expectation. In Hawaii, the land of romance, marriages fell by 3% from 1957 to 1958 and in Alaska, an increase of 3% was noted.

HOSPITAL CARE IS A BARGAIN

A RECENT Associated Press news item* concerning President Eisenhower's speech to the American Medical Association is a good example of tailoring a story to make it sound any way you want it.

The President's remarks in regard to inflation were addressed to doctors to remind them that medical fees should remain within a range that people could afford to pay. With this everyone agrees.

Between 1939 and 1959 the general cost of living increased by 108.6%. During the same period of time doctors' fees have increased 84%. So far, so good.

The news story, however, refers to the increase in hospital costs as its main point. The rise in such costs is quoted as being in the neighborhood of 300%

The facts—based on the average production workers' wages, five days in a hospital room in 1939 cost the worker a week's wages; in 1959 five days in a hospital room costs the worker only 5% more than a week's wages.

*News item is reproduced in "Fourth Estate," page 1430.

When it is considered that hospital treatment is much more efficient and effective now than it was 20 years ago, and that the hospital stay is much shorter, it would appear that the worker actually pays less now than he did in 1939, and in addition enjoys a higher cure rate and lower mortality rate than ever before. Hospital service today is actually one of the biggest bargains of them all.

The worker today in terms of real wages pays 52% of what he did in 1939 for medical care and drugs, 49% for physician's fees, 43% for an appendectomy, 47% for a house call.

The main reason why hospital rates cost a little more, in terms of wages, in 1959, is that wages which have increased in all other fields have also been forced upward for hospital employees. Between 65% and 70% of a hospital's total expense is represented by wages. When the payroll goes up, the cost of hospital rooms also goes up.

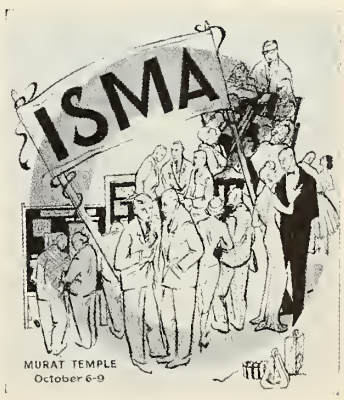
All those who worry about the size of hospital bills should spread their concern around a little and worry about the inflating effect of wage increases in general.

"Bigger and Better Than Ever"

Keeping in tune with our 1959 Convention—"bigger and better than ever"—the September Convention issue has a new look. It's "Kromekote," a high gloss cover paper designed to aid in finer reproduction of photography and colors. Starting with this issue, "Kromekote" will become a Journal "regular"—part of a continued effort to offer more attractive reading to the Indiana medical profession.

Our cover artwork featuring various sketches of convention activities is self-explanatory. We wrote to Miki Wilson, artist currently living in Hawaii, sending photos of last year's convention. She created this artistic montage to depict Hoosier physicians working to improve their profession.

We'll see you at the Convention in Indianapolis!



President's Page

Hearings by the House Ways and Means Committee of the Congress on the Forand Bill has brought nation wide attention to the problem of the aged. Also it has created a demand on the part of some that the medical profession and the insurance industry must do something to solve the problem at once, or else the government will step in to provide the medical care for these people. The Indiana State Medical Association filed with the committee a statement pointing out the bill did not begin to cover the problem of the aged, and while it is evident the hearings were put on for a show, and it is not thought the bill will get anywhere this session, the fact remains it has served to add encouragement to those who would have the government take over the responsibility of the medical care for the people of our nation.

In reviewing the statements made by several of those who are proponents of the bill, it is interesting to note that all were in the same vein. Mainly that people could not afford to pay the present day high cost of medical care, nor could they afford to pay the high cost of insurance for hospital and medical care. The AF of L-CIO representative pointed out that while physicians and the Blue Plans were doing a good job—more had to be done—and especially something had to be done on the high cost of hospital stays.

Even though the bill does not come out of committee this session, physicians and especially hospital staffs should take warning of some of the charges being made toward our present day medical care system.

The doctor is the only one who can properly direct patient care and the hospital is an important facility for the doctor to use to attain the goal of proper patient care. Medical staffs in all hospitals should review their organization and their objectives. The medical staff should see to it that the medical practice is good and ethical. It should also help by setting up standards and helpful guides for all doctors. Programs should be established to help young doctors become aware of all the facilities and methods of procedure as well as the problems facing the profession. Every patient should have all available means to return him to health as soon as possible.

Medical care has become more and more complicated as well as improved and I hope that more and more of us will become interested enough to volunteer our services in hospital and medical society work to help solve the many ramifications of attaining good health for our people at a cost they can afford.

Kenneth L. Olson M.D.

What to Look for in Comparing Health Insurance Programs

This article is the seventh in a series prepared by Blue Cross-Blue Shield.

Back in the late 1940s, when Blue Cross and Blue Shield were new in the field, we had very little competition from commercial insurance companies. At that time most of them believed that health care was uninsurable. But with the successful growth of our Plans, commercial companies gradually developed health care programs, and today Blue Cross and Blue Shield are active in an extremely competitive field.

Some of the things we have learned in meeting competition can be helpful to anyone interested in comparing the value of a Blue Cross-Blue Shield program and a commercial program. To start with, we know we're in business to provide necessary benefits to members at the lowest possible cost. We also know that our competition is in business to make a profit.

The next step is to find out how our competitor intends to make the profit. First, the *benefits* as well as the *benefit patterns* of the commercial company should be compared item by item with the Blue Cross-Blue Shield program. In making this comparison, search for the profit-making "gimmick."

Many times a commercial company will list a higher allowance than Blue Shield for surgical procedures of low frequency, while carrying a lower indemnity than Blue Shield for high frequency procedures. The commercial company may pay $200.00 for a "spinal accessory-hypoglossal neuroanastomosis," as compared to our $150.00. The same commercial program may pay only $90.00 for an appendectomy, while Blue Shield pays $100.00 for the higher frequency procedure.

Commercial companies many times furnish brief lists of surgical indemnities, selecting those in which they excell and playing down or omitting others.

Often they pay a set room allowance for hospital charges. This allowance may be adequate locally, but inadequate in a nearby large city.

A similar technic is used frequently in paying for the physician's services for in-hospital medical care. The commercial company may pay a higher allowance for the first day, but taper off so the total benefits received would be less than those furnished by Blue Shield.

Blue Cross-Blue Shield pays out almost 90 cents of each membership fee dollar received for doctor and hospital bills. How much of the premium dollar does our competitor plan to return in benefits? Many times this figure will be padded by the use of reserves, commissions, etc.

Quite often the commercial company pays for anesthesia only if such services are rendered by a salaried employee of the hospital. Blue Shield pays anesthesia indemnities to practicing physicians.

Also check the limitations of the contract. In the hospital portion of the program, does the contract set up a 30-day maximum per *admission*—or 30 days per *condition?* Blue Cross pays on an admission basis, which means more benefits to the member. Is the in-hospital medical program set up on an admission or condition basis? Blue Shield also furnishes protection on an admission basis, with corresponding added benefits.

Does the surgical maximum apply to condition or procedure? Blue Shield's $300.00 program—compensation on a procedure basis—has paid up to $1,500.00 for one condition for one patient. Most commercial companies pay so much per condition, rather than per procedure.

Another thing to check is what the commercial program offers in the way of conversion privileges to retired or terminated members, including those leaving employment due to a serious health condition. Blue Cross-Blue Shield allows these people to retain membership. Many commercial companies cancel coverage at the time it is needed most. Some companies allow a conversion privilege, but the cost of their direct pay contracts is formidable.

All these points have proved of value to Blue Cross-Blue Shield sales representatives in competitive situations. They can be used to advantage by anyone interested in knowing the facts about how a particular commercial program *really* matches up with a corresponding Blue Cross-Blue Shield program.

Warren C. Huddlestone

The Woman's Auxiliary

REPORTS TO I.S.M.A.

DISTRICT COUNCILORS



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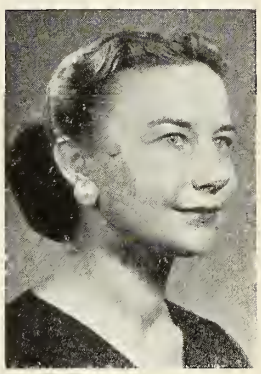
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District 13

The chairman of our councilors is elected at each House of Delegates meeting. A district councilor is elected by the auxiliary members present at their district meeting. She serves a term of three years and may not succeed herself.

Our councilors help organize new counties, and act as liaison between the state and county organizations. They are members of the State Legislative Committee and the State Board of Directors. The councilors plan their district meeting.

EVERYONE COME TO THE INDIANA STATE MEDICAL MEETING IN INDIANAPOLIS OCTOBER 6, 7, 8 and 9. EDUCATION AND ENTERTAINMENT FOR ALL!

Mary Annette Black

MARY ANNETTE BLACK, *President*

Statement of the Indiana State Medical Association

Re: H. R. 4700 (Forand Bill) to the 86th Congress House Ways and Means Committee

Presented by
DONALD E. WOOD, M.D.
July 14, 1959

I am Dr. Donald E. Wood, a practicing physician in Indianapolis, Indiana. I am representing Dr. Kenneth L. Olson of South Bend, Ind., president of the Indiana State Medical Association. I am here to file with your committee a statement on behalf of the 4,217 practicing physicians of Indiana who comprise the Indiana State Medical Association. This statement is intended to show that the provisions contained in H.R. 4700, known as the Forand Bill, do not meet the need and are not necessary so far as Indiana is concerned.

The physicians of Indiana, in cooperation with many groups such as the State Board of Health, The Governor's Committee on the Aged and Aging, the state universities, professional and civic organizations, and local community committees, have had a deep interest in the problems of the aging for several years. Studies have been made and are currently under way in many communities throughout our state. Experimental pilot programs in various fields have been instituted and are in operation. We believe these programs already have evidenced the ability of Indiana people and communities to solve any and whatever problem exists in the group of individuals which H.R. 4700 is intended to benefit.

From our studies of H.R. 4700 as now written, and from our studies of the problem of the over 65 age group in our state, we do not believe the Forand Bill intends to solve the problem, but serves only as a vote-getting mechanism, a means of increasing the social security taxes from which the public will gain little or no benefit.

For your information and your record, let us give you some statistics on Indiana so far as the aging problem is concerned:

Estimated population as of today of people in Indiana age 65 and over, 442,000. (Estimate by Indiana State Chamber of Commerce.) (1950 U. S. Census, population age 65 and over, 361,026.)

Of the above number, we know the following:

112,000	are veterans of military service
105,000	are protected by Blue Cross and Blue Shield
128,331	are protected by private insurance carriers
110,510	are drawing pensions or retirement from private sources
3,381	are domiciled in mental institutions
79	are domiciled in T. B. hospitals
475	are domiciled in Soldiers and Sailors Home
100	are incarcerated in penal institutions
2,500	are miners covered by UMW Retirement and Welfare Fund
325,583	are drawing monthly social security benefits totaling $17,978,200 per month (as of December 31, 1958.)
30,875	is the average number of people receiving medical aid per month from the Indiana State Department of Public Welfare
300,560	own their own homes. (Report Indiana Commission on Aged, September 1957.)

In a study of nursing homes in Indiana, we



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With its selective action on the vomiting center, or the medullary chemoreceptor "trigger zone," Mornidine possesses the advantages of the phenothiazine drugs without unwanted tranquilizing activity.

Doses of 5 to 10 mg., repeated at intervals of six to eight hours, provide excellent relief all day. In patients who are unable to retain oral medication when first seen, Mornidine may be administered intramuscularly in doses of 5 mg. (1 cc.).

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G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

ISMA Statement

Continued

have studied the homes in 44 of Indiana's 92 counties and to date we find the following facts concerning census and payment for care:

4,334 people 65 years of age and over reside in nursing homes
1,083 of these are paid for by welfare
66 are paid for by the township trustee
301 are paid for by a combination of social security and welfare
811 are paid for by private organizations
1,951 are paid for by the individual or family

The remainder of the nursing homes throughout Indiana will be studied within the next two weeks by personal visit by our staff. We will have a complete picture of the type of resident in our nursing homes and facts as to who is paying for their care. Indications in the approximately 50% of our counties are that the majority of the residents are able to provide for their own care.

We only regret that time has not permitted a complete census of our total population over 65. This plan is off the drawing board and, in a matter of weeks, a complete census of our 65-year population, their economic status and their needs will be collected by hundreds of volunteer workers throughout the state.

We firmly believe a thorough analysis must be made of every suggested problem and every recommended remedy. We are not convinced this has been done by those who are credited with supporting H.R. 4700. Instead, they appear to be making educated guesses based on hearsay and meager localized statistical information which has been projected as the true situation throughout the nation.

Facts readily available to the Congress can prove conditions vary in every section of our nation. It is proved there is a segment of our population which rejects hospital, surgical and medical care for religious belief. It is proved a segment of our population does not believe in insurance and would not accept it if given or offered for as low as a dollar a year. None of these facts has apparently been taken into consideration in the formulation of this proposed legislation. No legislation can be offered which will solve the problems of all our citizens other than under a dictatorship type in which all could be forced to follow the will of the dictator. History is full of evidence showing that even this type of government has not solved all problems, but on the other hand, has created many, and eventually unrest always develops among the masses.

They Want to be Free

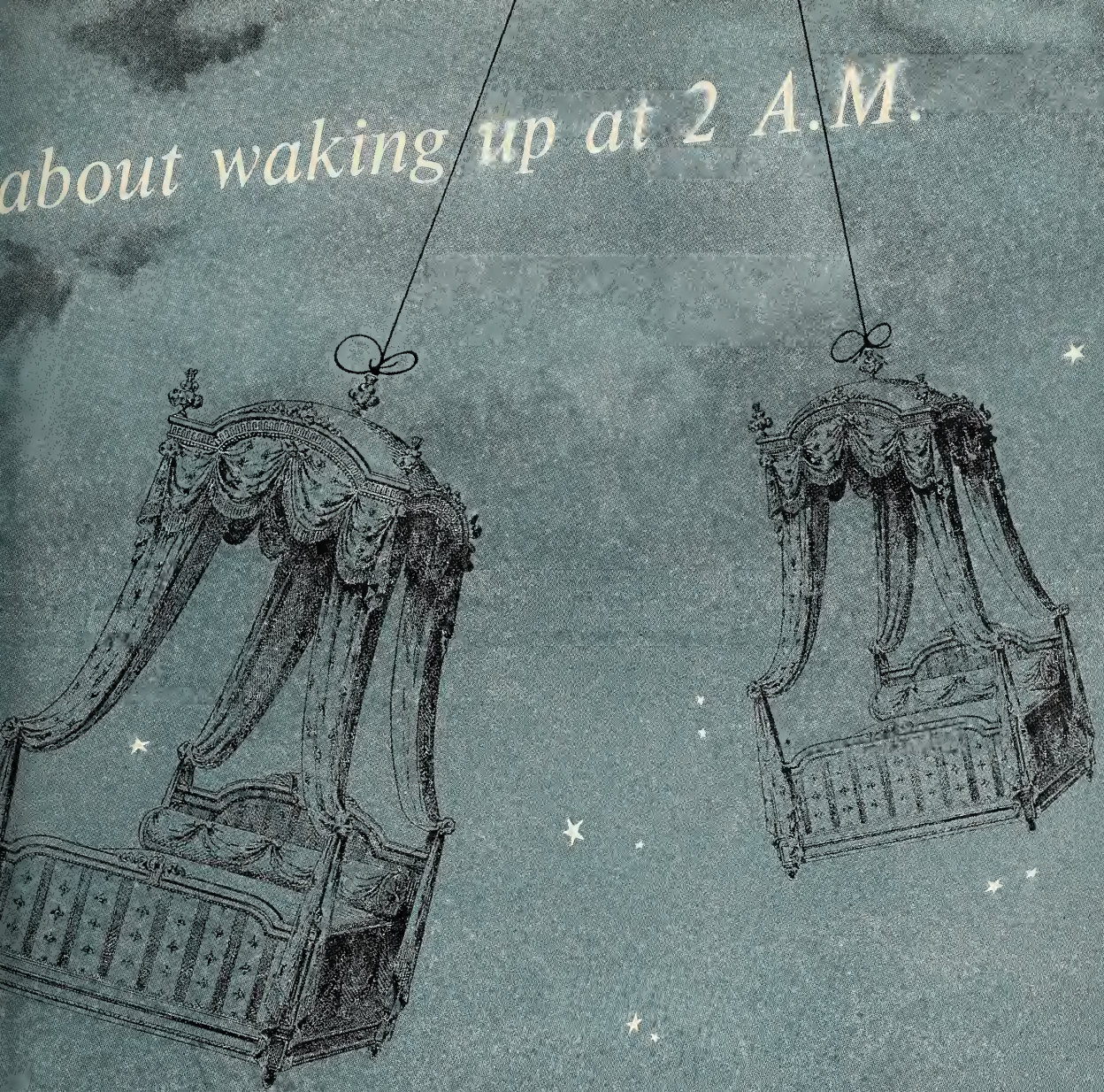
From our experience, we firmly believe the majority of our people want only a few basic benefits. They want to be free souls . . . they want the right to make their own decisions and to determine their own destinies . . . they want the opportunity to work . . . they desire the opportunity to occupy a place in gainful employment so long as they are able to produce and until they themselves decide to change their mode of living . . . they want the opportunity to earn their income, to spend or save as they desire, without the government's taking all their money except that which is necessary for a bare existence. No man appreciates living a "hum-drum" existence because high taxes leave him little or nothing with which to do the things he desires to accomplish.

Continued to page 1490



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with low incidence of sensitivity reactions . . .
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0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION
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timed-release tablet

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NEBRALIN is designed to duplicate the normal sleep pattern. It encourages muscular relaxation and induces sustained, relaxed sleep by the release of Dorsital and mephenesin in a timed-release tablet. Rapid-acting mephenesin quickly relaxes skeletal muscles to overcome "fatigue-tension" and conditions the body for sleep. Dorsital provides CNS sedation to induce sound, relaxed sleep. The initial and sustaining dosages are designed to keep the amount of barbiturate to be inactivated at any one time at a low level tapering toward morning. Evidence indicates that mephenesin is capable of producing sleep,[1] and when combined with a barbiturate enhances barbiturate action.[2, 3] Moreover, the integrated action of the two components permits smaller dosages of each,[4] assuring your patients refreshed awakenings without "morning hangover."

1 Schlesinger, E. B.: Tr. New York Acad. Sc. 2:6, (Nov.) 1948.
2 Richards, R. K., and Taylor, J. D.: Anesthesiology 17:414, 1956.
3 Shideman, F. E., Postgrad. Med. 24:207, 1958.
4 Berger, F.: Pharmacol. Rev. 1:243, 1949.

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ISMA Statement

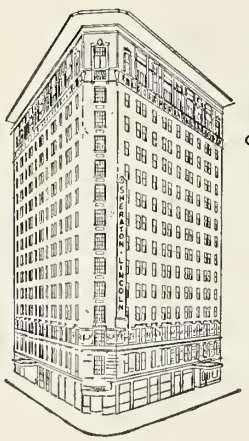
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Since 1939, the people of Indiana have witnessed an increase of 1,421% in federal taxes levied on them in addition to an increase in state and local taxes amounting to 687% during this same period. Now, you are proposing to add again to the already too high tax burden, which will leave still less for family needs and wants.

The youth of today are beginning to calculate the amount of money which legislation such as this will take from them during the 45 years of their earning capacity and comparing the "benefits" with those they could provide for themselves from private investments and insurance programs with this same amount. A careful analysis will soon prove H.R. 4700 is no bargain for the people of our nation.

We have mentioned previously that many people in Indiana are actively engaged in many different experimental or test programs and searches for facts and problems in order that the people and the community together can approach an intelligent solution to whatever problems they may find. We would like, as briefly as possible, to tell you of these programs.

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Allen County
Stroke Patient Project

Planned in 1958, the Visiting Nurses Association of Fort Wayne undertook the responsibility of administering this project. Financial assistance was obtained from the Indiana State Board of Health for the employment of extra personnel to carry on the project.

Fifty-three stroke patients have been admitted to the project since its beginning in January of 1959. Of these, six have been moved to nursing homes, one to a boarding home, one has moved from the city, four have expired, nine have progressed to the point where health guidance only is being given. Of the remaining 32, many are making spectacular improvement, many are making better use of their remaining functions and others are learning to live with their afflictions. Several patients who have had six months or more elapse since the occurrence of their stroke are making good progress . . . beyond their hopes.

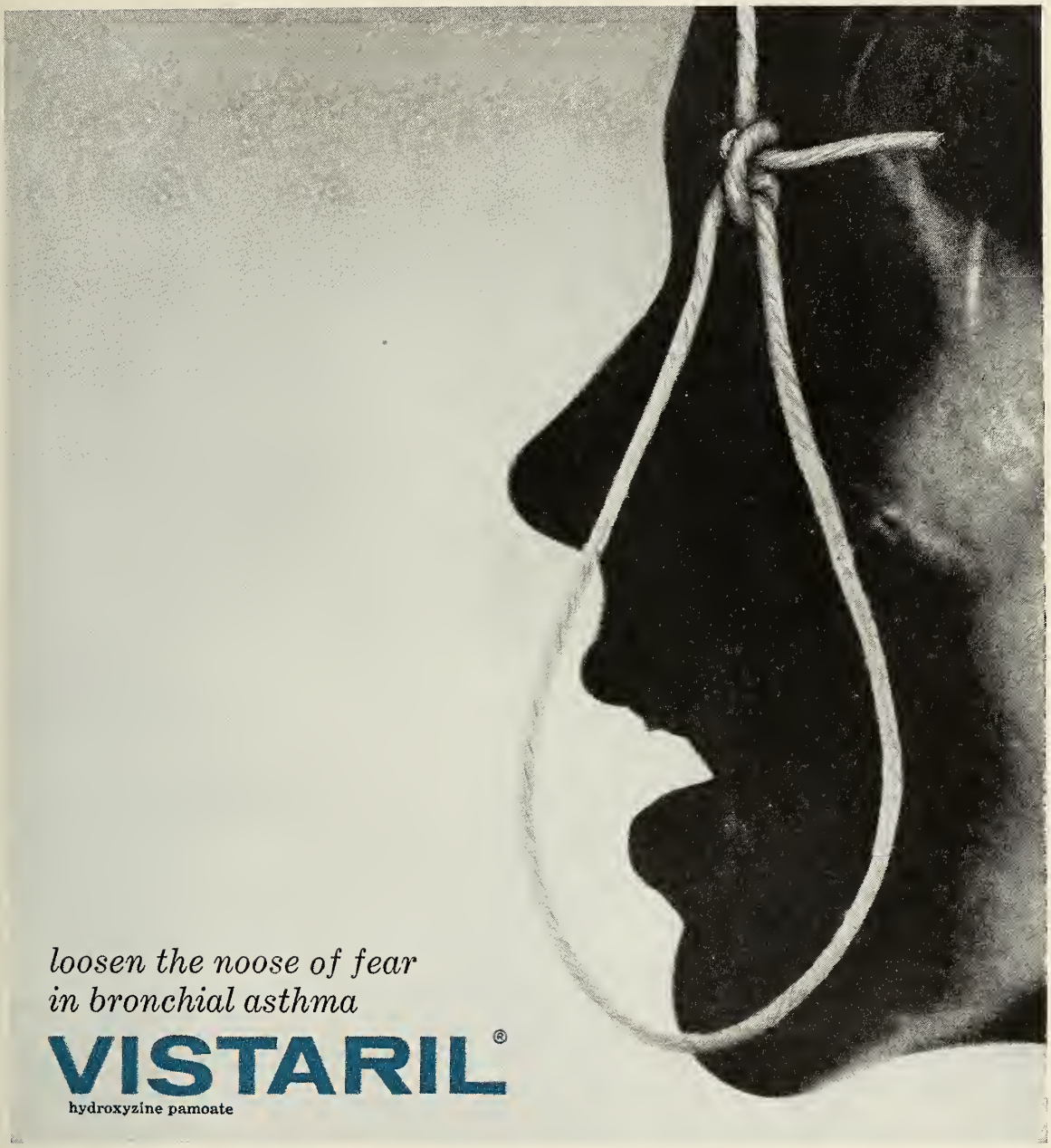
This test program had as its purpose, "To demonstrate that the stroke patient can, with Visiting Nurse Service and housekeeping aid, carry on a restorative program at home to the end that independent living will be achieved more rapidly for more patients."

The objectives of this test program were:

a. To define the kinds of service that are needed in homes which are reasonable in cost and effort as they relate to the standard of living in each home.
b. To determine the number, amount and level of patient care that is needed to reach and maintain maximum restoration.
c. To determine whether it is administratively feasible and practical for a voluntary nursing service agency to recruit, train and utilize "housekeeping aides."
d. To determine the influence of housekeeping aid service in extending nursing care.

The objectives of this plan necessitated the following:

A. Orienting and initiating visiting nurse staff to integrate this plan into present program.
B. To evaluate current case load of "stroke" patients as to specific services needed by patient.
C. To establish criteria for the selection of



...*unties the mental and physical knot* • tranquilizes anxious asthmatics • relieves apprehension • relaxes muscular tension • supplements anti-asthmatic medication

Vistaril was designated as a psychotherapeutic antihistamine by the A.M.A. Council on Drugs in 1958. A professional information booklet providing complete details on Vistaril is available on request.

Suggested oral dosage – adjust according to response: Adults, 50 mg. q.i.d., initially. Children over 6, 50-100 mg. daily in divided doses. Children under 6, 50 mg. daily in divided doses.

Supplied as Capsules – 25, 50, and 100 mg.; bottles of 100 and 500.
Oral Suspension – 25 mg. per teaspoonful (5 cc.); 1 pint bottles.
Parenteral Solution (as the HCl) – 25 mg. per cc.; 10-cc. vials and 2-cc. Steraject® Cartridges.

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ISMA Statement

Continued

patients to receive housekeeping aid service.

1. Patient requires some daily exercise or practice of affected parts to promote the return of normal function of affected part. These exercises are of such a nature that non-professional assistance, when supervised, can be useful. There is no family member available or competent to do this service as often as it is required.
2. Patients who do not have the assistance that they require to maintain daily hygiene (bathing, mouth care, elimination care) are expected to be only temporary patients and that either family or community agents will obtain permanent care.
3. Patients similar to those described in 2 above who need assistance with nutrition and food services.

D. To recruit and train housekeeping aides in accordance with the criteria listed below.

E. To select and assign patients to receive housekeeping aid service according to above criteria.

F. To obtain physical evaluation of each patient as he is admitted to the program.

G. To conduct actual housekeeping aid services in accordance with the purposes of this project.

H. To obtain periodic physical evaluations of the patient and his progress.

I. To analyze and study information twelve months after initiation of the program and annually thereafter.

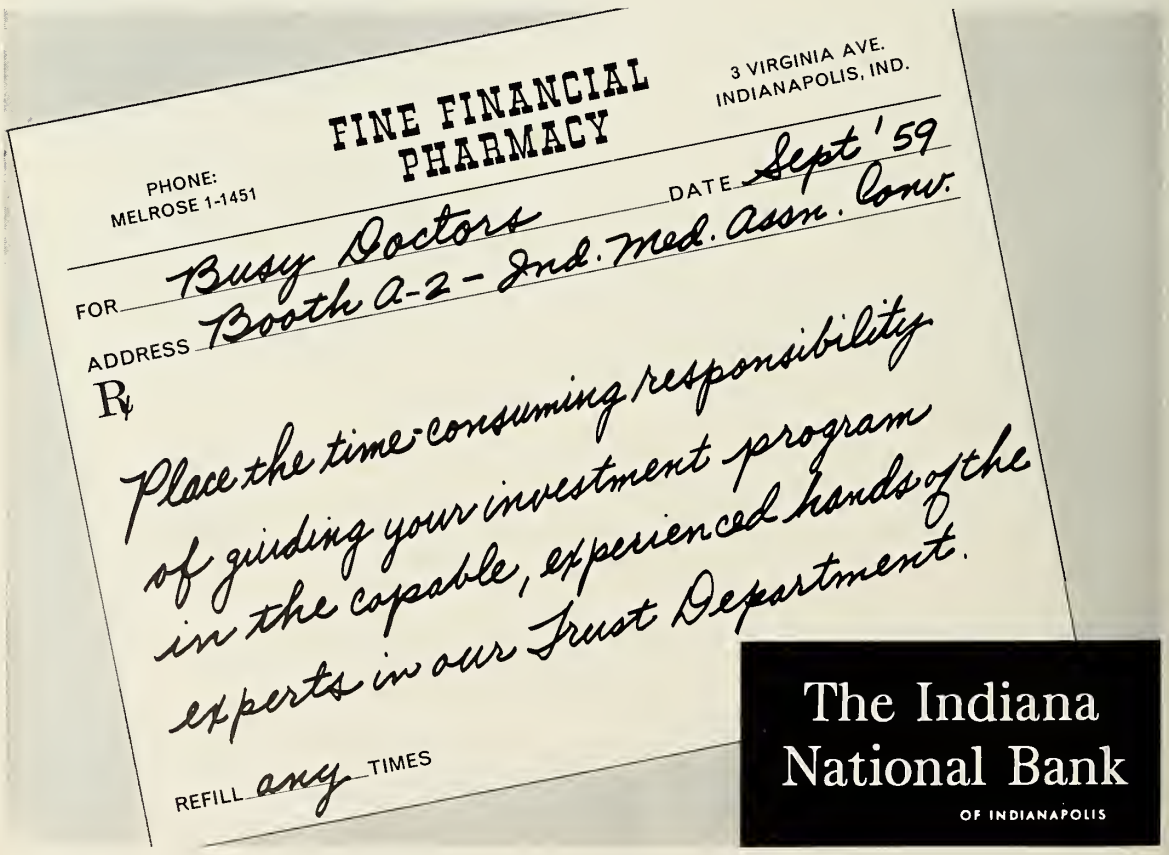
The following guides were established for defining functions and duties of housekeeping aides:

A. Carry out personal care procedures after demonstrated and approved for care of the patient.

B. Carry out exercise practice (such as crutch walking) or other written instructions for rehabilitative procedures after demonstration and approval.

C. Assist with those housekeeping tasks which the patient or family are temporarily un-

Continued to page 1496



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In anxiety, tension and agitation, ATARAX "... produced a more favorable state of calm and tranquility than any drug previously used."[1]

☞ **widest latitude of safety and flexibility**

No serious adverse reaction ever documented – five dosage forms and sizes

☞ **chemically distinct among tranquilizers**

Not a phenothiazine or a meprobamate

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These unique benefits in specific indications

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BACKED BY A WORLD OF EXPERIENCE

Dosage: ADULTS, one 25 mg. tablet, or one tbsp. Syrup q.i.d. CHILDREN – 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.

Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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ISMA Statement

Continued from page 1492

able to carry out, but which are directly related to patient care and well-being.

This program, while in operation only a few months, has shown much can be done in handling age 65 and over stroke victims. Present findings are expected to lead to great advancement in helping to keep these people useful and happy citizens and prevent many from becoming totally dependent upon charity to look after their wants until death.

It is impossible to evaluate the amount of emotional release to both family and patient as a result of having a change of atmostphere, which this plan allows. Also, in cases in which the aide has helped with exercises and encouragement of the patient, both patient and family benefited. The road toward maximum restoration following a stroke is long and difficult when viewed as a whole. When short-term goals are established, and appreciated when reached, all those involved with the restorative process gain new strength and courage. It is worthy to note also the increased interest the children are taking in their parents who are involved in this test program. It seems they, too, have caught the spirit of hope and interest, and want to have a part in the care and assistance of their parents. This is a different attitude of the children toward the aged parent than that which has been experienced in the past.

We sincerely believe further testing of this program will conclusively show that proposals, such as H.R. 4700, are not only not necessary but useless in situations such as those provided for under this program.

While this test program has been beneficial in learning what can be done, and how patients and their families would accept such a program, it represents only a small portion of the research necessary to determine the total problem.

Retirement Study

In still another test program currently being conducted in Indiana we refer you to the Bartholomew County (Indiana) Retirement Study.

The study of the problem of the aging and the aged in Bartholomew County is designed to bring into focus: *"What do the people, as citizens of Bartholomew County, need to know about the problems of the aging and the aged in their community?"*

In order to answer this question, it was necessary for the committees of the Foundation to develop studies:

1. *To collect* data about needs and problems which people face before and after retirement;
2. *To inventory* resources available for meeting of these needs and the extent to which they are being used;
3. *To determine* if there are needs which are not being adequately met;
4. *To gather* information about the attitude of older and/or retired workers toward themselves, toward each other, toward the world in general, and the attitudes of other age groups toward them;
5. *To evaluate* the influence of these studies and projects within the community and the effectiveness of the methods used;
6. *To provide* a procedure for community self-study, and the means with which such study can be carried out, for use by other communities.

These studies lead to action designed:

1. *To help* the community develop and conduct programs and services designed to meet the needs of people before and after retirement;
2. *To promote* a better understanding of the problems of aging among the participants and general public in the community;
3. *To help* participants gain insights and experiences in the use of systematic methods in community problem solving;
4. *To pass on* information and experience which may prove useful to other agencies and/or communities in the state of Indiana and the entire country in conducting similar studies.

A view into the future indicates it is necessary to study further the needs and problems of the individual, as well as the availability and use of community resources in order to discover what additional services and facilities will be required to meet adequately the needs of a growing number of older persons in Bartholomew County.

Further, it implies that plans for meeting the needs of the expanding aged population cannot be left to chance. The Study Foundation can

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ISMA Statement

Continued from page 1496

serve a real purpose in providing information upon which facilities and services are developed in terms of actual community needs.

How Do We Get There? Some of the steps that can be taken are:

A. *Encourage* continued study by committees in terms of gathering data for future action;

B. *Utilize* the local, state and national resources available to aid in the activities as determined by committees;

C. *Inform* the general public through educational programs and specific projects;

D. *Establish* means through which the Foundation can grow and develop leadership within the county;

E. *Evaluate* continuously the activities of the Foundation as a means of projecting future action.

What Have We Done?

The activities of the Study Foundation are carried on through committee action in seven major areas of community interest; namely, education, religion, health, recreation, housing, employment and income, and fact finding.

Following a series of community meetings and discussions, a group workshop was held in which 275 citizens participated. This was only the beginning of a pattern of group action which is now functioning in Bartholomew County in an effort to find ways and means of facing the problems inherent in the aging and the aged population.

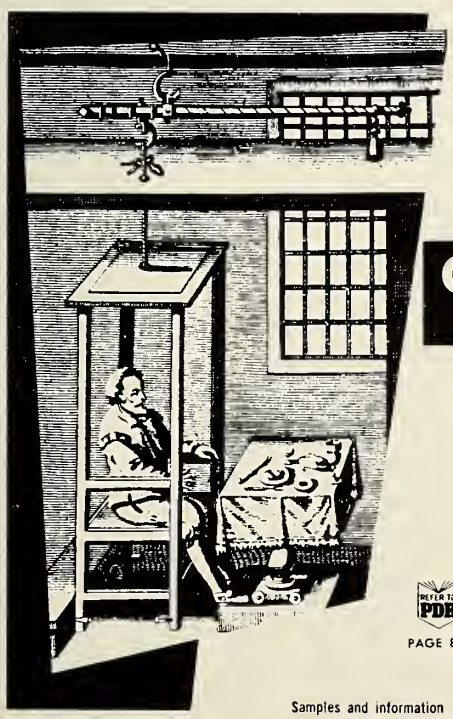
Out of this workshop were evolved seven major committees. The result is that some 250 people have found themselves meeting in committees and subcommittees, inspecting institutions, exploring literature and thinking about problems of older people—and of younger ones who are getting no younger—which had seldom, if ever, occurred to them before.

Committee Activities

As the citizens continued to meet, discuss and study their specific areas of interest, action has resulted in accomplishments through the efforts of the following committees:

1. **Education for Retirement**

This committee seeks to determine content for and give general orientation on preparation



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in obesity

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Dextro Amphetamine Sulfate	15 mg.	Vitamin C	30.0 mg.
Amobarbital	45 mg.	Ferrous Sulfate	20.0 mg.
Vitamin A	6,600 Units	Cobalt Sulfate	0.49 mg.
Vitamin D	400 Units	Copper Sulfate	2.8 mg.
Vitamin B-1	1.6 mg.	Sodium Molybdate	0.45 mg.
Vitamin B-2	2.5 mg.	Zinc Sulfate	3.9 mg.
Niacinamide	15.5 mg.	Potassium Iodide	0.13 mg.

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PAGE 826

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ISMA Statement

Continued

for retirement, and to help those who have retired to adjust and live happily. In keeping with this purpose, it has

a. Initiated and conducted retirement study courses for employees approaching retirement age;

b. Obtained the coperation of the Adult Education Division of the Columbus City Schols;

c. Appointed liaison representatives to all other committees;

d. Appointed a subcommittee on program;

e. Compiled questions for securing information desired about individuals.

2. **Employment and Maintenance of Income**

This committee's principal concern is with determining the need, finding opportunities, and securing resources to help older people continue to be employed. Its achievements to date are

a. Appointment of subcommittee to obtain information from individuals and employers, and to explore ways and means of providing employment opportunities and services for older people;

b. Obtaining cooperation of Indiana Employment Security Division for establishment of an employment registration and placement service for those over age 65. The job placement service was inaugurated on Oct. 24, 1957. Services rendered as of Feb. 20, 1958, are 51 registrations, 71 interviews, 21 referrals, 15 job placements, and 18 employers' use of services;

c. Acquaintance of local employers and prospective employees with the plan for Senior Achievement, Inc.

3. **Fact Finding and Research**

This committee, in cooperation with the university, is concerned with the planning, coordination, and conduct of various community surveys. To further its work

a. Subcommittees have been appointed to meet with, to evaluate and to assist in the preparation of the surveys which are being planned by the committees;

b. A special census to determine the actual population of Bartholomew County was completed. The census project is the largest undertaking of the Foundation to date. It involved organizing the county into township and city block areas in order that canvassers would be contacting people in the vicinity of their own homes. Subdivisions were set up in each of these areas and each was led by a chairman who received special training for this purpose. More than 600 volunteers contacted about 10,000 families in the county.

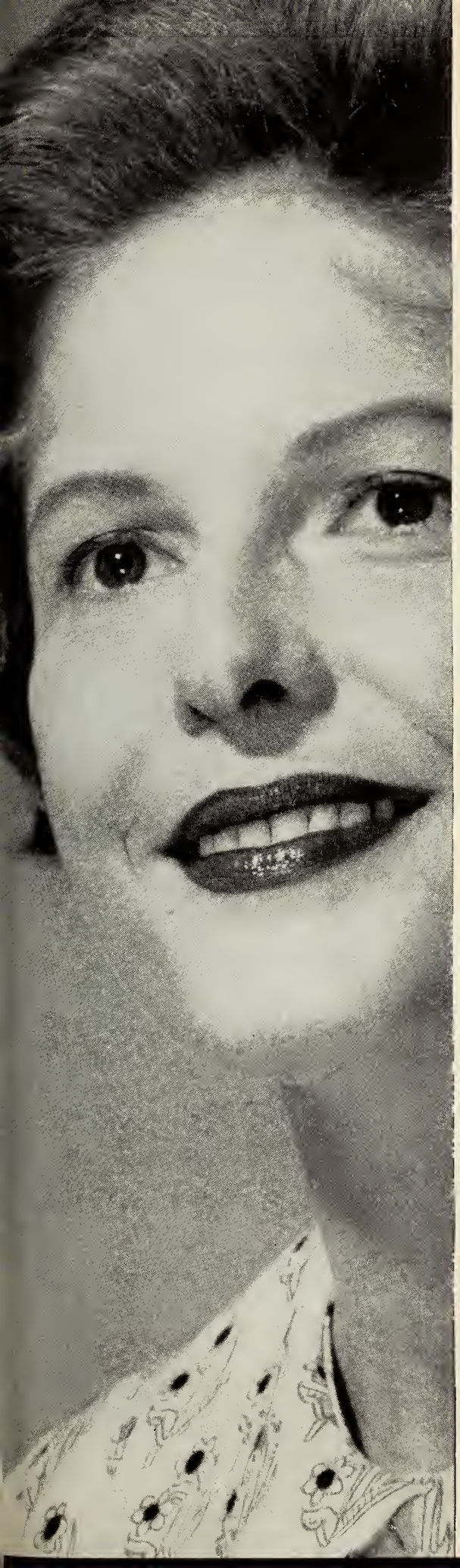
The information obtained from the census has already proved to be valuable to some groups in the community. Some representatives of city, county and township school systems have been able to pinpoint several specific problems related to expansion and future development and, therefore, have been better able to deal with these problems.

In addition, one of the major benefits is that many of the canvassers learned more about their community and became aware of the problems connected with the aging and the aged in Bartholomew County. Drawing on data from this census, several

Continued on page 1504



provides therapeutic levels . . . for 24 hours . . .
with low incidence of sensitivity reactions . . .
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Attention at Pfizer Research was then directed to a new drug that would overcome this disadvantage. NIAMID significantly raises the cerebral level of *both* serotonin and norepinephrine under experimental conditions.

The dramatic discovery of NIAMID now makes available an extremely effective, safe antidepressant for the successful treatment of a full range of depressive states.

Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance, in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.

The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

Supply

NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

References

Complete bibliography and Professional Information Booklet are available on request.

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the mood brightener

ISMA Statement

Continued from page 1500

research projects have already been started, such as:

(1) Survey of attitudes of the high school students toward the aging population;

(2) Poll of the attitudes of adults by decades in relation to the aging;

(3) A study of leisure time activities for individuals who have lived 10 years beyond the expected life span;

(4) The development of an instrument for measuring attitudes of the adult population.

The census project was completed with the preparation and distribution of a report on the census of Bartholomew County in December 1957.

c. Reports outlining the factual information desired by each committee have been prepared and submitted to the university, and are the basis for the proposed survey.

4. **Health (Mental and Physical)**

This committee is primarily concerned with studying the health needs and related problems of the individual, availability and use of community resources, and additional services and facilities required to meet the needs of the growing number of older persons in the county. This committee has progressed by

a. Exploring data relative to health problems of the aging and the aged;

b. Appointment of liaison representatives to all committees;

c. Appointment of subcommittees for program, recruitment, projects and statistics;

d. Group experience in thinking through and developing information needed to plan for health needs of the aging and the aged;

e. Preparing a schedule of questions for securing information about health problems of individuals;

f. Undertaking an analysis of community facilities available for health services.

5. **Housing and Living Arrangements**

The purpose of this committee is to study and evaluate needs and desires of older and retired people as relating to housing. It also seeks to determine how housing for them can be improved. Its activities to date include

a. Preparation of a questionnaire for a housing survey in the area of institutional and private housing;

b. Joint meetings with the Health Committee;

c. Appointment of liaison representatives to other committees;

d. Sponsoring of community meetings on housing for the general public;

e. Cooperation with county official bodies in developing plans for a new county home.

6. **Recreation and Leisure Time Activities**

This committee is concerned with investigating the need for additional recreational programs and facilities for people of retirement age and with planning to meet these needs. To date, this committee has

a. Compiled and submitted to the Fact Finding Committee a list of questions to which answers are needed for effective long-range planning;

b. Sponsored a Fun Fest for Senior Citizens, at which questionnaires on areas of interest were filled out;

c. Appeared before the Park Board to inform them of programs and plans of this committee;

d. Secured the cooperation of the City Department of Parks and Recreation;

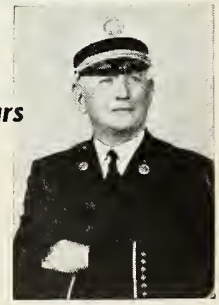
Continued on page 1508

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Hanger Limbs are being successfully warn by amputees of all oges. David Canfield, just 13 months (*illustrated*), is one of the many young children growing up on Hanger Legs. In cantrost, Captain W. T. Traylar, aver 75 (*illustrated*), now wears his fifth Honger. He is a fire inspectar who must caver continually haspitals, schools, sparts events, etc., and be on his feet for hours at a time.

Age: 13 Months



The success af Hanger Limbs with amputees of such widely varying types can be largely attributed to custam manufacture and individual fitting. Unusual canditians are carefully investigated by experienced fitters, and limbs are manufactured to meet individual requirements. The experience af Hanger's 95 years is given to every amputee so that his rehabilitation may be successful.

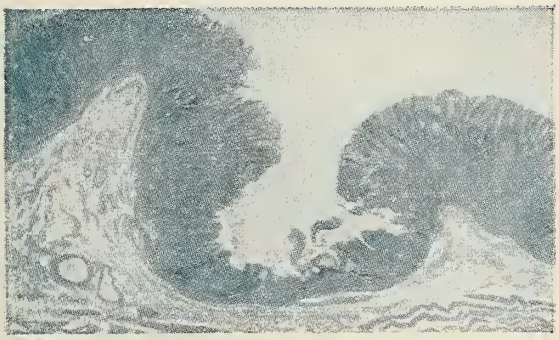
Age: 78 Years

Hanger PROSTHETIC

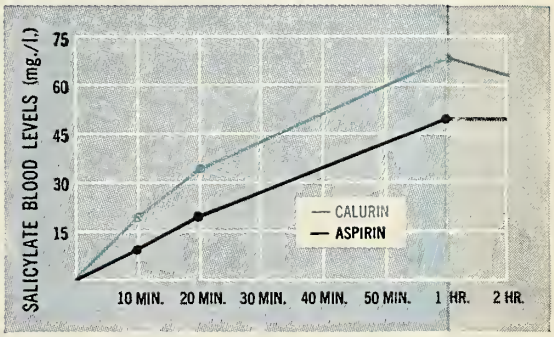
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Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

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2. Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritic effect.
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Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

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ISMA Statement

Continued from page 1504

e. Cooperated in a general community meeting on recreation.

7. Religion and Retirement

This committee is concerned with collecting information about the church-related activities of individuals and programs and services for the elderly presently provided by various churches. This information will be available to all churches as an aid in planning programs to meet the needs of the elderly. This committee's accomplishments include

a. Study and preparation of a list of questions to secure information about individuals and church programs for the elderly;

b. A public meeting on "Church Members in Later Maturity," held to focus the attention of the community on some of the problems of the aging and the aged;

c. Meetings with the Ministerial Association for the purpose of interpreting the aims of the Foundation and enlisting the cooperation of the churches.

What Are the Present Program Plans?

The seven study committees are continuing their analysis of the problems of the aging and the aged. *Program plans* currently being initiated by the several committees are:

A. Public meetings on special topics as determined by committees, to be conducted in cooperation with the Adult Education Division of the Columbus City Schools;

B. The forming of subcommittees to collect information and to initiate studies and projects;

C. Recreation programs for the aging and the aged as a demonstration of need;

D. The sponsoring of a Social Recreation Leadership Institute of general community interest, in cooperation with the Indiana State Board of Health;

E. The instituting of a series of craft classes in cooperation with the Columbus Department of Parks and Recreation;

F. Collaborating with the Bartholomew County Health Council with respect to problems of the aging and the aged in the conduct of its current evaluation of community health facilities;

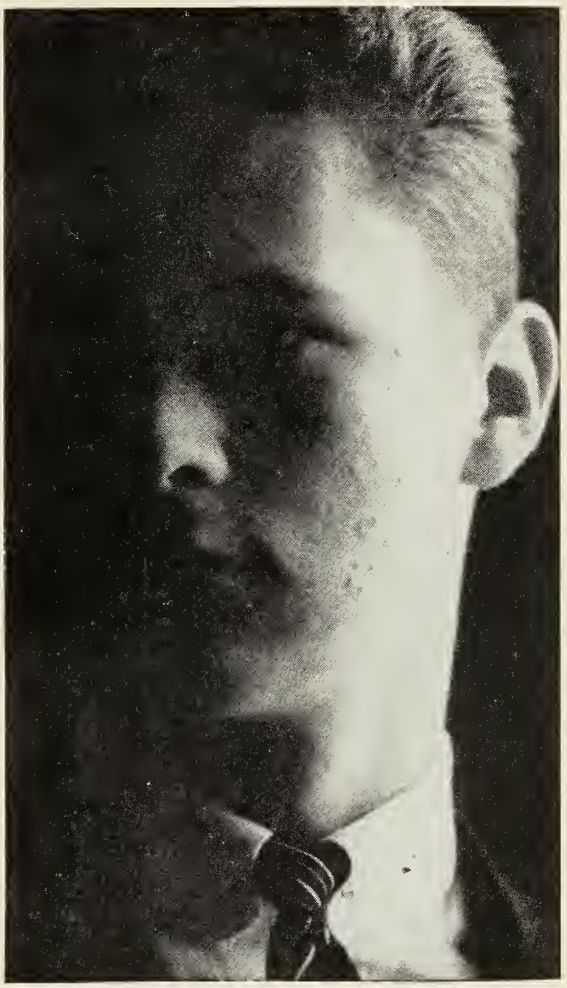
G. Contacting the elderly about the extent of their participation in church activities;
H. Creation of program subcommittees responsible for developing interesting content and variety in method at all levels;
I. Continuation of the current series of preparation for retirement discussion groups, with plans for a repetition of the same series in the fall;
J. Continuation of the employment registration and job placement service in cooperation with the Indiana Employment Security Division;
K. Establishment of a work project for senior citizens, such as Senior Achievement, Inc.;
L. Continued study and evaluation of the activities and accomplishments of each committee.

The interest of the community is not only reflected by citizen participation on the study committees, but also by the character of the continuing organization which has been created by a representative group of civic leaders. The committees, in their planning, anticipate involving an increasing number of citizens in the activities of the Foundation.

Eventually, through the processes of group study and action, and through involvement of many individuals, it is expected the citizens of Bartholomew County will have a better understanding of the problems of the aging and the aged.

What May We Expect As Outcomes?

A. Better appreciation and understanding of the conditions and problems which arise as a result of aging and retirement from work;
B. Knowledge of how to work together more effectively to meet community problems as they arise;
C. Realization that all individuals have problems with which they must make adjustments for effective living;
D. A better understanding by individuals of what they can do to prepare themselves for later life;
E. Achievement of positive attitudes toward retirement from an individual and a community point of view;
F. Better use of community facilities and resources by the aging and the aged;
G. Information basic to providing facilities



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1. Hodges, F.T.: GP 14:86, Nov., 1956.

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and services necessary to meet the problems of the aging and the aged;

H. Development of a model community self-study guide;

I. Accumulation of data and the reporting of a total experience which may be useful to other communities.

Community Participation Value

The means of arriving at the end result often is as important as the result itself. The processes which the community uses will determine its success in reaching the ultimate goals. The sharing of experiences and exchange of data among committee members, community groups and agencies create a better understanding of the problems of the aging and the aged.

The power for meeting situations and achieving results rests in the ability of the people to express themselves, to communicate and to learn how to utilize other resources in addition to their own initiative for finding solutions to problems.

The Retirement Study project in Bartholomew County may be viewed as a genuine "grass roots" activity, indicating that the community is willing to take the necessary steps to solve its own problems. In the light of past occurrences, there is no question that the community also has the ability to solve these problems.

As this study progresses and knowledge is gained, it may well serve as a basis for studies by other communities and may help them in problem solving. If so, its results will be felt throughout the entire state.

But in Bartholomew County, there is hope for more than statistics . . . there is hope for a better community in which lives can be lived to the end with satisfaction and enjoyment.

State and National Significance

Community self-studies such as the citizens of Bartholomew County are engaged in appear to be rare. Inquiries from various Indiana communities have indicated a strong interest in knowing how they are going about it, not only in factual findings, but in program framework. It is anticipated that the data and experience gained in Bartholomew County will prove useful in the development of other similar programs in many counties of Indiana.

The Indiana State Commission on the Aging and the Aged has from the outset evinced great interest in the study. Inasmuch as the State Commission's funds do not permit establishment of community projects, the Bartholomew County Retirement Study is serving the commission as a laboratory and as a pilot project.

It is our further belief that the information and data garnered in Bartholomew County will prove of value to many other communities in the United States and to the whole "Aging" movement.

Nationwide attention has already been attracted in many ways, as illustrated by the recognition given to this study by the U. S. Department of Health, Education and Welfare in the February 1958 issue of its publication, "Aging."

Insurance for the Aged

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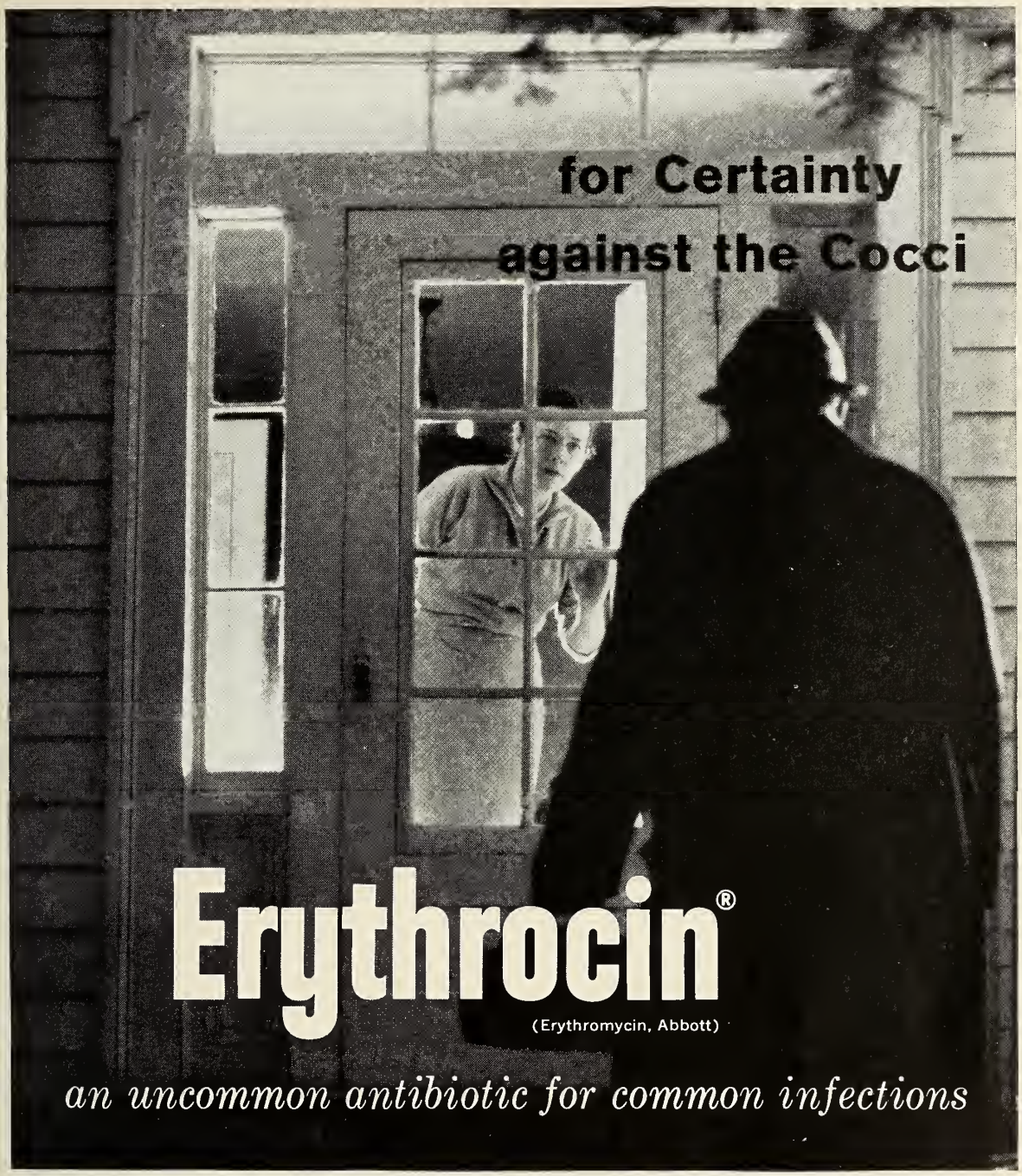


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ISMA Statement

Continued

pital services, regardless of cost. It provides for all professional services in the hospital as well as emergency outpatient hospital services. In addition, it provides for payment for surgery in the hospital, home or physician's office and for the physician's call on the patient in the hospital for medical cases, surgery calls being covered under the surgery section. This program costs a single individual $7 per month or the family of two or more, $12.40 per month.

We are, therefore, of the opinion that H. R. 4700 does not meet the need, nor solve the problem for the people who are covered or eligible for coverage under social security. We firmly believe it is only a vote-getting mechanism, and a means to further increase the tax burden upon the people of this nation. Under present findings on a national basis, less than 1% of the people will receive benefit from this program, and even that benefit will be limited. The truly indigent will not be covered as the great majority of them are not participants in social security.



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We believe further study should be made of the people falling in this age group, and that such study should be made upon a local basis. This is the only true means of finding what problems, if any, exist, and then intelligently developing a program to meet any found problems.

We believe the proposals in H. R. 4700 are ill advised, unrealistic and usurp from the people the right to exercise their own initiative in solving their needs at the local level. Therefore, we respectfully request your committee to continue to hold this proposed legislation until such time as the communities of our nation have an opportunity to complete work now being undertaken. Private initiative, self-reliance and human ambition have been the strength in building our great nation . . . not confiscatory taxes and government paternalism. We work as doctors of medicine to extend the life and improve the health of the people of America . . . we do not subscribe to any program which would bring about moral decay in the self-reliance and self-initiative of these same people. Let us think about ways to rebuild our nation and our people to new ambitions and new strength, and stop the weakening process which is a part of paternalism. We, the medical profession . . . and we feel we can say the same for the religious groups and the people of every community throughout the land . . . can assure you those who are unfortunate will not be allowed to suffer in want. But we believe we can accomplish this better and more economically than it can be done by federal legislation.

Thank you for the opportunity to present our views.



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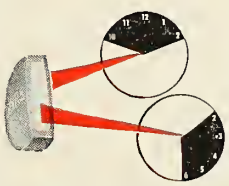
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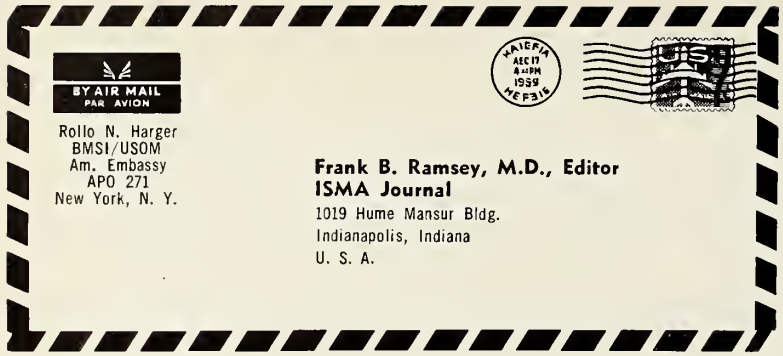
Dosage: One tablet in the morning, mid-afternoon and at bedtime.

References: 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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Report from Pakistan

Karachi, Pakistan
July 19, 1959

Dear Doctor:

Thanks for your kind invitation to myself and colleagues to send your JOURNAL an occasional report on our experiences in Pakistan.

Perhaps I should first explain why, after serving 36 years as a professor on the Indianapolis campus, I rather suddenly decided to jump half way around the world to this very strange country. Well, some of the motivating reasons were, an "itchy foot," a salary not unattractive to the average professor, and a feeling that the ageing ex-head of a medical school department might be wise to seek new pastures and thus avoid some possible embarrassments for his successor.

At any rate, Mrs. Harger and I arrived in Karachi via Pan American on May 9, 1958, having made stops of a day or two in Athens, Istanbul and Beirut. At the last two places I visited the medical schools. In Istanbul our host was a Turkish physician who is distantly related by marriage to the wife of our son, Bob. In Beirut, Dr. Kerr, the biochemistry professor at the American University there, was most hospitable. He even induced us to accompany him and a party on an all-day trip to the old Roman ruins at Baalbek. To us, Baalbek was very impressive, even after seeing the Acropolis at Athens.

Our project here is called the Basic Medical Science Institute. It is operated under a 3-way contract between Indiana University, the U.S. International Cooperation Administration (I.C.A.) and the Government of Pakistan (GOP over here). Our assignment is to conduct postgraduate teaching in the six basic medical sciences which we teach our first and second year medical students at home. Our students here are selected graduates from the Pakistan medical college, plus a few men with a master's degree in science.

After graduating from our 2-year course, these men will receive a master's degree and then will each teach the science in which he majored at one of the nine Pakistan medical colleges. At present there is a serious shortage of basic medical science teachers here, particularly at the instructor or assistant professor level. A few of our most promising graduates will be sent to the U.S. for further training.

Indiana University has furnished a staff of six professors, a li-

Continued on page 1519

Report from Karachi

Continued from page 1514

brarian and a shop foreman-instrument maker. Our physiologist and Chief of Party is Dr. Paul A. Nicoll, who taught I.U. first year medics 1940-1955. He has been here since 1955, on an I.U. project, teaching in one of the Pakistan Medical colleges and planning the present Institute. Incidentally, Paul was born in Pakistan, his father being a missionary-professor at Gordon College at Rawalpindi.

Our microbiologist, Dr. Sherman A. Minton Jr., also needs no introduction. In addition to doing efficient teaching here, Sherm is consulted from the Ambassador down whenever a snake pops up in one of our compounds (yards). Sherm is also a non-salaried representative of the American Museum of Natural History, New York, and scours the country for snakes and other "varmints." Dr. E. C. Bernstorf, our anatomist, received his Ph.D. from I.U. and came here from Hahnemann. In pharmacology we have Dr. O. D. Priddle, whose last post was in drug toxicity studies at Mellon Institute.

Our pathologist is Dr. James C. Cash, who for many years was head of that department at the University of Virginia School of Medicine. Mrs. Eileen Cunningham, our librarian, was formerly chief medical librarian at Vanderbilt. The shop man, John E. Guthrie, was previously with an electronics factory at Bloomington. All of us teaching here retain our status as I.U. professors.

Our building is a remodeled, greatly enlarged unit of the Jinnah Central Hospital. The Government of Pakistan financed our building construction and furnishes us with locally-purchased items and also a crew of laboratory assistants and "peons," as they are called here. Our steel laboratory furniture, scientific apparatus, chemicals and books are all imported from the U.S., with our contract funds.

We have a very respectable library which will be used by many physicians here, as lack of foreign exchange prevents the purchase of recent foreign medical journals by the local people. Our shop equipment is also good. In fact, our equipment is up-to-date and much better than I had anticipated.

The BMSI is a small segment of the U.S. mutual security foreign aid program. As you probably know, the primary purpose of this "give-away" program is not charity per se, but to keep these under-developed countries operating on their own steam and out of the clutches of the Russians. Besides the U.S., several other Western countries have similar, but smaller, aid programs here. So far, I think this program has paid off, because Pakistan remains one



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Report from Karachi

Continued

of the staunchest allies of the West here in Asia. The tctal U.S. foreign aid program--military and non-military--amounts to only 3 or 4 cents of the U.S. tax dollar. Fifty cents of our tax dollar goes to direct armament.

Since our Institute started from scratch, it took a long time to get everything ready for teaching. Formal instruction began on June 1 of this year. When I came I anticipated having a lot of free time on my hands and brought along some unfinished research work. However, I was kept on the go all the time, and have made no progress on the research. I have done everything from serving as storeroom supervisor to running clinical chemistry analyses during a serious gastrointestinal epidemic last January and determining urinary copper and serum copper oxidase in a couple of cases of Wilson's disease picked up by an Australian WHO doctor who had a pediatrics assignment at the Jinnah Hospital. Jinnah was the G. Washington of Pakistan and many things here bear his name.

All the Pakistan medical colleges, except the one up near the Khyber Pass--it is called Khyber--are under the complete supervision of the Pakistan Ministry of Health. The GOP selects the professors, specifies the courses of study and selects all the students. Final examinations are conducted by professors from medical schools other than the one where the student is enrolled; external examiners they call them. Our students are also selected by the GOP, but we still retain the U.S. system of having the professor decide who passes or does not, and we are the sole judges of the ground covered in our courses and how they are run.

We have a nice bunch of students and they are working hard. They are very deficient in quantitative laboratory training. Although my students minoring in biochemistry all have the M.B., B.S., not one had ever operated an analytical balance, polariscope, spectroscope, or pH meter and only one or two had run a colorimeter. At that, they are eager to learn and appreciate the opportunity to have this sort of training. Some of them would stack up well with our U.S. medical school students in mentality, but their own medical schools are too poor to buy much laboratory equipment. ICA has given them some.

Will later try to report on some of the curious sights, and smells, here, the bizarre customs and dress, and a delightful 2700 mile automobile trip Sherm and I took last March to visit medical schools in upper West Pakistan. Maybe Sherm will be willing to do that. Some of us have been invited to lecture at Dow Medical College here, where the students must rise when the professor enters. We are all well and enjoying our work. End of assigned two pages.

Best regards to you and all my former pupils,

R. N. Harger

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References: 1. Menger, H. C.: Clin. Med. 4:313 (March) 1957. 2. Charles, C. M.: Geriatrics 2:110 (March) 1956. 3. Shuster, B. H.: M. Clin. North America 40:1787 (Nov.) 1956. 4. Dolowitz, D. A.: Rocky Mountain M. J. 55:53 (Oct.) 1958.

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The Ultimate Surgeon

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NO MATTER how many scientific papers one may have given, a first opportunity to express one's own surgical philosophy as, in a presidential address, is regarded with joy, apprehension and mixed emotions in general.

If one has definite ideas, the first opportunity may well be the last, also. You can well imagine my joy when Kentucky and Indiana decided to meet together and I realized that the size of my captive audience would automatically be doubled.

When one considers that the human body is the temporal dwelling place of the Holy Spirit, that portion of the religious Trinity first visited on man as tongues of flame, and when one further considers that a surgical operation invades the temple of the Holy Spirit, humility demands that we must, from time to time, sum up what kind of a job we are collectively doing as Keepers of the Keys to the Temple. This thought has led me to my subject: *The Ultimate Surgeon.* What should he be, and how can he best get that way?

Any evaluation of what a surgeon should be must necessarily envision an ideal, and we must realize that few will completely achieve this ideal. I am not now speaking of the average surgeon, but rather the one among many who embodies those attributes and qualities in their ultimate combination. It is urgent that this ideal be defined and even more urgent that all of us keep it close to us and try, within the limitations of our feet of clay, to approach it. It is most urgent, even mandatory, that when such a one is recognized, the shackles of conformity be thrown off and the way made clear for him to reach his star. This is necessary if we are not to create generations of good, average surgeons, but none of those whose accomplishments inspire us for all time. We live in the era of the average man, but, in surgery, as in no other walk of life, the average must not be confused with excellence, nor the mean with genius. Surgery has reached its present state of accomplishment by dint of the efforts of brilliant individuals, never through the stultifying plodding of groups or committees.

America has always been a land of extremes in which the pendulum rests at one end or the other of its arc, seldom on center. Thus our present-day middle-aged surgeons, trained by masterful preceptors with close-at-hand, word-of-mouth supervision, have given way to those trained by the residency system of training wherein large groups of surgeons are trained at one time and in one place. This modus operandi has raised the quality of the average surgeon in the United States immeasurably, and the American Board of Surgery is to be congratulated for all time for setting up a minimum set of standards by which surgeons can be judged. All of us are aware of the abuses of the preceptorship system which had become common prior to 1937 when the American Board of Surgery came into being. In typical American style we have junked this system, and gone to the opposite end of the cycle where personal passing-on of surgical lore from one generation to another is forbidden and unacceptable. This is a real victory for the average man, but what of the uncommon man who has that chaos in his soul which gives birth to a dancing star?

In preparing for this address it seemed quite natural to read previous presidential addresses.

Continued on page 1524

Presidential address, Indiana Chapter, American College of Surgeons, read May 15, 1959 before a joint meeting of the Indiana and Kentucky Chapters and the Kentucky Surgical Society at French Lick, Ind.

How Much Are YOU Paying for Socialism?

You wouldn't knowingly pay a cent toward socializing the U.S.A.

Yet you and other Americans have already paid more than 5½ billion dollars in taxes toward the socializing of the electric light and power business. So-called "public power" has now put control of almost 1/5 of the country's electricity in government's hands.

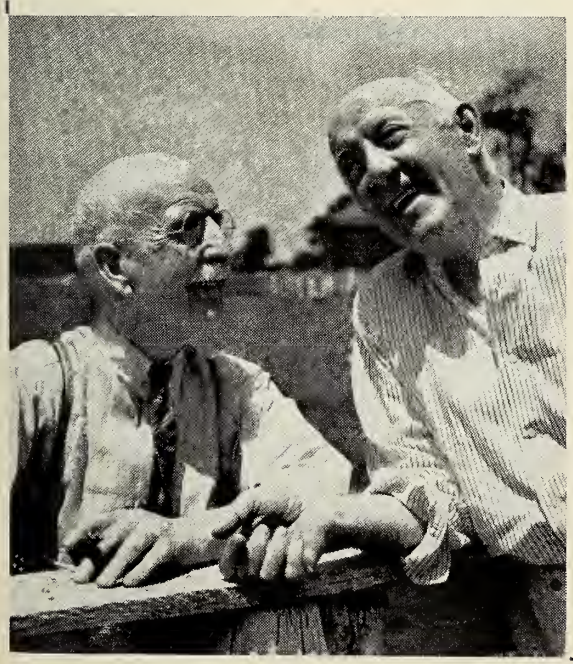
And that's just the beginning. The federal "public power" pressure groups are pushing the idea that Congress should spend billions more to carry this grab farther —with taxes from you!

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The Ultimate Surgeon

Continued

This, I did. One of the interesting facets of this reading was that starting in 1911 and progressing until today, one noticed that in the beginning there was much talk of the art of surgery. This type of address came to full flower in a magnificent creation titled *Surgery, Queen of the Arts,* delivered by Dr. Thomas B. Haggard of Nashville, Tennessee, on the occasion of his inauguration as President of the American College of Surgeons in 1933. As one progresses toward today, a change becomes obvious in that less is said of the art of surgery and more of the science. It is interesting to note that this tendency almost exactly parallels the decreased esteem of the public for the medical profession and the energetic talk in official circles of the necessity for good "public relations."

I would like to say that in my estimation the public relations of our profession as a whole are not and can never be more nor less than the sum total of the public relations of each of us as individuals. They are not a matter of campaigns nor newspaper ads, but rather a matter of how each of us impresses that segment of the public with which we deal. This is the art of surgery, and until such time as the variables of human nature are leveled off, so that nothing in surgery is unpredictable, just that long surgery is at least as much an art as a science.

In Dr. Haggard's excellent address he points out that the arts as illustrated by Leonardo de Vinci, Raphael, Cervantes and Shakespeare reached their pinnacle centuries ago, and indeed may never again be equalled; whereas surgery has had a steady march forward, always forward, and has never lost anything. It will be remembered that this address was given in 1933, shortly after our country and the world embarked on a socialistic course destined to defy the average and to abhor the excellent. I am afraid that if Dr. Haggard were alive today, and I am certain if you read his address you will agree with me, he would be forced to admit that we have indeed lost something, and that best we set about to retrieve it.

Our training system of today, while it has vastly improved the average, has overlooked the fact of the Genes and Chromosomes, and the inherent differences in people. It has overlooked the fact that if one wishes to store and move water, he must necessarily have a water-tight vessel to store it in. Neither water nor knowledge can be stored in a sieve. It must be such a vessel that loses only that which splashes over the top on movement and which can be easily replaced by a short trip back to the source. Needless to say, the container can hold water no more pure than the source so that a pure source is also necessary. Our system has also overlooked the fact that all people are not alike and that a course of training satisfactory for an average man might prove frustrating and stultifying to an outstanding man. We might indeed lose him along the way.

I sometimes feel that some of our teaching centers have overlooked the fact that the end and aim of all surgical training is to produce men and women to diagnose and treat surgical disease and to restore other men and women to useful places in society. Any purpose above this is of the professor's creation and to the eternal detriment of us all. There is no higher calling than the desire to heal humanity by the application of excellent surgical principles.



The preceptor system has been condemned on the basis that many preceptors taught their pupil little and enslaved him. Where does this differ from the lengthening of surgical training so that the trainee can produce reams of literature to be published in our journals when its connection in many cases to clinical surgery is somewhat less than obvious. J. Englebert Dunphy of Harvard, in his presidential address to the Society of University Surgeons four years ago, pointed out that research is not surgical research until it has some definite bearing on clinical surgery.

This generation of surgeons has been taught to worship intellectual accomplishment and erudition while being taught that technic is of utterly no importance. Listen to Dr. Haggard, and I quote: "After all, a surgeon must not only possess knowledge and science, he must be an artisan of the highest degree." Again he says, and I quote: "Of all the arts surgery is the most important and the most imperative. The skillful use of the hands in the service of the brain, applied to wound and disease is a service such as that of angels." We all take for granted that a surgeon of today must understand the basic sciences cogent to his art, and that he must be conversant with advance and with literature, but to say that he is a good surgeon because of his knowledge when he cannot operate is to say that if I had the same training as Caruso, you would gladly pay to hear me sing though I sang miserably, or that because I knew batting averages and baseball strategy I was a fine ball player even though I had never played baseball. Knowledge, judgment, conscience, religion, morals; all these play a part, but without dexterity and technical ability they are of themselves pale and anemic just as technic is pale and anemic by itself. The advances in antibiotics and anesthesia have allowed technic to be shunted to the back row, but now that the antibiotics are losing some of their charm, I believe technic can come back to the table and join the family at dinner. To say that a surgeon is an excellent surgeon who lacks any of the mentioned attributes is a clarion call of inadequacy.

Is it possible that by losing association with pure clinicians our surgical trainees are losing their sense of privilege, for as Dr. Haggard says "ours is the work of angels." Kahlil Gibran* has said, and I quote: "And what is it to work with love? It is to weave the cloth with threads drawn from your heart, even as if your beloved were to wear that cloth. It is to build a house with affection even as if your beloved were to dwell in that house. It is to sew seeds with tenderness and to reap the harvest with joy, even as if your beloved were to eat the fruit. It is to charge all things you fashion with a breath of your own spirit, and to know that all the blessed dead are standing about you and watching." Again, he says, and I quote: "Work is love made visible, and, if you cannot work with joy but only with distaste, it is better that you should leave your work and sit at the gate of the temple and receive alms of those who work with joy."

What then to do about re-instilling that sense of privilege without which surgery is a means of earning ones daily bread? With the sense of privilege surgery is a way of life, a jealous mistress, a merciless taskmaster and a vocation calculated to fill one's cup to overflowing.

The clinician must participate in the training of these young men, all of them. This is to say that the excellent clinician must participate. Many surgeons have no desire to teach, but those who

From "The Prophet."

Continued on page 1528

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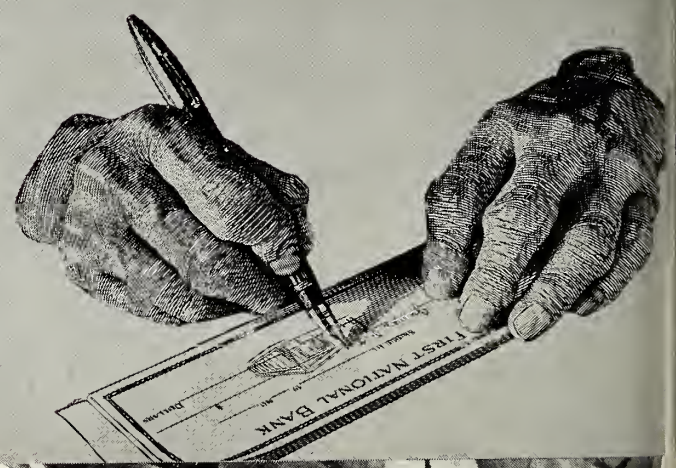
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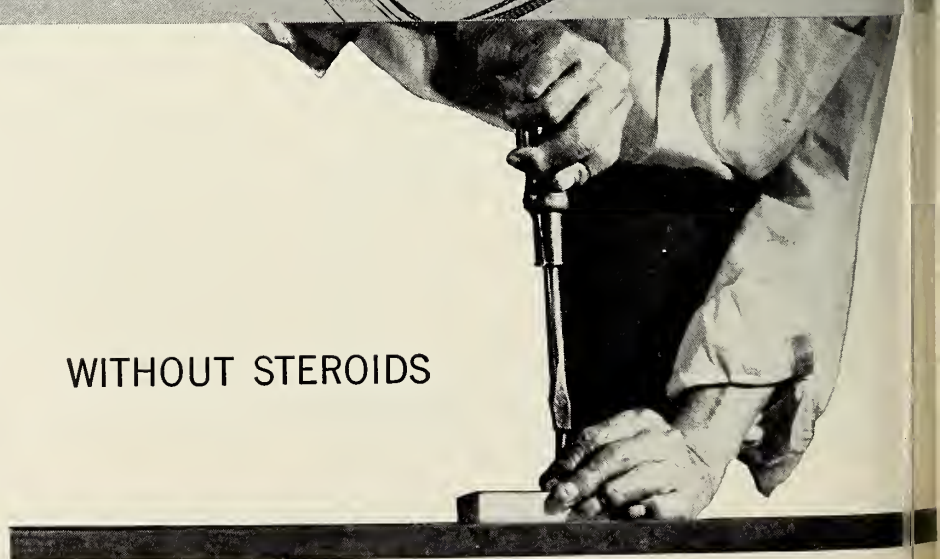


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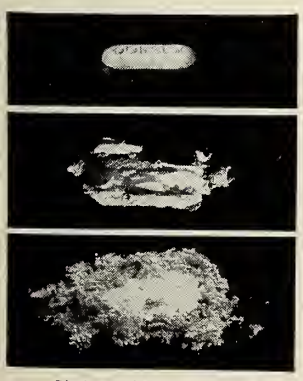
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References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. 257:278 (Aug.) 1957.

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The Ultimate Surgeon

Continued from page 1525

do and have proven their clinical excellence must be allowed to get close to the young man on the way. These young men must be exposed to private patients in non-university situations where the sum total of the patients make up public opinion, which public opinion may one day soon decide whether our beloved profession can remain free or must, like so many others, lose its power of self decision and become another notch in the belts of those people dedicated to our socialization. The schism between the university group of surgeons and the excellent practicing clinicians has done more to foster our downfall perhaps than any other single entity. It has long been known that a house divided against itself cannot stand. We as clinicians are not complete as a training entity. Neither are the universities, and each of us needs the other. God grant this will be recognized before some of the hierarchy of our profession in their well meaning rush to belong to exclusive societies hand us over bodily to the harbingers of doom.

Perhaps a division of trainees should take place along the way. Those who want to remain in research to remain at the university center, but should they change their minds, they should no more be allowed to represent our profession to the public than an untrained man be allowed to operate. One does our profession as much damage as the other. On visiting a huge training center two years ago, I expounded these thoughts to the distinguished professor, and discussed with him the desirability of the good proven clinical situation participating in the training of surgeons. His answer was that this was not of interest to him because he was not interested in training clinical surgeons, but rather research surgeons. There must have been 60 residents there, and I could scarcely resist asking in God's Name how many research surgeons do we need? On spending several days there and watching the surgery, it seemed that some of the research was being done in the operating room because I would not classify what I saw as clinical surgery. If the type of surgery I saw there were done in Fort Wayne, the surgeon wouldn't last one year. These things are confusing.

Certain it is, however, that some men can learn surgery and become excellent surgeons either because of a system of training or in spite of it, while other men cannot be taught surgery no matter what the system. It seems to me that in a large situation with many residents, a person who was never meant to represent the surgical profession can be covered up, and finish his training and pass a written and oral examination; whereas, under the close scrutiny of one excellent clinician, his inadequacies would be found in time to keep him out of the surgical profession and to keep him from misrepresenting us to the public, because again our public relations are nothing more nor less than the sum total of the public relations of all of us.

For the occasional man whose promise is obvious and whose surgical zeal overflows, and again overflows, I remain among those who feel he could do worse than to associate himself with an outstanding member of a preceding generation who has been investigated and found worthy. In this manner alone can the milk of love, knowledge and skill be passed on unadulterated from one generation to the other. At the end of his time let this man take the examination of the



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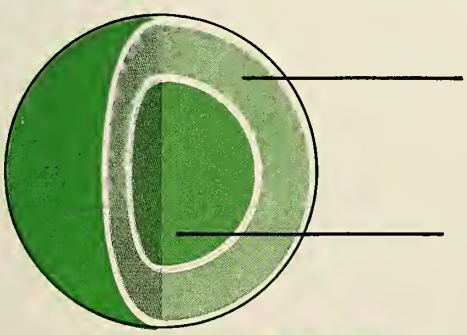
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The Ultimate Surgeon

Continued

American Board of Surgery and be judged by the same standards as his resident brothers. It should be much easier to investigate a man than a hospital, and Dr. Walton Lillihei has said it takes only one good man to run a good residency program.

Also I believe that the large teaching centers must from time to time encourage the outstanding clinicians in their areas to teach in the center, and to bring with them all the clinical acumen accumulated through long years of days and nights; this lest we lose the development of the senses including the 6th sense, which senses are, after-all, the chief differences between surgeons. We can all memorize and order laboratory tests. In this manner alone can we foster generations of surgeons who, having the basic intellectual attributes, the scientific knowledge and the zeal, can also have that semi-divine presence which leads the patient to say "I feel better just because he is here." This type of presence is our one opportunity to retain our place of esteem in the public eye, and to remain free.

The best public relations program in the world can do nothing in a situation where competence is rife and the milk of kindness and human understanding is gone. When a surgeon operates a member of a family who dies and shortly, thereafter, other members of the family come back to him to be operated, this is our pearl of great price, the pinnacle of the art, and it can be learned only from a master of the art, a master who is no less scientific because of being artistic but rather more complete than his purely scientific colleague. The College has always recognized the great clinicians, and therein lies its great strength.

The problem of surgical completeness has confounded, and interested me for many years. Several years ago in the middle of the night I wrote what I thought the ultimate surgeon should be. May I close by reading it to you.

THE ULTIMATE SURGEON

Bring to each new day the sum of all yesterday's mistakes, triumphs, accomplishments, failures and inspirations. Bring a hunger for perfection that denies all emotions, save humility. Bring integrity that seeks quality for others. Bring a trained and orderly mind whose forces move forward with a sure, cautious step and an insight born of rigid discipline. Bring the exactness and precision which are an integral part of well borne responsibility. Bring the enthusiasm of first discovery made mellow by the teachings of the masters. Bring solid respect for yesterday and religious faith in tomorrow. To all these add an humble yearning to restore and to heal and to be consumed by the yearning. This is the Ultimate Surgeon.

Only 2% of the babies born are potential geniuses. Half of these are girls. Yet despite our urgent national need for genius, our customary attitude about "women's place" is such that only 8% of America's scientists and engineers are women. By contrast, ⅓ of Russia's scientists and engineers wear skirts, ½ of Russia's engineering students are coeds.—*Science News Letter.*



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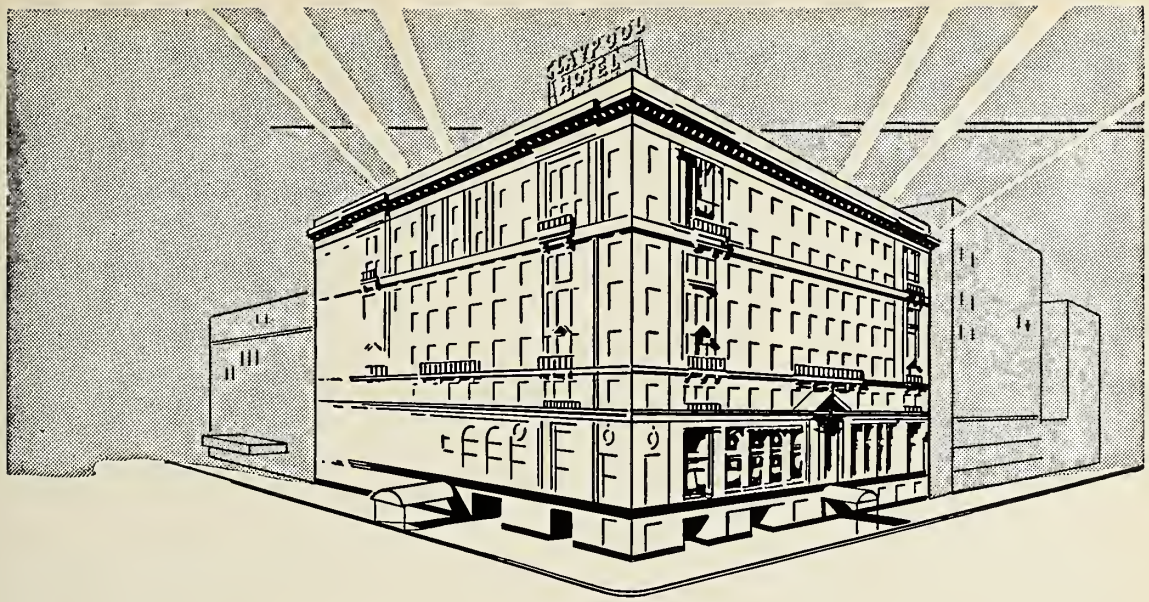
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to the editor:

July 14, 1959

Dear Sir:

I have had the distinct pleasure in the past few weeks of representing the Medical Advisory Board of the Sears-Roebuck Foundation in helping to dedicate two medical facilities—one in Germantown, Ill., a town of 900, and in Kinmundy, Ill., also a town of 900. It was gratifying to see the enthusiasm of these communities in the realization of obtaining a physician and a modern office in their areas.

The Sears Foundation, through its Medical Advisory Board, appointed by the AMA trustees, has been endeavoring to help communities that pass a stringent survey in obtaining medical facilities and a physician to cover their medical needs. Any young physician would think he is in Heaven to see one of these functional units. This is strictly a business-like approach by a community to obtain a physician. Public meetings are held after a survey has been made to determine the need and feasibility of having a physician. Funds are raised locally to meet the building costs, and an all-out participation by the citizenry results in an almost tailor-made practice for a young physician.

Further help is afforded by the Foundation in planning, architectural advice and blueprinting for the actual structure. Once the building is completed and the physician has been obtained, business management consultants help in local financing and in equipment purchasing, this all being done by experts of the Sears Foundation. Close cooperation between the state and AMA Physician Placement Service is a must to assist communities who have had the intestinal fortitude to raise money and build an office to obtain a physician.

I would like to urge any of you who are aware of an area needing a physician to contact your state secretary or Mr. Norman Davis of the Medical Advisory Committee, Sears-Roebuck Foundation, 3333 Arthington Avenue, Chicago, of this need. It is the desire of the Foundation Committee to work closely with the local, state, and AMA group in providing physicians to a community who can support one, as determined by their survey.

This is democracy in action and is an answer to the plea of many areas, "How can we obtain a physician?"

Sincerely yours,
Walter L. Portteus, M.D.
Franklin

MEDICAL AND CHIRURGICAL FACULTY
OF THE STATE OF MARYLAND.
1211 Cathedral Street.
Baltimore.
Zone 1

July 24, 1959

Dear Dr. Ramsey:

The Medical and Chirurgical Faculty of the State of Maryland (Maryland State Medical Association) has, for many years, expressed concern over the inroads the Veterans Administration Hospitals are making into the realm of the private practice of medicine. In order to combat the fantastic growth of treatment of non-service connected ailments of veterans, the faculty has passed many resolutions condemning this practice and urging that something concrete be done to curtail or stop this insidious growth.

The faculty's House of Delegates at its 1959 annual meeting passed a resolution that all component medical societies of the American Medical Association be contacted and urged to support the faculty's stand in this respect.

As a result of a letter sent to every AMA component medical society, 11 answers have been received all in the affirmative.

It is anticipated that other societies will also reply in the affirmative and that full support to this projected concerted action will be forthcoming from them as well.

I sincerely hope that you will see fit to publish this letter and alert your readers to the steps that are being contemplated along these lines, not the least of which is the hope that an appropriate resolution will be introduced in the AMA's House of Delegates at its clinical session in Dallas in December.

Sincerely,
Amos R. Koontz, M.D., Chairman
Committee on Veterans' Medical Care



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References:
1. Alexander, L.: J.A.M.A. 166:1019, March 1, 1958.
2. Current personal communications; in the files of Wallace Laboratories.
3. Pennington, V.M.: Am. J. Psychiat. 115:250, Sept. 1958.

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MADISON COUNTY—Pendleton, population 2,100. Located near Anderson where hospital facilities are available. Two physicians in the town. Community can support another physician. Contact C. P. McLaughlin, M.D., 200 West State St., Pendleton, Ind. Lions Club is interested in having another doctor located in the community.

HARRISON COUNTY — Elizabeth, population 300. Located near Corydon where hospital facilities are available. Small community in southern Indiana close to the Ohio River. Contact Mr. George W. Hoke for details.

WARREN COUNTY—Williamsport, population 1,500. Industrial and agricultural community. Hospital located there. Opening for a physician who does general practice and surgery. Contact James W. Crain, M.D., Williamsport, Ind., for details.

WARRICK COUNTY—Chandler, community population 2,000 to 3,000. Well equipped office for sale. Located close to Evansville where there are three hospitals. Kiwanis Club interested in having a physician locate in community. Contact Sid Shapinsky, 255 West Lincoln, Chandler, Ind., for further details.

VERMILLION COUNTY—Clinton, population 6,500. Four physicians located in the town. Hospital available. Chamber of Commerce interested in getting a physician to locate in Clinton. Contact Mr. Eugene York, 223 Elm Street, Clinton, Ind.

Physicians Seeking Locations

Allen D. Pierson, M.D., 305 E. Main St., Crawfordsville, Ind.

Ronald L. Peterson, M.D., 34 Hatcher St., Wichita Falls, Texas.

Donald G. White, M.D., USAH (Prov) Camp McCoy, Wis.

H. Joseph Cronin, M.D., c/o E. E. Van Sickle, 214 E. 9th St., Rushville, Ind.

H. Max Landey, M.D., Box 156, 1200 N. State St., Los Angeles.

Lawrence Webb, M.D., Warren, Ind.

Specialists

Carl B. Grothouse, M.D., 10210 LaSalle Ave., Los Angeles 47. Group or associate **Orthopedic Surgery.**

William E. Rush, M.D., 25815 Harper, St. Clair Shores, Mich., **Pediatrics.**

Irving A. Ratner, M.D., 309 Summit Ave., Brookline, Mass., **Pediatric Surgery.**

Goetz J. Klein, M.D., 107 Combs Street, Beckley, West Virginia, **Surgery.**

Alfred M. Tocker, M.D., 2110 E. Douglas St., Wichita, Kans., **Surgery.**

William J. Barrison, Jr., M.D., 1248 Rolleston St., Harrisburg, Pa. Solo, partner or associate **Sugery,** available July 1960.

Richard K. Meinke, 523 11th St., S.E., Rochester, Minn. Small group of association **Vascular and Pediatric Surgery.**

Ross M. Orr, Jr., M.D., Greane Ranch, R.F.D. #1, Dudley Township, Kenton, Ohio, **General Surgery.**

A. S. Akad, 167 E. 90th St., New York 28, **Internal Medicine.**

Stuart K. Olson, M.D., 106-B Wonju Circle, Camp Pendleton, Oceanside, Calif., **Internal Medicine,** available summer of 1960.

Milton R. Glaser, M.D., 4444 N. 85th St., Milwaukee 18, Wis. Medical group or internist **Internal Medicine.**

Walter R. Thayer, M.D., 1 Cherry Hill Circle, Branford, Conn. Solo or group **Internal Medicine and Gastroenterology.**

Robert L. Hast, M.D., Henry Ford Hospital, Detroit 2. Solo or group **Internal Medicine,** available July 1960.

Clare Charles Hugan, Jr., 9121 Prest, Detroit. Solo or partnership **Internal Medicine,** available July 1960.

William E. Greer, M.D., R.R. #1, Birch Lake, Vandalia, Mich., **Ear, Nose and Throat.**

William M. Brownell, P.O. Box 135, Fort Meade, S. D. Group practice **Opthalmology or EEN&T.**



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DIVISION OF COMMUNICABLE DISEASE CONTROL

MONTHLY REPORT - JULY, 1959

Disease	July 1959	June 1959	May 1959	July 1958	July 1957
Animal Bites	605	1264	648	881	561
Chickenpox	35	142	346	94	37
Conjunctivitis	43	68	114	68	39
Diphtheria	1	0	1	0	0
Dysentery, Unspecified	3	7	14	33	7
Impetigo	57	69	70	114	46
Infectous Hepatitis	17	19	23	22	18
Infectious Mononucleosis	2	8	18	17	9
Influenza	88	217	498	122	62
Measles (Rubeola-Rubella)	141	582	759	570	176
Meningitis, Meningococcal	2	2	2	7	2
Meningitis, Other	15	6	8	10	22
Mumps	65	248	299	240	126
Pertussis	65	44	91	130	112
Pneumonia	54	106	156	130	50
Poliomyelitis	24	7	3	13	19
Streptococcal Infections	124	285	495	204	88
Tinea Capitis	0	7	9	4	2

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(*e.g.*, digitalis, nitrogen mustard, aminophylline)

TOXICOSIS
(*e.g.*, uremia, diabetic acidosis, leukemia, carcinomatosis)

MORNING SICKNESS

HYPEREMESIS GRAVIDARUM

OPERATIVE PROCEDURES

MENIERE'S SYNDROME

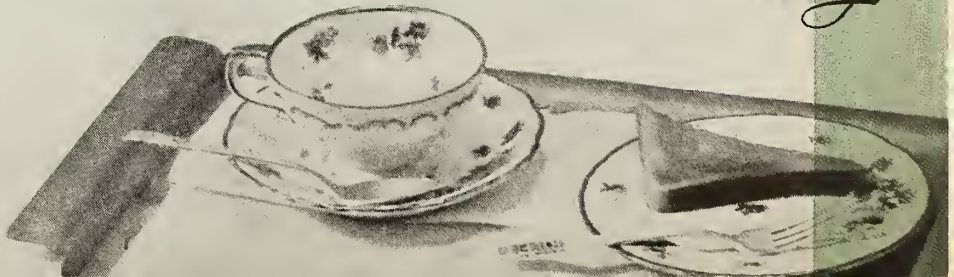
RADIATION SICKNESS

PSYCHOGENIC PHENOMENA

S-273



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NEWS NOTES—from State and Nation

ISMA Receives Merit Award For Outstanding AMEF Gifts

The Indiana State Medical Association was one of 11 state societies to receive an Award of Merit from the American Medical Education Foundation at the recent A.M.A. meeting in Atlantic City. The Awards were given for "outstanding contributions to the preservation and continuance of high standards of medical education."

The Woman's Auxiliary to the Indiana State Medical Association also received an Award of Merit, based on per capita contributions to the Foundation. Nine other state auxiliaries received awards. The 1958-59 contributions of the national auxiliary reached a record high of $137,291.

Gifts from all sources to the A.M.E.F. during 1959 have topped the totals for 1958 for several months. In May of this year, the total was $146,981, as compared to $137,423 of last year. Contributions made during June 1959 amounted to $325,310.

The A.M.A. House of Delegates unanimously passed a resolution introduced by the delegation from Louisiana, commending the A.M.A. trustees for continued support of A.M.E.F. and urging every member of the American Medical Association to give a substantial gift to the Foundation. The reference committee, reporting on the resolution noted, among other findings that "The mutual understanding between the schools and the medical profession created by the work of the Foundation has resulted in an increase in the quality of medical education and medical practice in this country."

ISMA Members Invited to New York Meeting

The New York Academy of Medicine will hold its Third Annual Postgraduate Week (formerly the Graduate Fortnight), from Monday, October 5, through Friday, October 9, 1959. The title of the program will be "Research Contributions to Clinical Practice."

It will consist of a daily evening lecture, a daily afternoon panel meeting and a Scientific Exhibit. Members of ISMA are invited to attend. No fee is charged.

Details may be obtained by addressing The New York Academy of Medicine, 2 E. 103rd St., New York, 29.

The Indiana Academy of Opthalmology and Otolaryngology meeting will be held in the Spring of 1960. Members will be notified as to the exact date.

District V Meeting Planned By Obstetricians and Gynecologists

The annual District V meeting of the American College of Obstetricians and Gynecologists for the states of Indiana, Kentucky, Michigan, Ohio and Ontario, will be held at the Statler-Hilton Hotel, Detroit, November 18 to 21.

The scientific program on the 19th and 20th will consist of five panels, eight scientific papers and two prize-award papers by residents.

On Saturday, November 21, the Michigan—Ohio State football game will be played at Ann Arbor. Football tickets may be obtained by writing Dr. Tommy Evans, University of Michigan Hospital, with check for the tickets at $4 each.

Program details and other information may be obtained from Dr. Arthur G. King, 199 William Howard Taft Road, Cincinnati, 19. Dr. Charles F. Gillespie, Indianapolis and Dr. Alexander W. Cavins, Terre Haute, are chairman and vice chairman of the Indiana Section.

Drs. James C. Katterjohn and Chester A. Stayton, Indianapolis, have announced the association in the practice of radiology of Dr. William M. Anshutz, formerly of Henry Ford Hospital, Detroit.



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Booth B-11—ISMA Convention

Blue Cross–Blue Shield Offers New Non-Cancellable Membership

A new non-cancellable membership in Indiana Blue Cross-Blue Shield will be offered in the special enrollment campaign starting September 19th and ending September 30, according to representatives of Blue Cross-Blue Shield.

All Indiana residents not employed in a group of five or more, or whose spouse is not so employed, are eligible for the new memberships. There is no limit as to age or physical condition.

Blue Cross-Blue Shield reports that the new membership may not be cancelled because of the member's age, the condition of his health or the number of times the membership is used.

The Blue Shield part of this membership includes the $200.00 surgical program; payment of in-hospital medical services in the amount of $10.00 for the first day, $3.00 for the next 29 days, and $1.50 for each day thereafter, up to a total of 60 days per certificate year.

Also included are allowances for x-ray services in a physician's office for possible fractures and dislocations up to $15.00 per person for each certificate year. There is an allowance for anesthesia when the services are rendered in a hospital by a physician in the amount of $10.00 for surgical procedures under $50.00, and 20% of any surgical indemnity in the Standard Schedule over $50.00.

Other special features are: up to $5,000 in hospital benefits per year, the option of making payments by the month or several months in advance, and a free inspection offer which allows the certificate to be examined and returned within five days if the member is not completely satisfied.

In this, the first "open" membership offer since 1955, the Blue Cross-Blue Shield monthly fee will be $7.00 for single and $12.40 for family membership.

Blue Cross-Blue Shield Plans in Illinois, Kentucky, Michigan, Wisconsin and Toledo, Ohio, will conduct similar enrollment campaigns during the same period.

Dr. Russell Joins Dr. Cure in Indianapolis

Dr. John R. Russell, M.D., recently became an associate to Dr. Charles W. Cure, at 315 Hume Mansur Building, Indianapolis, specialist in neurological surgery.

Currently an assistant professor of surgery at the Indiana University Medical Center in Indianapolis, Dr. Russell is on the executive and international committees, and chairman of survey and program committees for the 1960 meeting of the Congress of Neurological Surgeons. He is also chairman of the world directory committee of the World Federation of Neurological surgeons.

Dr. Russell received his B.S., M.S., and M.D. degrees from the University of Chicago. He was an intern and surgical resident at Chicago Memorial Hospital, and was neurological surgery resident at the Baptist Memorial Hospital in Memphis. He is currently a consultant in neurological surgery at Veterans Administration Hospital in Indianapolis.

Interstate Postgrad Assembly Planned for November

The Interstate Postgraduate Medical Association will conduct its annual Assembly at the Palmer House in Chicago, Monday, November 2 through Thursday, November 5.

In addition to all-day scientific lectures, scientific exhibits, and special recess teaching programs in the exhibit hall, there will be breakfast conferences on November 3 and 4. There are six breakfast meetings scheduled on each of the two mornings for a limited number of physicians, at which well known clinicians will discuss clinical subjects.

Information may be obtained from Erwin R. Schmidt, M.D., Box 1109, Madison, 1, Wisconsin.

I.U.'s Dr. Hickam Receives Insurance Research Grant

The Life Insurance Medical Research Fund recently announced a total of $1,205,510 in grants to 64 medical research institutions and to 19 young research fellows in the field of heart research. Indiana University School of Medicine will receive $31,350 for research by Dr. John B. Hickam on the retinal circulation.

Hill-Burton Share for Indiana Listed

Hill-Burton grants for Indiana, as of June 30, include 49 projects in operation at a total cost of $49,308,195. This includes federal contributions of $17,602,416. Twelve additional beds were supplied.

The Department of Health, Education, and Welfare also reports that there were 36 projects, at a total cost of $39,786,023 under construction at the same time. Federal contributions totaled $10,903,499; 129 additional beds are planned.

ISMA Arranges Dr. Anderson's Appearance

Dr. Otis Anderson, M.D., appeared on an Indianapolis television program in July to tell of his experiences as a member of the Public Health Mission to the Union of Soviet Republics. Dr. Anderson has made extensive studies of medicine and health in Russia. His appearance was arranged by the I.S.M.A.

Military Surgeons to Meet

The Association of Military Surgeons of the United States will hold an Annual Convention in Washington, D. C., at the Mayflower Hotel, on November 9, 10 and 11.

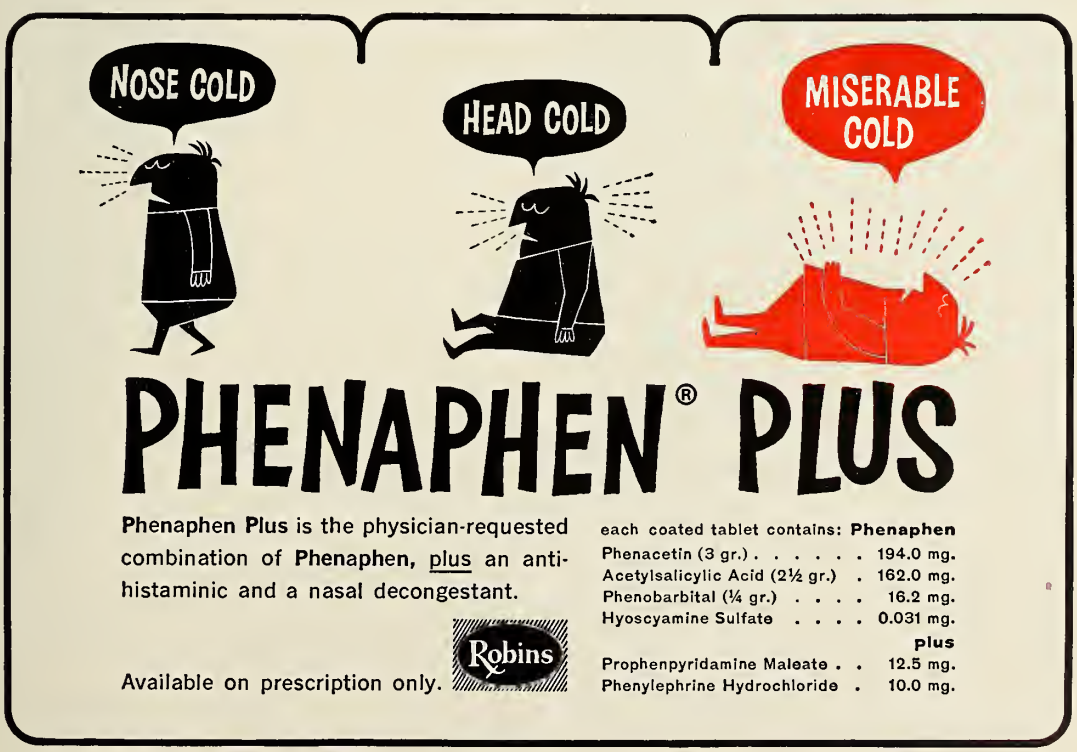
Acton Physician Receives Pediatric Fellowship

Dr. Charles I. Sheaffer, Acton, Ind., is one of 16 doctors who were awarded a Wyeth Laboratories pediatric residency fellowship this year. He will take his residency at the University Hospital, Cleveland, where he recently completed his internship. Dr. Sheaffer received his B.S., M.A., and M.D. degrees from the University of Virginia.

College of Surgeons Section to Meet

A Sectional Meeting of the American College of Surgeons will be held at the Brown Hotel Louisville, January 21-23, 1960. Inquiries may be addressed to Dr. H. P. Saunders, 40 E. Erie St., Chicago, 11.

Francesville, Ind., has obtained the services of Dr. James J. Sullivan, who recently opened a practice in general medicine there. A former Orlando, Fla. practitioner, Dr. Sullivan served his residency at St. Vincent's Hospital, Indianapolis.



I. U. Admits Record Number— 180 in Fall Med Class

Indianapolis—Admission of 180 students, the largest class in history, to enter the Indiana University School of Medicine next month was announced recently by Dean John D. VanNuys.

The beginning class numbers 20 more than last year's. The increase, Dean VanNuys explained, was made possible by the added facilities of the recently completed Medical Science Building. Nine of the students will enter the University's new experimental medical program on the Bloomington campus, and the others will begin their 4-year course at the Medical Center in Indianapolis.

Hoosiers selected by the School of Medicine admissions committee on the basis of pre-medical scholastic records, aptitude and other tests, and personal interviews include the following: Indianapolis—Richard J. Albright, David D. Aldrich, Lawrence E. Allen, Theodore F. Botkin, Frederick H. Buehl, Mary A. Burton, Robert D. Chaney, Joseph K. Cummings, David A. Darbro, M. Eugene Dewell, William M. Dugan, Jr.



Also, Paul W. Elsea, Alonzo J. Fields III, Herbert N. Hill, Frank Johnson, Jr., Preston L. Judson, Charles R. King, John H. Kneipple, Richard E. Kremp, Linda L. Ledgerwood, John C. Linson, Mary Ann Mericle.

Lee H. Miller, John F. Parker, Maxwell D. Patton, Thomas E. Reed, Merrill A. Ritter, Joseph L. Rizzo, Lowell D. Smith, Aaron K. Warren, Myron H. Weinberger and Richard E. Wurster.

Speedway—Ronald N. Beams and Charles M. Clark.

Others from throughout the state are: **Anderson**—Thomas W. Alley, David F. Poore; **Arcadia**—Phillip G. Mosbaugh; **Argos**—Charles F. Allen; **Attica**—James P. Mitchell; **Auburn**—James H. McIntyre; **Aurora**—Peter J. Horn; **Bedford**—John E. Pless, Don C. Smallwood; **Berne**—Roger E. Hirschy; **Bloomington**—David F. Bucher, Donald D. Cofield; **Bluffton**—John P. Tyndall; **Boonville**—Noel J. Martin, William J. Wilson.

Carmel—William B. Moores; **Columbia City**—Thomas L. McConnell; **Columbus**—William D. Baxter, Dean L. Mattox, Joseph E. Overmire; **Connersville**—Harry D. Shull, Jr.; **Crawfordsville**—Paul R. Jack; **Delphi**—John E. Wagoner; **East Chicago**—William R. Bartok, John A. Smith, Albert T. Willardo; **East Gary**—Lloyd O. Long; **Elkhart**—Thomas B. Glendening, Tony G. Pagedas; **Eminence**—Larry D. Ratts; **Etna Green**—Alvin R. Graber; **Evansville**—Robert S. Griffin, Lawrence A. Reitz, Stanton P. Speer, Arvel D. Tharp.

Also, **Flora**—Robert H. Adams; **Fort Branch**—John R. Elpers; **Fort Wayne**—Larry L. Blair, Dean D. Dauscher, Robert E. Duncan, Thomas D. Foy, Steven R. Glock, Thomas W. Knipstein, William A. Lynch, Ned P. Masbaum, William C. Parke, Alan D. Richards, Donald J. Russell, Thomas G. Sawyer, Beverly A. Zelt; **Frankfort**—Larry G. Bond, J. Ronald Waddell; **Gary**—Frank J. Enderle, Joseph P. Fiacable, Russell J. Johnston, Theodore L. Megremis, Robert M. Senese; **Goshen**—Gerald L. Miller, David L. Pringle; **Greensburg**—Richard M. Weisner.

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Kasdon, S. C., Morentin, B. O.: J. Internat. Coll. Surgeons 31:455 (Apr.) 1959.

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I.U. Admits 180

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Also, **Marion**—Keith E. Fraker, LeRoy D. Kinzer, Richard A. Modlin, David L. Peters; **Martinsville**—Robert W. Holden; **Mentone**—Jon L. Cullum; **Michigan City**—John E. Kemp; **Middlebury**—Benjamin R. Graber; **Mishawaka**—David L. Spalding; **Monon**—John F. Border; **Muncie**—Paul F. Bedell, Barbara J. Cummins, Anthony R. Dowell, Jerry R. Myers; **Munster**—Stephen E. Kroczek.

Newburgh—Herman F. Rusche, Thomas J. Rusche; **New Castle**—Raymond N. Cooper; **New Haven**—Robert M. Schleinkofer; **North Manchester**—Donald R. Hardman; **Plainfield**—J. Lee Aiken; **Rensselaer**—Richard E. Linback; **Richmond**—Fred C. Schwendenmann; **Rossville**—Charles W. Greenwood; **San Pierre**—Donald L. Weninger; **Scottsburg**—Sherman G. Franz, Karl F. Napper; **Shelbyville**—James R. Spindler; **South Bend**—Michael D. Bailie, Robert R. Nelson, Robert B. Pauszek, John A. Roe.

Terre Haute—Jerry H. Connelly, Helen K. Hertwig, Gerald L. Stoker, J. Franklin Swaim; **Tipton**—John P. Quakenbush; **Union City**—Joe A. Greenlee; **Upland**—William B. Hughes; **Valparaiso** — J. Thomas Telle; **Vincennes** — Larry L. Conrad, Ralph J. Jacqmain; **Warren**—John F. Clouse; **West Baden Springs**—Morris L. Sorrells; **West Lafayette** — James D. Rogge; **Whiteland**—Mary E. Kattaux.

Completing the list are: **Whiting**—Thomas A. Gehring; **Winchester**—M. Franklin Longnecker Jr.; and **Winslow**—Earl E. Nelson.

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References: 1. Finkelstein, M., et al.: J. Pharmacol. & Exper. Therap. 125:330 (April) 1959. 2. McHardy, G., et al.: Postgrad. Med., in press. 3. Winkelstein, A.: Amer. J. Gastroenterol., in press. 4. Finkelstein, M., et al.: Presented at Fall Meeting, Amer. Soc. Pharmacol. & Exper. Therap., 1958. 5. Leming, B.: Clin. Med. 6:423 (March) 1959.

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Add 1

A Jungle, Fishing for Ducks, Science Fair and Barefoot Blues

by corki

'It's Like a Jungle!'

A modern jungle! A jungle devised by man in his efforts to progress, to invent wonderful and amazing technological ways of living.

I speak of the lead story in the August 18 *Indianapolis Star* (and I'm sure in all other dailies thruout the state) about the power failure in New York City.

"A baby was born by flashlite . . ."

". . . institutions sent all their plasma and other perishable medicines to St. Luke's . . ."

A boy with appendicitis while at one hospital had to be sent to another.

"In the hospitals, operations were performed by light from battery plants and iron lungs were operated with similar equipment."

"Food spoiled in city markets . . ." (And in how many home freezers?)

Apartments with self-pumping systems "were left without water and sewage disposal."

Movies closed, banks put on extra guards for doors too huge to close by hand; and lights, radios and TV's went out. Fans were off in a sweltering city. Inoperable electric stoves left owners without means of cooking dinner. Traffic jammed—in California they have an expression for it in modern slanguage—a tremendous "hassle" of immovable traffic, lost tempers, harried police who were powerless to break up the mess.

Police called out reinforcements, the next shift of police was called in early.

But where, in this dire emergency of failure in a modern metropolitan, highly organized, highly technical way of life, where, oh where, was mention of a citizens' group helping out—where *was* Civil Defense?

There's a couple of dire lessons in this front page news story . . . one concerning the citizen's duty to his society in emergency . . . a concept upon which our democracy is based.

And the second to medicine.

So let's look at that one first, doctor. The Army learned the lesson of preparedness in emergency by the very basis of its existence—which is to act in emergency. The Army doesn't always trust to technology—even if it did disband its mules to the highpowerd trucks that won't traverse mountain paths. The Army carries emergency portable power with its field hospitals . . . and its main Stateside medical installations, such as Letterman Army Hospital (of which I know personally), have their own complete powerhouse systems which will keep the hospitals supplied with needed power in event of civilian power failure. I've seen this happen at Letterman!

True, the powerhouse can't keep all the lights in the hospital going; the office forces operate in the dark. But the *surgeons do not operate in the dark!*

Yet, in the huge modern metropolis of New York City, USA, the largest city in the world, electricity failed and a hospital had to transfer an emergency patient and send its perishable plasma and medications—lifesaving elements of modern medicine—to another hospital not affected by this failure!

Oh, what food for thought this is! Thought about our "jungle!"

And on the Civil Defense side—definitely a citizens' duty type activity which also affects the medical profession.

Where *were* the huge crews that have been



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Continued

practicing the orderly evacuation of the biggest city in the world? Why *did* traffic get "hassled?" Why was there not some almost immediate order of the chaos?

What could an enemy do if such a paralysis could be caused by partial power failure?

Just as apropo, and something I sometimes think Mr. and Mrs. American Citizen are prone to forget, Civil Defense isn't just for what to do when an enemy drops a bomb . . . but for the *civil emergency that can occur at any moment.*

If a tornado would hit the heart of Indianapolis, or South Bend or Evansville, would there be trained people administering to the injured, aiding enforcement officers in directing traffic, etc.? Are the physicians and technical medical people ready and prepared to be in the right place at a minimum of time?

Are there centers set up for emergency conditions where everyone knows to go and set up shop to treat the injured?

(The Army does this, too, and goes thru actual operation—speaking in Army terms, not medical—so that all personnel concerned, military and civilian, have a place, an important place, in the scheme of things!)

Take the now infamous Texas City fire of a few years back . . . the more recent explosion in a small Oregon town . . . the yearly tornados, hurricanes, floods—things over which men have little control except to control themselves after the disaster . . . these emergencies can throw a whole population into chaotic, mass hysteria without sufficient controls by the citizens themselves. Citizens led by law officials and backed by organized medical teams!

Here in Indianapolis I am told that Red Cross, that the truckers, that Civil Defense police teams are out working for preparedness; and maybe there are others my informants failed to mention. But these alone are not enough!

And on this other emergency point—one I feel we emphasize too much to the slighting of natural emergencies which are far more likly to occur—on the point of an atomic attack by an enemy . . . let's look at it "on the ground."

True, if an atom bomb hit Indianapolis, there'd be little need for a city civil defense team in the immediate bomb area.

But, doctor-citizen, this thought is a misleading one which helps create public apathy, public suicide. What of the outlaying areas, outside the actual "kill" area of the bomb? What if it hit in Chicago and no closer? People in droves of thousands would pour into the heart of Indiana.

If my memory serves me right, Nap Town, Indiana, would be at the edge of such a nuclear explosion "affected area" on a calm day. On a windy day, the fallout might be much more serious. But from a 200-mile radius, we in Indianapolis could be saved, as well as untold thousands of "refugees," by having a well organized Civil Defense and well informed general public . . . and organized, equipped medical treatment centers. In such an emergency, we have not enough professional physicians to "go to the ill" . . . the *ill must go to the physician!* And they must know how to protect and treat themselves first!

Without this pre-planned control, what happens in any mass emergency when great areas are affected by a "blackout" of power, of transportation, of adequate police protection, of centralized medical centers?

Like the New York pedestrian said during that blackout emergency there, "It's like a jungle!"

But it need not be!

Tell It To The Editor

Would like to call to mind the new section in the *Journal* called "to the editor." Doctor, this is your chance, not only to take part in publishing your own *Journal,* but to say what you think—of the *Journal,* of medicine, of anything affecting your own profession.

So if you have anything to say, tell it to the editor.

Science Fair Report

Since the association is taking an active part in presenting the National Science Fair for youths in Nap Town next year, you might be interested to know that the AMA public information section is reprinting, in part, that National Science Fair spread used in the July *Journal* for U.S.-wide distribution to tell "what the doctors in Indiana are doing."

Soon as plans for the 1960 Science Fair begin to jell real good early this fall, the *Journal* staff

Continued on page 1553

hopes to begin reporting on them to keep you posted.

From what I've heard thus far, indications are that it'll be one of the best yet. As has been pointed out in official convention reports, the science of medicine will play a big part in this fair, especially with the many top ranking medical facilities and pharmaceutical houses available in this area for field tours.

So keep watching for this information. From what I saw at the Hartford fair, you just might want to pop in and view the work these kids are doing.

End of Summer Note

It's always a delightful thrill to go fishing and reel in a whopper. But how many of you sportsmen have gone fishing and reeled in a duck? Well, I did! Nice big one to tickle the trigger finger of any hunter.

Said duck tried to eat my bobber and got tangled in the line. Had to reel him in to get his feet loose. Bet if I'd go hunting for a duck, I'd shoot a fish! (Note: never did catch a fish either.)

Barefoot Blues

Speaking of summer, where, oh, where did it go? Seems like the sun just got good and warm and here it is well into August . . . September by the time you read this. (I DO have at least ONE reader, don't I???) Time to dust off the ice hockey sticks, the basketballs . . . and get out the blankets for that first cold football game (only blankets?). And time to get out the wools so we can smother thru Indian Summer.

But worst of all, time to put shoes back on! How I hate to give up that delightful feeling of walking barefooted in the yard, the grass soft and cool underfoot. And wondering just when I'll step on a bee! And how I dread groaning under heavy clothing again. Let's face it; I'm not a good Eskimo! Give me the hot, even the humid, in preference to a winter like the last one.

Anyone care to join me in California?

Motor vehicle accidents killed 36,700 and injured 2,825,000 on U. S. highways during 1958.

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Deaths...

James M. Garland, M.D.

James M. Garland, Indianapolis general practitioner, died at his home July 5 at the age of 85.

A graduate of the University of Louisville, Dr. Garland also attended Little Rock School of Medicine and the University of Chicago Medical School. He practiced in Bloomington before coming to Indianapolis 40 years ago. Although he retired before World War II, Dr. Garland practiced during the war because of the shortage of physicians.

He was a member of the Marion County Medical Society, AMA, Third Christian Church, Indianapolis, and the Masonic Lodge.

Glen D. Larrison, M.D.

Dr. Glen D. Larrison, Morocco, a practicing physician for 40 years, passed away while on a fishing trip to Wisconsin on June 29. He was 70.

A graduate of Hering Medical College, Chicago, Dr. Larrison was on the staff of Iroquois and Jasper county hospitals, and belonged to the Newton-Jasper Medical Society, AMA, Morocco Methodist Church, Morocco F. and A. M., and the American Legion. He was a World War I veteran.

Milo G. Meyer, M.D.

Dr. Milo G. Meyer, specialist in internal medicine, died at his Michigan City home on June 23.

A graduate of the University of Iowa School of Medicine, Dr. Meyer was active in the La Porte County Cancer Society, Laporte County Medical Society, American Legion and several civic groups.

David Joseph Cummings, M.D.

Dr. David Joseph Cummings, senior and 50-year Club member of ISMA, passed away July 26 at the Jackson County Hospital. He practiced medicine in Brownstown from 1901 until his health forced retirement in 1956.

Dr. Cummings was a Jackson County health officer for 42 years. He was a graduate of Indiana Central Medical College, and also attended Vanderbilt Medical School, Nashville, Tenn.

He was a past president of the Jackson County Medical Society, a 50-year mason, and a 70-year member of the Brownstown Christian Church.

Harry M. Shultz, M.D.

Dr. Harry M. Shultz, 68, Logansport, passed away June 28. A general practitioner and dermatology specialist, Dr. Shultz had practiced medicine since 1903.

Dr. Shultz was a former Cass County Health Officer and served on the Memorial Hospital staff. He was a captain in the Medical branch of the Armed Forces during World War I.

Albert Fred Clements, M.D.

An Evansville physician and surgeon, Dr. Albert Fred Clements, passed away July 9 at his home. Dr. Clements practiced in Evansville from the early 1920's until 1954, with the exception of the time he served in World Wars I and II. He became a member of Evansville Hospital staff after his retirement.

Dr. Clements attended Indiana University and was graduated from Rush Medical College, University of Chicago. He served on the staffs of all three Evansville hospitals, and was a member of AMA, American Legion and Nu Sigma Nu. He was a past president of the Vanderburgh Medical Society.

Andrew Hofmann, M.D.

Injuries received when he was struck by an automobile on July 9 claimed the life of Dr. Andrew Hofmann, 81-year-old Munster physician. He had practiced medicine for 51 years.

A senior member of ISMA, Dr. Hofmann served as Lake County coroner for two terms. He obtained his M.D. from the University of Illinois, and began practicing in Hammond, in 1909, where he continued until his death.

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Middle age is when you stop having emotions and start having symptoms.—*Kroehler News,* Kroehler Mfg. Co.

A father is a thing that is forced to endure childbirth without an anesthetic. . . .

A father never feels worthy of the worship in a child's eyes. He's never quite the hero his daughter thinks, never quite the man his son believes him to be, and this worries him, sometimes. . . .

A father is a thing that gets very angry when the first school grades aren't as good as he thinks they should be. He scolds his son, tho he knows it's the teacher's fault.

Fathers are what give daughters away to other men who aren't nearly good enough, so they can have grandchildren who are smarter than anybody's. . . .

I don't know where father goes when he dies. But I've an idea after a good rest, wherever he is, he won't just sit on a cloud and wait for the girl he's loved and the children she bore. He'll be busy there, too, repairing the stairs, oiling the gate, improving the streets, smoothing the way.—Paul Harvey.

Criticism wouldn't be so hard to take if it weren't so often right.—*Empire Magazine.*

An optimist is a person who drops a quarter in the collection plate and expects a $5 sermon.—*Banking.*

A man can fracture his pride in a fall over his own bluff.—*Kroehler News,* Kroehler Mfg. Co.

"How do you know you're Napoleon?" the hospital attendant asked.

"God himself told me," the patient answered.

Said a voice from the next bed, "I did not!"—*Bruce Magazine,* E. L. Bruce Co.

An old-timer is one who used to think that a hand mower was noisy . . . who remembers when the telephone was a convenience.—*Quote*: Gordon E. Thatcher, Frances Rodman.

It isn't the things that go in one ear and out the other that hurt, as much as the things that go in one ear and get all mixed up before they slip out the mouth.—*Nuggets,* Barnes-Ross Co.



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Association Reports

INDIANA STATE MEDICAL ASSOCIATION

The Council

July 12, 1959

The Council of the Indiana State Medical Association convened for its summer meeting at 10:05 a.m., Central Daylight Time, Sunday, July 12, 1959, in Room M-124, Indiana University Student Union Building, Indianapolis, with Dr. Guy A. Owsley, chairman, presiding.

Roll call showed the following present:

Councilors:

First District—William B. Challman, Mount Vernon.

Second District—Not represented.

Third District—John M. Paris, New Albany (alternate AMA delegate).

Fourth District—Not represented.

Fifth District—Robert K. Webster, Brazil.

Sixth District—Harry P. Ross, Richmond; William R. Tindall, Shelbyville, alternate.

Seventh District—Not represented.

Eighth District—Guy A. Owsley, Hartford City; Gordon B. Wilder, Anderson, alternate, and AMA delegate.

Ninth District—Kenneth O. Neumann, Lafayette.

Tenth District—James P. Vye, Gary; Ralph C. Eades, Valparaiso, alternate.

Eleventh District—Max R. Adams, Flora; Earl W. Bailey, Logansport, alternate.

Twelfth District—Milton F. Popp, Fort Wayne, alternate.

Thirteenth District—G. O. Larson, LaPorte; Raymond E. Nelson, South Bend, alternate.

Officers:

Kenneth L. Olson, South Bend, president.

Okla W. Sicks, Indianapolis, treasurer.

Frank B. Ramsey, Indianapolis, editor *The Journal.*

Executive Committee:

Don E. Wood, Indianapolis, chairman.

Wendell E. Covalt, Muncie, member.

Guests:

Harold C. Ochsner, Indianapolis, AMA delegate.

Francis L. Land, Fort Wayne, AMA delegate.

E. S. Jones, Hammond, AMA delegate.

Harry Pandolfo, Indianapolis, chairman, Commission on Public Information.

Burton E. Kintner, Elkhart, chairman, Building Committee.

Edward T. Edwards, Vincennes, chairman, Commission on Medical Economics and Insurance.

Philip B. Reed, Indianapolis, chairman, Grievance Committee.

Andrew C. Offutt, Indianapolis, State Health Commissioner.

Mr. John B. Twyman, Gary, secretary, Lake County Medical Society.

Robert H. Rang, Washington, member, Commission on Inter-Professional Relations.

Staff:

Robert Hollowell, Indianapolis, attorney.

Robert J. Amick, field secretary.

Howard Grindstaff, field secretary.

James A. Waggener, executive secretary.

Minutes of the Council meeting held on April 5, 1959, were approved by consent.

Reports of Councilors

The councilors gave brief reports on their spring and summer district meetings.

Dr. Paris reported the election of Dr. Donald M. Kerr, Bedford, as alternate councilor of the Third District to succeed Dr. A. Lyle Havens, Jeffersonville.

Dr. Neumann reported the election of Dr. A. E. Stouder, Kempton, as alternate councilor of the Ninth District to succeed Dr. Robert H. Leak, Boswell.

The chairman introduced Dr. Milton F. Popp, Fort Wayne, new alternate councilor of the Twelfth District, representing Dr. Maurice E. Glock, councilor, who was absent because of illness.

The chairman also introduced Dr. Earl W. Bailey, Logansport, new alternate councilor for the Eleventh District.

The chairman announced that Dr. Joseph E. Dudding, Hope, had resigned as councilor of the Fourth District, effective at the completion of his term in October, 1959, and that he will be succeeded by Dr. Joe M. Black of Seymour.

The chairman also announced that Dr. Fletcher W. McDowell of Muncie had been elected to replace Dr. E. H. Clauser as the Eighth District's representative on the Blue Shield Board.

Dr. Max R. Adams announced that the fall meeting of the Eleventh District would be held at Roth Park in Monticello.

Reports of Officers

Dr. Kenneth L. Olson, president, reported on his activities since the last meeting of the Council.

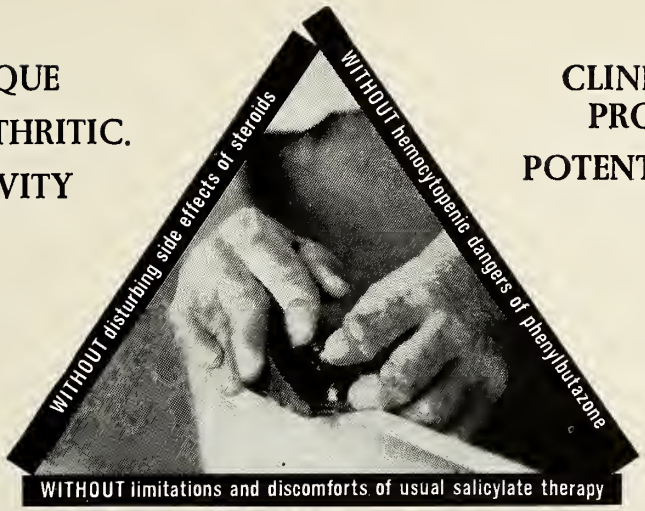
Dr. Okla W. Sicks, treasurer, gave the treasurer's report.

Dr. E. S. Jones, AMA delegate, reported for the delegates on the recent AMA meeting and discussed at length the action of the House of Delegates on the report on osteopathy and free choice of physician.

Dr. Gordon B. Wilder, AMA delegate, reported on the action of the House of Delegates regarding the Social Security question, stating the association had turned down a poll of its membership on

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"Patients who had been taking steroid preparations before using Choline Salicylate [Arthropan] were able to reduce the doses (of steroid) and in some instances to discontinue it entirely."[3]

"In no instances did gastrointestinal symptoms preclude administration of Choline Salicylate [Arthropan]."[4]

These reports have emanated from extensive clinical trials[5] in thousands of patients by more than 180 physicians.

RECOMMENDED DOSAGE: (Adults and children over 12 years) *As an anti-inflammatory agent in rheumatoid arthritis and rheumatic fever:* 1-2 teaspoonfuls, 4 times daily at onset of therapy. *As an analgesic or antipyretic:* 1 to 2 teaspoonfuls, 3 to 4 times daily.

NOTE: Unless satisfactory relief is obtained, it is advisable gradually to increase dosage by increments of 1 teaspoonful per day until maximum benefit, without side effects, is attained. *In every case the dosage should be adjusted upwards or downwards to assure full therapeutic activity up to the limit of the patient's tolerance (in the absence of gastrointestinal distress or early salicylism).*

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CITED REFERENCES: 1. Clark, G. M.: Personal Communication, 1958. 2. Feldman, H. A.: Personal Communication, 1958. 3. Scully, F. J.: Treatment of Rheumatic Disorders with Choline Salicylate (to be submitted for publication). 4. Friedland, C. K.: Personal Communication, 1958. 5. Complete data available on request to the Medical Director.

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this question. He also reported on the discussions which took place regarding the expansion by the National Foundation for Infantile Paralysis into other fields of health programs.

Dr. Francis L. Land, AMA delegate, reported on the discussions which took place before the Committee on Medical Education and Hospitals and told of the resolution which he introduced calling for a change in the report of the committee on preparation for general practice, in which obstretrics was deleted as a part of the required training. Dr. Land's resolution had the effect of saying that the training in obstetrics should be mandatory, and as a result, the matter is to be discussed further by the Committee on Medical Education of the AMA in establishing the rules.

Dr. Harold C. Ochsner, AMA delegate, reported on the Indiana resolution which was presented calling for the AMA and the various states to make a thorough study on "Aging," and on the discussion before the reference committee on the responsibility of Blue Cross and Blue Shield to offer adequate coverage for these people.

Unfinished Business

(1) **Nomination for Editorial Board.** On motion of Dr. Vye, duly seconded, Dr. Franklin F. Premuda, Hammond (pediatrics), was nominated to succeed Dr. George N. Lewis, Gary, for a three-year term, January 1, 1960, through December 31, 1962.

On motion of Dr. Popp, Dr. Samuel R. Mercer, Fort Wayne (dermatology), was renominated to succeed himself for a three-year term ending December 31, 1962.

(2) **Student Loan Fund.** Dr. Ross, chairman, gave a detailed report on the activities of the Student Loan Committee and discussed off the record one case in particular. Following his discussion, on motion of Drs. Popp and Larsen, the Council voted to approve Dr. Ross's administration of the Student Loan Fund and his position in this matter, and commended him for the time and effort he has given to this responsibility.

(3) **Medical Care for Military Dependents.** The secretary reported on the Medicare program, stating that the volume had fallen off as a result of the recent restrictions in the program; however, Congress had seen fit to increase the appropriation for this program and indications were that an extended program as originally offered would be resumed.

(4) **Building Committee.** Dr. Burton E. Kintner, chairman, reported on the activities of the Building Committee and on the poll which had been conducted by the committee in which the membership indicated by a large majority that they favored a building. He reported also that it was the intent of his committee to have a very complete and comprehensive report for presentation to the House of Delegates, listing available sites, building costs, etc.

Dr. Ochsner spoke as a member of the Levey Memorial Foundation and informed the Council that the members of the Indanapolis Medical Society would soon take title to the home which had been willed to them by Mrs. Levey. He extended an invitation to the Indiana State Medical Association to occupy this building with the Indianapolis Medical Society, assuring the Council that it is his personal belief that suitable arrangements could be made in all respects for the combination of the State Association and the Indianapolis Society to occupy this building. He further requested that consideration be given to this property and invited those interested to view the property following adjournment of the Council.

(5) **Liaison Committee between Council and Blue Shield.** Dr. Challman, chairman, reported on the May 17, 1959, meeting of the Council Liaison Committee with Blue Shield. It was his feeling that some progress had been made and he stated that the committee would attend the Board meeting on July 19 to determine what progress had been made.

(6) **Commission on Medical Economics and Insurance.** Dr. Edward T. Edwards, chairman, reported on the activities of his commission and his attendance at a meeting in Pittsburgh recently with representatives of other medical groups, the steel workers' union and management officials, to discuss the problem of coverage under the steel workers' contract.

Dr. Edwards also mentioned to the Council that he had previously requested funds for the purpose of publishing for distribution to all the members of the association a copy of his commission's report on the Relative Value Study, listing in detail all procedures and point values. The estimated cost for the printing of this was given as $2,500.00. The Executive Committee had recommended that the report not be published in detail, only the results of the commission's findings and its recommendations. On motion of Drs. Ross and Paris the Council adopted the recommendation of the Executive Committee that the Relative Value Study not be published in detail at this time.

Dr. Edwards pointed out that the commission was out of funds. On motion of Drs. Paris and Larson the Council voted to supplement the budget of the Commission on Medical Economics and Insurance by an additional $500.00 appropriation.

(7) **Grievance Committee.** Dr. Philip B. Reed, chairman, reported on the activities of the Grievance Committee, pointing out that it was the opinion of the members of this committee that the component county societies should take an active and concerned interest in grievance matters. He also reported that his committee had had referred to it a letter from the AMA concerning the establishment at the national level of a Medical Disciplinary Committee.

(8) **Executive Session.** At this time the Council went into executive session.



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1959 Annual Session, Indianapolis, October 6-9, 1959

The Council reviewed the outline of the proposed scientific and entertainment programs, and the report on sale of exhibit space, which were accepted as presented without any action.

Membership Matters

(1) **The membership report** was reviewed and was accepted as presented by consent.

(2) **Remission of state dues.** The chairman called attention to the April 5 Council action whereby the Bylaw concerning the remission of state dues was referred to the Commission on Constitution and Bylaws for further study and clarification. A letter from Dr. A. W. Cavins, chairman of the Commission on Constitution and Bylaws, was read in which Dr. Cavins stated he felt this matter was perfectly clear and time should be given to prove or disprove the feasibility of the procedure outlined in the Bylaw in question before any changes are made. It was agreed by consent that no further action would be necessary on this item.

Dr. Larson recommended the remission of the state dues of a member of the St. Joseph County Medical Society, because of retirement from practice, and this recommendation was approved on motion of Drs. Larson and Ross.

Legislative Matters

The chairman reported on the trip to Washington made by the officers on April 27, 1959, to meet with the Indiana delegation in Congress and stated in his opinion this was one of the best meetings ever held with this group. Every member of the Indiana delegation was present, plus the two senators.

New Business

(1) **1960 Science Fair.** Dr. Harry Pandolfo, chairman of the Commission on Public Information, appeared before the Council, stating that the Executive Committee had recommended that the commission appropriate $1,000.00 of its funds to help finance the 1960 Science Fair, to be held in Indianapolis. He further stated that he thought this was inadequate and that inasmuch as the State Medical Association had been instrumental in inviting the Science Fair to Indianapolis it should contribute additional funds.

Following discussion, on motion of Drs. Paris and Vye the sum of $5,000.00 was appropriated for the 1960 Science Fair.

Coaches' Conference. Dr. Pandolfo then discussed the coaches' conference which has been conducted by the State Medical Association for the past two years and recommended that a similar conference be held in October 1959, which would be sponsored jointly by the Indiana State Medical Association and the Indianapolis Medical Society.

Following discussion, Dr. Ross moved that $250.00 be appropriated for the coaches' conference. Motion lost for want of a second.

(2) **Election of two members to Trust Committee of Indiana Medical Education Foundation.** On motion of Drs. Paris and Challman, Drs. Maurice V. Kahler and Lawson J. Clark, both of Indianapolis, were re-elected to succeed themselves for a three-year term expiring October 31, 1962. Membership of this committee is as follows:

	Term Expires
Don E. Wood, Indianapolis	October 31, 1960
Roy Geider, Indianapolis	October 31, 1960
James W. Denny, Indianapolis	October 31, 1961
Roy V. Myers, Indianapolis	October 31, 1961
Maurice V. Kahler, Indianapolis	October 31, 1962
Lawson J. Clark, Indianapolis	October 31, 1962

(3) **Blue Shield members at large.** No action was taken on the nomination for Blue Shield members at large whose terms expire March, 1960.

(4) **Matters referred to Council by Executive Committee.**

A. M. A. membership. Dr. Wood, chairman of the Executive Committee, reported that the members of the committee had studied the matter of A. M. A. membership and that they recommended that the Council prepare a resolution for presentation to the House of Delegates in October making dues in the American Medical Association mandatory for all members of the Indiana State Medical Association.

Upon motion of Drs. Vye and Paris the Council voted to prepare such a resolution for submission to the House of Delegates.

(5) **Dr. Andrew C. Offutt**, State Health Commissioner, appeared before the Council regarding a survey which the State Board of Health proposed to make on tuberculosis cases, and on motion of Dr. Challman and taken by consent, his request was approved.

(6) **Dr. E. S. Jones** reported on the meeting on Aging held in Atlantic City prior to the annual meeting of the A. M. A., and also on the Joint Conference on Aging which was held at Washington, D. C., under the sponsorship of the American Medical Association, American Nursing Home Association, American Hospital and American Dental Associations.

(7) **AMA Public Relations Institute, Chicago, August 19-20.** Dr. Pandolfo called to the attention of the Council the forthcoming AMA Public Relations Institute in Chicago and suggested that the Council consider recommending that the president-elect and also the incoming chairman of the Commission on Public Information be authorized to attend the Public Relations Institute, in addition to those who would normally be sent. No action was taken on this.

(8) By consent, the Council took action to express its regrets to Dr. Mericle on the death of his mother.



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(9) Dr. Larson stated that he felt it was essential that the councilors prepare a written report for the counties in their districts and made a motion that a summary of the actions taken at each Council meeting be prepared by the headquarters office and be sent to the councilors a few days following the meeting so that this information could be distributed. Motion seconded by Dr. Adams, and carried.

There being no further business the Council adjourned to meet again at 3:00 p. m., Monday, October 5, 1959.

The Executive Committee

July 11, 1959

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Kenneth L. Olson, M.D.; Guy A. Owsley, M.D.; Okla W. Sicks, M.D.

Robert Hollowell, attorney, and James A. Waggener, executive secretary.

Membership Report

The membership report was reviewed and upon motion of Drs. Owsley and Olson the Executive Committee voted to recommend to the Council that the Council prepare a resolution to the House of Delegates to provide that membership in the American Medical Association be mandatory for all members of the Indiana State Medical Association.

Number of members as of June 30, 1958	4,139
1959 members as of June 30, 1959:	
Full dues paying	3,544
Residents and interns	204
Council remitted	38
Senior	385
Military	43
Honorary	1
Total 1959 members as of June 30, 1959	4,215
Gain over last year	76
Number of members December 31, 1958	4,201
Delinquent members as of June 30, 1959	51
Number of AMA members as of June 30 1958	3,980
1959 AMA members: Dues paying	3,372
Exempt, but active	715
Total 1959 AMA members as of June 30, 1959	4,087
Gain over last year	107
Number of AMA members as of December 31, 1958	4,052
Delinquent AMA members as of June 30, 1959	184*

* 125 of these have paid state dues but have not paid AMA dues.

Treasurer's Office

Dr. Sicks gave the treasurer's report and it was accepted by consent.

Headquarters Office

The secretary reported on the activities of the field staff in compiling information on the aged residents in Indiana nursing homes, and contacts with legislators and newspapers.

Legislative Matters

National

Dr. Wood, chairman of the Commission on Legislation reported on the trip that he and the executive secretary would make to Washington on July 14 to file a statement on the Forand Bill, H. R. 4700. The proposed statement was reviewed and was approved for submission.

Dr. Wood also reported on the introduction of H. R. 6644 by Congressman Denton, which calls for the construction of an additional VA hospital in or near Evansville. By consent it was agreed that the Association should oppose this legislation.

1959 Annual Convention

Indianapolis, October 6 to 9, 1959

Report on sale of exhibit space was accepted by consent.

The convention program as outlined was accepted by consent.

The secretary called attention to the fact that the past presidents' luncheon was scheduled on the same day as the auxiliary luncheon and by consent it was agreed that the past presidents' luncheon should be held on Tuesday instead of Wednesday.

Upon motion of Drs. Owsley and Olson it was voted that a pin and certificate should be awarded posthumously to Dr. Will Thompson, being presented to his family.

Fifty-Year Club reception chairman. By consent it was agreed to ask Dr. Clay A. Ball of Muncie to serve as chairman for the Fifty-Year Club reception.

By consent the secretary was authorized to enter into a contract with Twiet's Display Company covering installation of booths for the annual convention.

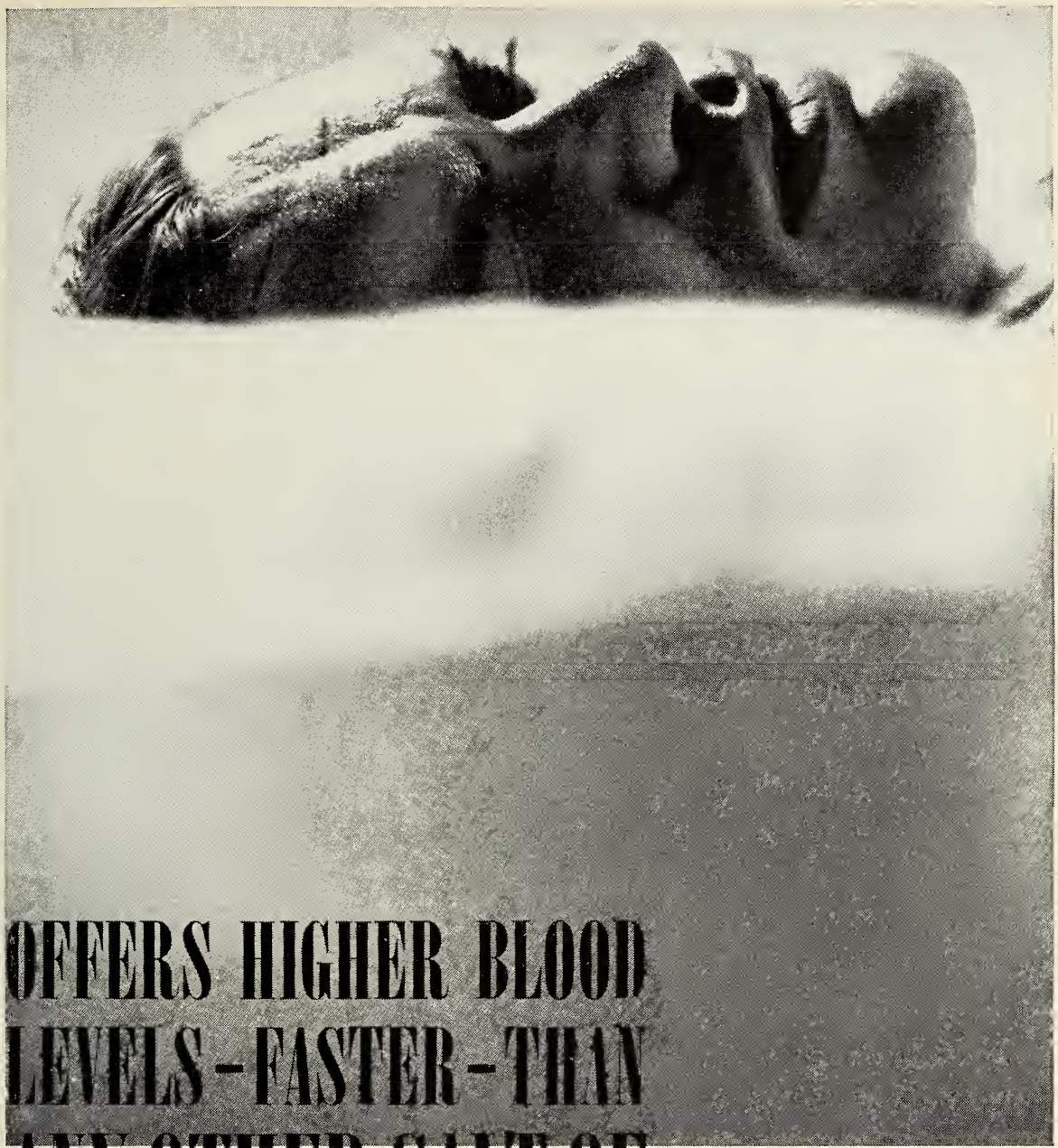
Upon motion of Dr. Owsley, taken by consent, the list submitted for seating at the speakers' table and for those to be invited to the annual banquet was approved.

Upon motion of Dr. Sicks and Dr. Covalt it was voted that the Governor should be invited to attend the banquet.

The secretary reported the fact that the Indiana Academy of General Practice had informed him that it would grant Category No. 1 credit for the instructional courses and Category No. 2 credit for the balance of the scientific program.

On motion of Drs. Owsley and Olson approval was given for holding an art and hobby show at the 1959 convention.

A letter from Mrs. J. M. Black, president of the Woman's Auxiliary, was read in which she stated she would have to be in Chicago for a meeting at



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the time she is scheduled to appear to give a report to the House of Delegates. By consent it was agreed that she have a representative give her report, or prepare it in written form for submission to the House.

Organization Matters

The Executive Committee reviewed the action of the American Medical Association concerning the relations with osteopaths and by consent it was agreed that this matter should be referred to the Council for its information and discussion.

The secretary submitted a survey being made by the Louisiana State Medical Society in an effort to determine the amount of time in value of dollars and cents that the physicians in that state contributed to various civic activities and in the care of the indigent. Upon motion of Dr. Olson and taken by consent, this is to be referred to the Commission on Special Activities for its consideration.

The secretary informed the Committee that in accordance with past action the Veterans' Fee Schedule for the period 1 July 1959 to 30 June 1960 had been signed with the proviso attached that the association could reopen negotiations at any time.

A letter from the American Medical Association asking the opinion of the association on medical disciplinary actions was read and by consent it was agreed that this should be referred to the Grievance Committee for reply.

A letter from the Indiana League for Nursing concerning the preparation and distribution of information concerning careers in nursing and requesting the Woman's Auxiliary to participate by designating a member to serve on a Nursing Careers Committee was read. By consent it was agreed to inform the auxiliary that it had the consent of the State Medical Association to designate a member to serve in this capacity, if such is the wish of the Woman's Auxiliary.

Letter received from the Governor's Youth Council requesting a recommendation by the association for a member of the official family of the Indiana State Medical Association to serve on the Advisory Committee for the Indiana Section of the 1960 White Conference for Children and Youth. By consent it was agreed to recommend Dr. Earl W. Mericle.

The secretary reported on the request of WFBM-TV for an expert on Russian Medicine to appear on its TV program at 6:30 p.m., Sunday, July 19. In response to this request he has been successful in procuring Dr. Otis L. Anderson, a medical liaison representative in the Washington office of the American Medical Association, as a participant on the program. Dr. Anderson was a member of a team sent to Russia to study Russian medicine and health program by the United States Public Health Service.

Fiscal year. The secretary asked for clarification regarding what position the association took in the recommendation of the Wolf Management Engineering Company concerning the fiscal year of the association. Upon motion of Drs. Owsley and Covalt, the Committee voted that the fiscal year of the association shall be October 1 to September 30, as recommended by the Wolf Company, and that the organization meeting of 1959-60 commission members shall be held at the annual convention following the close of the last session of the House of Delegates.

The Journal

The secretary called attention of the Committee to the report from the International Conference of Industrial Editors, in which this organization rated the Indiana *Journal* very highly.

On motion of Drs. Owsley and Sicks, it was agreed that the editor, Editorial Board, *The Journal* staff, and business manager be authorized to attend the State Journal Advertising Bureau meeting in Chicago on October 26 and 27, 1959.

Future Meetings

On motion of Dr. Owsley, taken by consent, the field secretaries, the chairman of the Commission on Public Information, and the executive secretary were authorized to attend the A.M.A. Public Relations Institute in Chicago on August 19, 20 and 21, 1959.

The invitation from the White House for a representative to attend a meeting of the President's Committee for Traffic Safety in Miami Beach, August 24 and 25, 1959, was presented to the committee. By consent it was agreed that no representative would be sent to this meeting.

A letter from the American Medical Association requesting representation of the association at a planning conference in Cleveland on July 28, 1959, to discuss plans for a Regional Conference on Aging was read, and on motion of Drs. Owsley and Covalt, Dr. Emmett Lamb and the executive secretary were authorized to attend this meeting.

There being no further business, the committee adjourned to meet again upon the call of the chairman.

110th
Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 6, 7, 8 and 9, 1959
All Time—Eastern Standard Time
Murat Temple
Indianapolis

Complete Program and Annual Reports on Following Pages

Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Murat Temple, Indianapolis, Ind., Oct. 6, 7, 8 and 9, 1959.

The House of Delegates will be constituted as follows: Marion County, 21 delegates; Lake County, eight delegates; Allen County, five delegates; St. Joseph County, four delegates; Vanderburgh County, four delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jasper-Newton, Jefferson-Switzerland, LaPorte, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union County Societies, each two delegates; the other 59 county societies, each one delegate; 13 councilors and the ex-presidents, namely Charles N. Combs, George R. Daniels, F. S. Crockett, R. L. Sensenich, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Carl H. McCaskey, Cleon A. Nafe, Augustus P. Hauss, Alfred Ellison, Paul D. Crimm, William Harry Howard, Walter L. Portteus, Walter U. Kennedy, Elton R. Clarke and M. C. Topping, and ex-officio, the president, president-elect, executive secretary and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in the case of a tie vote, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to the Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Ind., or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 9 a.m. Tuesday, October 6, in the Ballroom, Columbia Club, and again at 9:00 a.m. Friday, October 9, in the Dining Room, basement, Murat Temple.

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Tribute to members of House who have died since the 1958 session.
4. Reading of the minutes of previous meetings.
5. Introduction of guests.
6. Appointment of Reference Committees and assignment of meeting rooms.
7. Unfinished business.
 (a) Constitutional amendments.
 (b) Report of House Building Committee.
8. Address of president-elect.
9. Report of President of the Woman's Auxiliary.
10. Report of Indiana Chapter Student A.M.A.
11. Report by president of Blue Shield.
12. Report of executive secretary.
13. Report of treasurer.
14. Report of the chairman of the Council.
15. Reports of councilors.
16. Reports of committees and commissions:

 COMMITTEES:
 (1) Executive
 (2) Grievance
 (3) Student Loan
 (4) Medical-Legal Review

 COMMISSIONS:
 (1) Convention Arrangements
 (2) Constitution and Bylaws
 (3) Legislation
 (4) Public Information
 (5) Governmental Medical Services
 (6) Public Health
 (7) Voluntary Health Agencies
 (8) Medical Economics and Insurance
 (9) Inter-Professional Relations
 (10) Medical Education and Licensure
 (11) Special Activities
17. New business:
 (1) Resolutions from the floor.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire Dec. 31, 1959, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Gordon B. Wilder, Anderson, and Wendell C. Stover, Boonville; and alternates, Walter L. Portteus, Franklin, and John M. Paris, New Albany.

Delegates from the First, Fourth, Seventh, Tenth and Thirteenth districts are reminded that the terms of their councilors will expire Oct. 9, 1959 and the new councilors should be elected to succeed the following:

First District: William B. Challman, Mt. Vernon.

Fourth District: Joseph E. Dudding, Hope.

Seventh District: Ralph V. Everly, Indianapolis.

Tenth District: J. P. Vye, Gary.

Thirteenth District: G. O. Larson, LaPorte.

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, *Executive Secretary.*

HOUSE OF DELEGATES

Indiana State Medical Association

INDIANAPOLIS

County and Delegates	Alternate
ADAMS	
Arthur Girod, 1004 W. Monroe, Decatur	James Burk, Decatur
ALLEN	
Emory D. Hamilton, 228 Medical Center Bldg., Fort Wayne	Franklin A. Bryan, Fort Wayne
Frederic L. Schoen, 902 Wayne Street, Fort Wayne	Victor C. Moeller, Fort Wayne
Francis L. Land, 116 W. Rudisill Fort Wayne	John W. McCallister, Fort Wayne
Eugene F. Senseny, 2902 Fairfield Ave., Fort Wayne	Howard N. Stellner, Fort Wayne
Frederick W. Brown, 2609 Fairfield Ave., Fort Wayne	J. F. Jackson, Fort Wayne
BARTHOLOMEW-BROWN	
David Adler, County Hospital, Columbus	Robert Reid, Columbus
Robert Seibel, Nashville	K. D. Schneider, Nashville
BENTON	
V. L. Turley, Fowler	
BOONE	
Clarence G. Kern, 1726 N. Lebanon, Lebanon	Paul R. Honan, Lebanon
CARROLL	
T. Neal Petry, 111 E. Franklin St., Delphi	
CASS	
Lowell J. Hillis, 203 S. Third St., Logansport	Donald Winter, Logansport
CLARK	
Lee A. Dare, 209 E. Maple, Jeffersonville	
CLAY	
Charles Moon, Center Point	J. R. Glosson, Clay City
CLINTON	
Claude D. Holmes, 9½ W. Clinton St., Frankfort	George Hammersley, Frankfort
DAVIESS-MARTIN	
Robert H. Rang, 1312 Bedford Road, Washington	C. Philip Fox, Washington
E. B. Lett, 408 E. Main St., Loogootee	R. E. Chattin, Loogootee
DEARBORN-OHIO	
G. S. Fessler, Rising Sun	Charles Olcott, Aurora
John C. Elliott, Guilford	George Morrison, Lawrenceburg
DECATUR	
William R. Shaffer, Taylor Building, Greensburg	

County and Delegates	Alternate
DEKALB	
Bonnell Souder, Auburn	L. E. Jinnings, Garrett
DELAWARE-BLACKFORD	
Thomas M. Brown, 412 White River Blvd. Muncie	Glynn Rivers, Muncie
Francis E. Stout, 2423 W. Jackson St., Muncie	Donald Taylor, Muncie
Dean Jackson, 401 W. Washington St., Hartford City	George Parks, Hartford City
DUBOIS	
John Barrow, Dale	E. J. Ploetner, Jasper
ELKHART	
S. T. Miller, 506 S. Second St., Elkhart	F. S. Martin, Goshen
Burton E. Kintner, 506 S. Second St., Elkhart	James Hannah, Elkhart
FAYETTE-FRANKLIN	
G. T. Watterson, 1910 Virginia, Connersville	George Ellis, Connersville
Perry Seal, 901 Main St., Brookville	H. N. Smith, Brookville
FLOYD	
Herbert P. Sloan, 1207 E. Spring St., New Albany	Nelson A. Wolfe, New Albany
FOUNTAIN-WARREN	
Lee J. Maris, 201 Brady, Attica	Lowell R. Stephens, Covington
James W. Crain, Williamsport	Carl A. Nelson, West Lebanon
FULTON	
K. K. Kraning, Kewanna	Dean K. Stinson, Rochester
GIBSON	
Virgil McCarty, 113 S. Main St., Princeton	James F. Peck, 218 Broadway, Princeton
GRANT	
Robert M. Brown, 522 Marion Nat'l Bank Bldg., Marion	Max Long, Marion
GREENE	
Sam Rotman, Jasonville	H. B. Turner, Bloomfield
HAMILTON	
Joe R. Lloyd, 148 N. 9th St., Noblesville	Ray Shanks, Noblesville
HANCOCK	
Dee Dar Gill, 1001 N. State St., Greenfield	Wayne H. Endicott, Greenfield
HARRISON-CRAWFORD	
William E. Amy, Corydon	Richard A. Jordon, Corydon
N. E. Gobbel, English	Jesse Benz, Marengo
HENDRICKS	
O. T. Scamahorn, Pittsboro	M. O. Scamahorn, Pittsboro

County and Delegates	Alternate
HENRY	
W. S. Robertson, Spiceland	J. E. Fisher, New Castle
HOWARD	
Garvey Bowers, 210 W. Mulberry St., Kokomo	Frederick Schwartz, Kokomo
HUNTINGTON	
Howard Marks, 248 W. Park Drive, Huntington	S. E. Cope, Huntington
JACKSON	
Jack E. Shields, Brownstown	Kenneth Bobb, Seymour
JASPER-NEWTON	
R. S. Yegerlehner, Kentland	
K. R. Ockerman, Rensselaer	
JAY	
Forrest E. Keeling, 504 West Arch St., Portland	William H. Cripe, Portland
JEFFERSON-SWITZERLAND	
Francis Prenatt, Madison State Hosp., Madison	R. O. Zink, Madison
Noel S. Graves, Vevay	A. A. Hamilton, Vevay
JENNINGS	
D. W. Matthews, North Vernon	Benet W. Thayer, North Vernon
JOHNSON	
Charles A. Jones, 251 E. Jefferson St., Franklin	
KNOX	
E. T. Edwards, 1045 Washington Ave., Vincennes	V. C. McMahan, Vincennes
KOSCUISKO	
John M. Johnson, Court House, Warsaw	
LAGRANGE	
Philip E. Yunker, Howe	
LAKE	
Ray Elledge, 6415 Forest, Hammond	F. F. Premuda, Hammond
Nicholas Egnatz, 820 Highland, Hammond	J. B. Nicosia, East Chicago
P. J. Rosenbloom, 571 Lincoln, Gary	George M. Young, Gary
Peter Stecy, 1902 Indianapolis Blvd., Whiting	A. F. Gregoline, Gary
William R. Troutwine, 224 S. Court St., Crown Point	C. F. Bradley, Hobart
Harry R. Stimson, 504 Broadway, Gary	Michael Shellhouse, Gary
F. F. Boys, 4712 Magoun, East Chicago	
P. Q. Row, 7217 Indianapolis Blvd., Hammond	
LAPORTE	
J. C. Richter, 1110 Indiana Ave., LaPorte	R. A. Fargher, Michigan City
T. D. Armstrong 120 W. 9th St., Michigan City	F. M. Fargher, Michigan City
LAWRENCE	
Howard T. Hammel, Citizens Bank Bldg., Bedford	William Robinson, Mitchell

County and Delegates	Alternate
MADISON	
P. T. Lamey, 423 Citizens Bank Bldg., Anderson	S. W. Ellis, Anderson
Gordon B. Wilder, 338 W. 8th St., Anderson	J. L. Larmore, Anderson
MARION	
(All addresses Indianapolis unless designated)	
John W. Beeler, 712 Hume Mansur Bldg. (4)	Harold F. Burdette
Edward F. Bloemker, 2729 Shelby St. (3)	A. D. Dennison, Jr.
Floyd A. Boyer, 442 N. Drexel (1)	Albert M. Donato
Ralph V. Everly, 668 E. 38 St. (5)	Richard M. Nay
Roy A. Geider, 1525 Prospect St. (3)	Chester A. Stayton
Charles F. Gillespie, 3400 N. Meridian (8)	Robert W. McTurnan
Ted Grisell, 5317 E. 16th St. (18)	Hugh K. Thatcher, Jr.
John W. Hendricks, 911 Hume Mansur Bldg. (4)	Sam J. Davis
Lester H. Hoyt, Methodist Hosp. (7)	James H. Gosman
Francis P. Jones, 4212 E. Michigan St. (1)	Robert M. Hansell
Hunter F. Kennedy, 1105 Prospect St. (3)	Donald H. McCartney
James M. Leffel, 1633 N. Capitol Ave. (2)	Frederick A. Rice, Jr.
D. S. Megenhardt, 1633 N. Capitol Ave. (2)	Warren S. Tucker
Earl W. Mericle, 1633 N. Capitol Ave. (2)	Kenneth R. Woolling
Harold C. Ochsner, Methodist Hosp. (7)	John M. Young
Harry Pandolfo, 234 E. Southern Ave. (25)	Paul A. Des Jean
Russell J. Spivey, 2616 N. Penn. St. (5)	Rex M. Joseph
Lowell I. Thomas, 615 Hume Mansur Bldg. (4)	Kenneth G. Kohlstaedt
Irvin W. Wilkens, 1743 Shelby St. (3)	William T. Leffler
Howard S. Williams, 115 E. 16th St. (2)	William M. Matthews
Donald E. Wood, 6325 Guilford (20)	Ray Tharpe
MARSHALL	
James B. Kubley, 304 N. Walnut St., Plymouth	Maurice O. Klingler, Plymouth
MIAMI	
Donald W. Ferrara, 18 W. 5th St., Peru	L. L. Hill, Denver
MONTGOMERY	
James M. Kirtley, 416 Ben Hur Bldg., Crawfordsville	F. N. Daugherty, Crawfordsville
MORGAN	
Loren F. Taylor, 60½ E. Morgan St., Martinsville	Robert Van Bokkelen, Medical Arts Bldg., Mooresville
NOBLE	
Q. F. Stultz, Ligonier	J. R. Nash, Albion
ORANGE	
C. S. Manship, Paoli	W. E. Schoolfield, Orleans

County and Delegates	Alternate
OWEN-MONROE	
M. S. Brown, Spencer	Fred R. Smith, Spencer
William Stangle, 640 S. Rogers, Bloomington	Jean Creek, Bloomington
PARKE-VERMILLION	
Fred Evans, 242 S. Third St., Clinton	
Richard S. Bloomer, 115 N. Market St., Rockville	
PERRY	
Fred Smith, Jr., 507 Main St., Tell City	
PIKE	
Milton H. Omstead, Petersburg	Donald L. Hall, Petersburg
PORTER	
Ralph C. Eades, 6 Napleon St., Valparaiso	Paul C. F. Vietzke, Valparaiso
POSEY	
Frank W. Oliphant, 701 Mulberry St., Mount Vernon	Harold E. Ropp, New Harmony
PULASKI	
William R. Thompson, Winamac	E. L. Hollenberg, Winamac
PUTNAM	
V. Earle Wiseman, 239 Hillsdale, Greencastle	Lester W. Veach, Bainbridge
RANDOLPH	
Harvey E. White, Farmland	Paul W. Sparks, Winchester
RIPLEY	
Charles L. Lippoldt, 106 S. Main St., Batesville	Lowell G. Hunter, Milan
RUSH	
Frank Green, 134 E. Second St., Rushville	Robert Johnson, Rushville
ST. JOSEPH	
Louis Bixler, 615 Sherland Bldg., South Bend	Richard A. Ganser, Mishawaka
F. R. N. Carter, 605 Sherland Bldg., South Bend	D. Logan Dunlap, South Bend
Jene R. Bennett, 531 N. Main St., South Bend	B. J. Dolezal, South Bend
Merle E. Whitlock, 123 W. Fourth St., Mishawaka	Stephen Phelps, South Bend
SCOTT	
Marvin L. McClain, Scottsburg	Earl R. Bogardus, Austin
SHELBY	
Paul R. Tindall, 20 N. Pike St., Shelbyville	W. L. Dalton, Shelbyville

County and Delegates	Alternate
SPENCER	
N. L. Medcalf, LaMar	Michael O. Monar, Rockport
STARKE	
Guy B. Ingwell, Knox	Clark McClure, Knox
STEUBEN	
Donald G. Mason, 416 E. Maumee, Angola	Don Cameron, Angola
SULLIVAN	
Joe E. Dukes, Dugger	J. H. Crowder, Sullivan
TIPPECANOE	
R. B. Dubois, 23 N. 25th St., Lafayette	R. W. Vermilya, Lafayette
Harry E. Klepinger, 824 Lafayette Life Bldg., Lafayette	Forrest J. Babb, Stockwell
TIPTON	
A. E. Stouder, Kempton	M. B. Gossard, Tipton
VANDERBURGH	
Charles P. Schneider, 2211 W. Franklin, Evansville	P. J. V. Corcoran, Evansville
John E. Alexander, 609 Hulman Bldg., Evansville	Joseph Lawrence, Evansville
R. Case Hammond, 701 Chestnut St., Evansville	Robert B. Kessler, Evansville
Daniel M. Hare, 706 Walnut St., Evansville	John Sterne, Evansville
VIGO	
J. V. White, 502 Tribune Bldg., Terre Haute	A. W. Cavins, Terre Haute
Norman Silverman, 1634 S. 7th St., Terre Haute	Stuart R. Combs, Terre Haute
WABASH	
A. J. Steffen, 70 W. Hill, Wabash	
WARRICK	
Wendell Stover, 125½ S. Second St., Boonville	Don Woodson, Boonville
WASHINGTON	
E. R. Apple, Salem	I. E. Huckleberry, Salem
WAYNE-UNION	
Glen Ward Lee, 139 Medical Arts Bldg., Richmond	Tom Shields, Richmond
J. Frank Lewis, Liberty	C. G. Clarkson, Liberty
WELLS	
Truman E. Caylor, 303 S. Main St., Bluffton	Robert G. Cook, Bluffton
WHITE	
J. P. Galbreth, Burnettsville	
WHITLEY	
C. Jules Heritier, 116 S. Chauncey St., Columbia City	J. L. Langohr, Columbia City

EX-OFFICIO

Kenneth L. Olson, South Bend, President
Earl W. Mericle, Indianapolis 2, President-elect
Okla W. Sicks, Indianapolis 4, Treasurer
James A. Waggener, Executive Secretary

COUNCILORS

1st District—William B. Challman, Mt. Vernon
2nd District—J. H. Crowder, Sullivan
3rd District—John M. Paris, New Albany
4th District—Joseph E. Dudding, Hope
5th District—Robert K. Webster, Brazil
6th District—Harry P. Ross, Richmond
7th District—Ralph V. Everly, Indianapolis 5
8th District—Guy A. Owsley, Hartford City
9th District—Kenneth O. Neumann, Lafayette
10th District—James P. Vye, Gary
11th District—Max Adams, Flora
12th District—Maurice E. Glock, Fort Wayne
13th District—G. O. Larson, LaPorte

PAST PRESIDENTS

Charles N. Combs, Terre Haute
George R. Daniels, Marion
Franklin S. Crockett, West Lafayette
R. L. Sensenich, South Bend
Herman M. Baker, Evansville
Karl R. Ruddell, Indianapolis 8
M. A. Austin, Evansville
C. H. McCaskey, Indianapolis 4
Cleon A. Nafe, Indianapolis 4
A. P. Hauss, New Albany
Alfred Ellison, LaJolla, California
Paul D. Crimm, Evansville
William Harry Howard, Hammond
Walter L. Portteus, Franklin
Walter U. Kennedy, New Castle
Elton R. Clarke, Kokomo
M. C. Topping, Terre Haute

DELEGATES TO AMA

Gordon B. Wilder, Anderson
Wendell C. Stover, Boonville
Harold C. Ochsner, Indianapolis
E. S. Jones, Hammond
Francis L. Land, Fort Wayne

FIFTY YEAR CLUB—1959

BENTON
Dan Tucker Miller, Fowler

CASS
John C. Davis, Logansport

DEKALB
Charles R. Clarke, Auburn

DELAWARE-BLACKFORD
Oral A. Tucker, Daleville

ELKHART
Jancy S. Slabaugh, Nappanee

HAMILTON
Samuel W. Hooke, Noblesville

HARRISON-CRAWFORD
Alfred Mathys, Mauckport

LAGRANGE
Alfred A. Wade, Howe

LAKE
Andrew Hofmann, Hammond (deceased)

LAPORTE
Robert B. Jones, LaPorte
Nelle Cole Reed, Michigan City

MADISON
John I. Rinne, Lapel

MARION
Revel F. Banister, Indianapolis
Carl Habich, Indianapolis
Lillian Mueller, Indianapolis
Joseph W. Ricketts, Indianapolis
Ora W. Ridgeway, Indianapolis

POSEY
Arba L. Woods, Poseyville

ST. JOSEPH
Carl R. Bassler, Mishawaka
John J. Hardy, North Liberty
Byron J. Wyland, Mishawaka

SPENCER
Kenneth C. Atchison, Rockport

STEUBEN
Blaine A. Blosser, Fremont

SULLIVAN
Charles E. Whipps, Carlisle

VIGO
Orris T. Allen, Terre Haute

WAYNE-UNION
Will A. Thompson, Liberty (deceased)

REFERENCE COMMITTEES—1959

Sections and Section Work

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William J. Stangle, Bloomington (Owen-Monroe)
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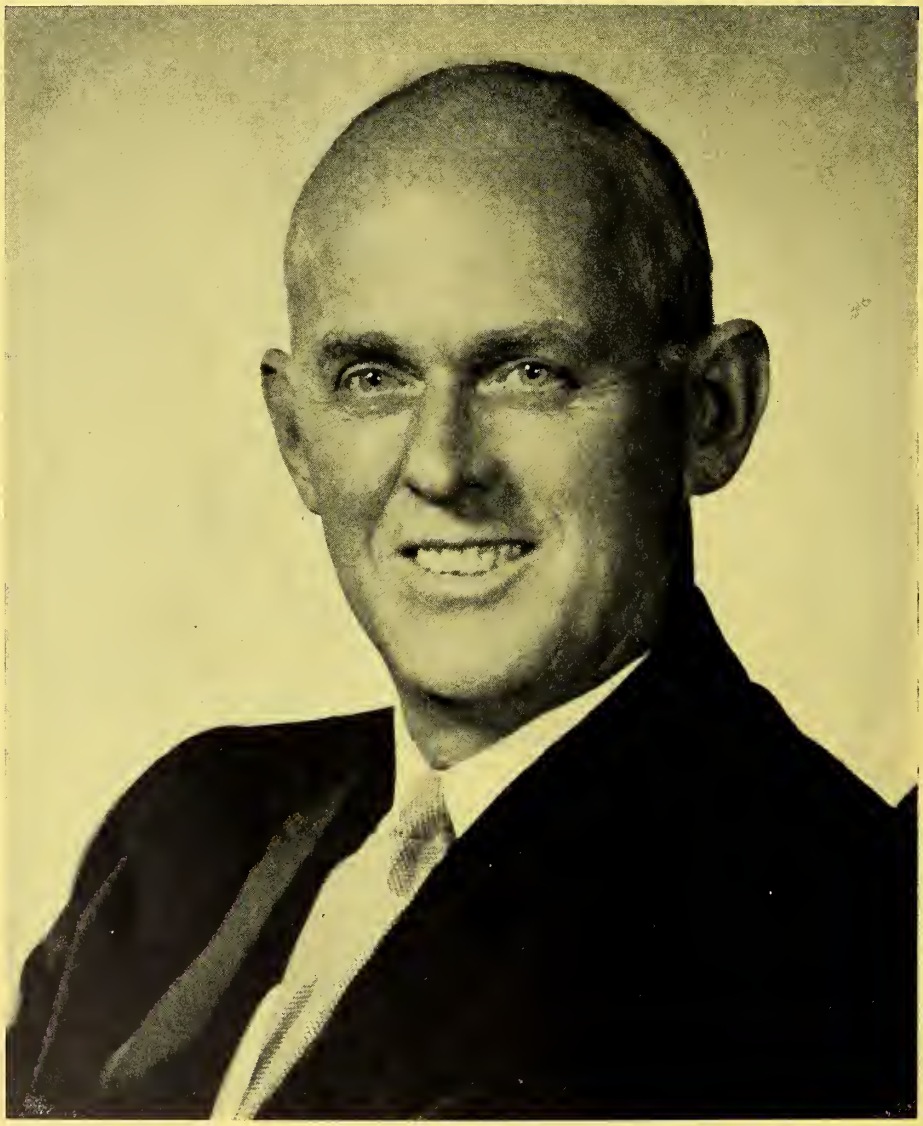
Miscellaneous Business

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D. S. Megenhardt, Indianapolis (Marion)
Lee J. Maris, Attica (Fountain-Warren)
Donald G. Mason, Angola (Steuben)
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NOTES

1958-1959

Officers of the I. S. M. A.



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PRESIDENT
INDIANA STATE MEDICAL ASSOCIATION
1958-1959



EARL W. MERICLE, M.D.
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Indianapolis



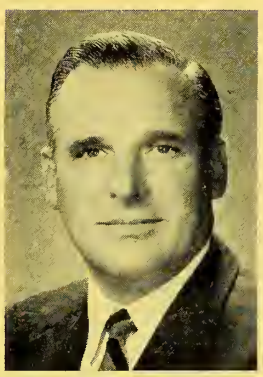
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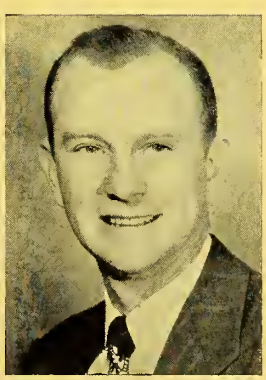
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HOWARD GRINDSTAFF
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The Journal



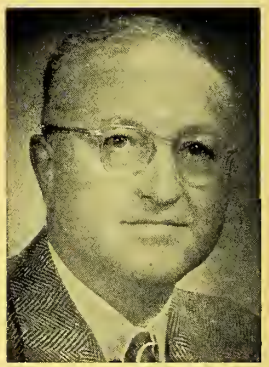
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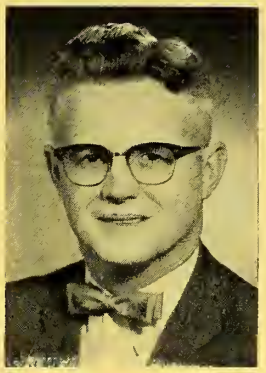
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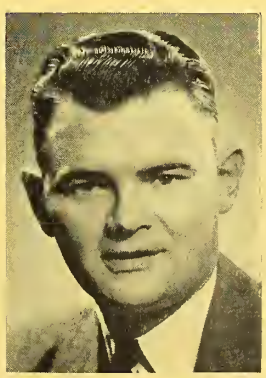
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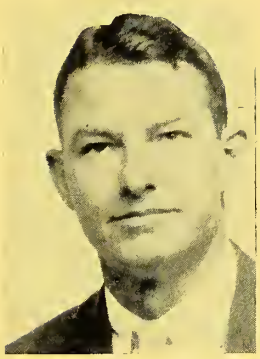
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South Bend

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Program

110th Annual Convention

Indiana State Medical Association

Murat Temple, Indianapolis

October 6, 7, 8 and 9, 1959

(All Events on Eastern Standard Time)

The entire scientific program of the 110th annual convention of the Indiana State Medical Association is approved for Category No. II credit by the Indiana Academy of General Practice for its members. Instructional courses are approved for Category No. I credit.

Monday, October 5

12:00 noon Executive Committee meeting, Fairbanks Room, fourth floor, Columbia Club.

3:00 p.m. Council meeting, parlors 2 and 3, fourth floor, Columbia Club.

Tuesday Morning, October 6

9:00 a.m. Meeting of House of Delegates, Ballroom, Columbia Club.

Tuesday Noon, October 6

12:00 noon Registration starts, lounge room, Murat Temple. Purchase your banquet tickets at the registration desk.

12:00 noon Opening of technical and scientific exhibits, lounge and Egyptian rooms, Murat Temple.

12:00 noon Luncheon meeting of past presidents of the Indiana State Medical Association, Veterans Room, Athenaeum.

12:00 noon Editorial Board luncheon meeting, Director's Room, Athenaeum.

12:00 noon Phi Beta Pi luncheon, Fraternity Room, Athenaeum.

Tuesday Afternoon, October 6

2:00 p.m. Reference Committees meet. Basement dining room, Murat Temple.

4:00 p.m. Blue Shield panel discussion, Candidates Room, Murat Temple.

Tuesday Evening, October 6

6:00 p.m. Reception and annual dinner meeting for women physicians, Parlors D and E, fifth floor, Indianapolis Athletic Club. (Dinner at 6:30.)

6:00 p.m. Buffet supper, smoker and stag party, Dining Room, Murat Temple.

Wednesday Morning, October 7

7:30 a.m. Breakfast meeting of the Council, Parlor 3, fourth floor, Columbia Club.

8 to 9:30 a.m. Instructional courses, Murat Temple.

8:30 a.m. Registration continues, lounge room, Murat Temple. Purchase your banquet tickets at the registration desk.

8:30 a.m. Technical and scientific exhibits, lounge and Egyptian rooms, Murat Temple.

GENERAL MEETING

(Murat Theater)

9:00 a.m. Call to order by Kenneth L. Olson, M.D., South Bend, president, Indiana State Medical Association.
James M. Leffel, M.D., Indianapolis, chairman of Committee on Scientific Work, presiding.

9:00 a.m. *Cancer of the Breast.*
GEORGE CRILE, JR., M.D., Cleveland.

Abstract: At the present time there is no conclusive clinical evidence as measured by the 5-year survival rate of patients with cancer of the breast that radical operations are more effective than simple, or that removal of involved lymph nodes is more effective than their treatment by radiation. Until there is conclusive evidence of the supriority of one method of treatment over another, or until cancer of the breast can be separated into categories each of which is best adapted to a certain type of treatment, we should not be too dogmatic in defending the type of treatment that at present we prefer.

Postoperative X-ray Radiation for Cancer of the Breast.
JOHN W. BEELER, M.D., Indianapolis.

Abstract: The past 10 years have brought an increased interest in the use of x-ray therapy in cancer of the breast. The role of radiation following radical mastectomy will be discussed along with the newer concepts of simple mastectomy and postoperative radiation.

Cobalt-60 Teletherapy of Mammary Carcinoma.

JAMES C. KATTERJOHN, M.D., Indianapolis.

Abstract: One of the features of cobalt-60 teletherapy is its remarkable skin-sparing effect, and this is the important advantage of cobalt therapy over the conventional forms of x-ray in treating carcinoma of the breast. Significantly larger doses of irradiation can be administered to the axilla, supraclavicular and parasternal areas by cobalt teletherapy than can be given with conventional x-ray without producing any skin effects whatsoever. The fear of producing untoward changes in the axilla and in the skin of the chest wall need no longer exist when cobalt-60 teletherapy is administered postoperatively.

Hypophysectomy in the Treatment of Advanced Cancer of the Breast.

BRONSON S. RAY, M.D., New York.

Abstract: The author has performed hypophysectomy in over 300 patients with advanced cancer of the breast. The discussion will describe the indications for operation, the technic employed, the substitution therapy required by the patients, the results of the operation and comments on the merits as compared to other forms of endocrine treatment and glandular ablation.

10:30 to 11 a.m. Time allowed to view technical and scientific exhibits.

11:00 a.m. Panel discussion, led by speakers of the morning session.

Wednesday Noon, October 7

12:00 noon SECTION ON SURGERY luncheon meeting, Kellersaal, Athenaeum.

Panel on: *Surgery of the Gallbladder and Allied Structures.*

Moderator: GEORGE CRILE, JR., M.D., Cleveland.

Speakers: ROBERT H. RANG, Washington, Ind.

JAMES S. FITZPATRICK, M.D., Portland, Ind.

HERBERT L. EGBERT, M.D., Indianapolis.

Election of section officers for 1960.

12:00 noon SECTION ON RADIOLOGY and Indiana Roentgen Society luncheon meeting, Blue Room, Athenaeum.

Speakers: Representatives of the American College of Radiology.

Subject: *College of Radiology Insurance Educational Program (Outpatient Radiologic Services and Their Economic Advantages to the Patient, the Insurance Company and the Physician).*

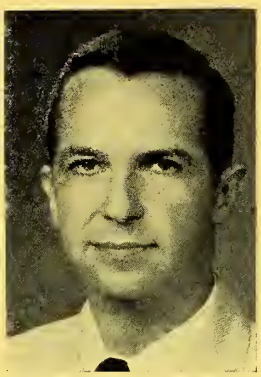
Election of section officers for 1960.

WEDNESDAY'S SPEAKERS



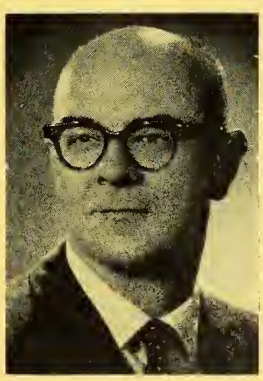
GEORGE CRILE, JR., M.D.
Cleveland, Ohio

General surgeon, on the staff of Cleveland Clinic, Cleveland, Ohio. M.D. from Harvard Medical School, 1933.



JOHN W. BEELER, M.D.
Indianapolis

Specialist in radiology and Associate Professor of Radiology, Indiana University School of Medicine. M.D. from Indiana University School of Medicine, 1944.



JAMES C. KATTERJOHN, M.D.
Indianapolis

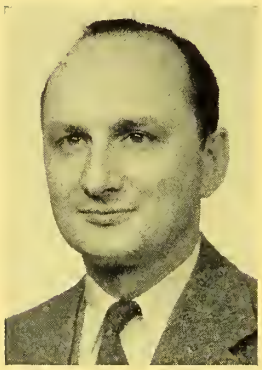
In private practice of radiology; radiologist, St. Francis Hospital; Diplomate, American Board of Radiology, member James Ewing Society, American Radium Society, American College of Radiology, American Roentgen Ray Society and Radiological Society of North America. Former trainee, national Cancer Institute; Fellow, University of Pennsylvania Hospitals; resident, Memorial Cancer Center (N.Y.C.) and assistant chief, Radiology Service, Walter Reed Army Hospital 1955-57. Graduate Indiana University School of Medicine 1942.



BRONSON S. RAY, M.D.
New York City

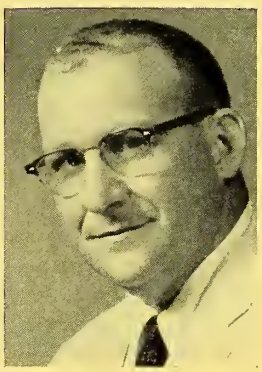
Specialist in neurosurgery; Professor of Clinical Surgery and Chairman of the Department of Neurosurgery, New York Hospital-Cornell Medical College. M.D. from Northwestern University, 1928.

WEDNESDAY'S SPEAKERS



ROBERT H. RANG, M.D.
Washington, Ind.

In private practice of general surgery. Internship and residency in pathology at Methodist Hospital, Indianapolis; 3-year Surgical Fellowship at Mayo Clinic; 3 years wartime and overseas duty as medical officer. M.D. from Indiana University School of Medicine, 1940.



JAMES S. FITZPATRICK, M.D.
Portland, Ind.

General surgeon; past president of Indiana Eighth District Medical Society, Jay County Medical Society; Jay County Hospital staff. Graduate of Indiana University School of Medicine, 1944.



HERBERT L. EGBERT, M.D.
Indianapolis

Associate Professor of Surgery, Indiana University School of Medicine; Fellow, American College of Surgeons; American Board of Surgery; private practice of surgery, Indianapolis. Procured M.D. from Indiana University School of Medicine, 1936.

Wednesday Noon, ,October 7

Continued

12:00 noon Luncheon meeting of Indiana Chapter of American College of Chest Physicians, East Room, Athenaeum.

Speaker: JOHN B. HICKAM, M.D., Indianapolis.

Subject: *Management of Cor Pulmonale.*

12:00 noon Buzz Session Luncheon for instructional course registrants and teachers, Kellersaal, Athenaeum.

12:00 noon Phi Chi luncheon, Fraternity Room, Athenaeum.

12:00 noon Phi Rho Sigma luncheon, Veterans Room, Athenaeum.

Wednesday Afternoon, October 7

GENERAL MEETING

(Murat Theater)

Kenneth L. Olson, M.D., South Bend, president, Indiana State Medical Association, chairman.

2:00 p.m. *Problem of Ovarian Cysts.*

J. DONALD WOODRUFF, M.D., Baltimore.

Abstract: A discussion of difficulties that arise in the routine pelvic examination related to the diagnosis of adnexal disease. Further discussion will be directed at attempts to differentiate the varieties of ovarian cysts both by pelvic examination, by the clinical history, and additional diagnostic aids as necessary.

Hyperfunctioning Lesions of the Adrenal Glands.

JAMES T. PRIESTLEY, M.D., Rochester, Minn.

Abstract: Clinical recognition of certain abnormal states related to hyperfunction of the adrenal glands is increasing in frequency as knowledge of the normal and abnormal physiology and biochemistry of these glands expands. Some of these abnormal states will be described in detail and the appropriate surgical treatment will be outlined.



JOHN B. HICKAM, M.D.
Indianapolis

Professor of Medicine and chairman, Department of Medicine, Indiana University School of Medicine; specialist in internal medicine and pulmonary physiology; Fellow, American College of Physicians; Diplomate, American Board of Internal Medicine; M.D. from Harvard University School of Medicine, 1940.

Surgical Anatomy of the Colon and Rectum.

Mr. C. NAUNTON MORGAN
London.

Abstract: The applied surgical anatomy of the ano-rectal region in the past has been much neglected.
A practical working concept of the linings of the anal canal and the relationship of the somatic and visceral muscles is presented.
The operations for fistula, fissure and hemorrhoids will be described on a sound anatomical basis.
The surgical anatomy of the blood supply of the colon, with special reference to high ligation of the inferior mesenteric vessel is also described.

Pituitary Tumors.

BRONSON S. RAY, M.D., New York.

Abstract: This paper discusses the clinical manifestations of several types of pituitary adenomas and their treatment. Attention is given particularly to surgery versus radiation therapy of the common chromophobe adenoma. The management of acromegaly will be similarly discussed and examples shown of cessation of progression and partial reversal of acromegaly following hypophysectomy. Examples of Cushing's syndrome requiring pituitary surgery will be shown also.

3 to 3:30 p.m. Time allowed to view technical and scientific exhibits.

3:30 p.m. Panel discussion, led by speakers of the afternoon session.

5:15 p.m. Reception for members of Fifty-Year Club and guests, Parlors 1 and 2, Columbia Club.

Chairman: CLAY A. BALL, M.D., Muncie.

Wednesday Evening, October 7

6:15 p.m. President's reception, Main Dining Room, third floor, Columbia Club.

7:00 p.m. Annual dinner, Ballroom, Columbia Club.

Presiding officer, KENNETH L. OLSON, M.D., South Bend, president, Indiana State Medical Association.

Invocation.

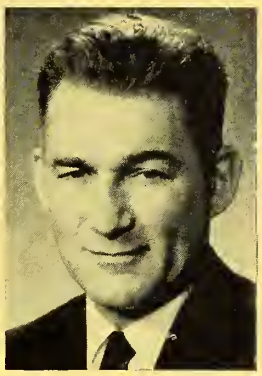
Recognition of Fifty-Year Club members.

Award to Physician of the Year.

Presentation of plaque to KENNETH L. OLSON, M.D., South Bend, president, 1959, by EARL W. MERICLE, M.D., Indianapolis, president, 1960.

Speaker: CARL WINTERS, Ph.D., Detroit, Public Relations Department, General Motors Corporation.

WEDNESDAY'S SPEAKERS



J. DONALD WOODRUFF, M.D.
Baltimore, Md.
Specialist in gynecology and female urology; Associate Professor of Gynecology, Johns Hopkins Medical School, head of Gynecologic Pathology Laboratory, Johns Hopkins Hospital; chief, Gynecologic Service, Hospital for Women of Maryland; graduate of Johns Hopkins Medical School, 1937.



JAMES T. PRIESTLEY, M.D.
Rochester, Minn.
Professor of Surgery, Mayo Foundation, Graduate School, University of Minnesota, head of Section in Surgery, Mayo Clinic, Rochester, Minn.; M.D. from University of Pennsylvania, 1926; M.S. in experimental surgery and Ph.D. in surgery, University of Minnesota, 1931 and 1932.



MR. C. NAUNTON MORGAN
London, England
Widely-known surgeon, specializing in surgery of the colon.

THURSDAY'S SPEAKERS



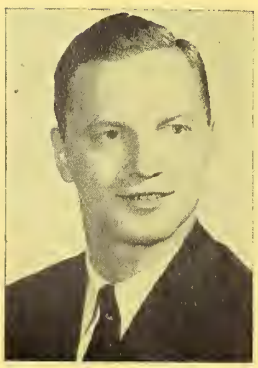
CHARLES W. MAYO, M.D.
Rochester, Minnesota

Professor of Surgery, Mayo Foundation, Graduate School, University of Minnesota; consultant, Mayo Clinic; honorary member of the Royal College of Surgeons of England. M.D. from University of Pennsylvania, 1926.



LEONARD L. LOVSHIN, M.D.
Cleveland, Ohio

Associate Professor of Medicine, Frank E. Bunts Institute —Cleveland Clinic Foundation; member, Department of General Internal Medicine, Cleveland Clinic; M.D. from the University of Wisconsin, 1939.



N. HENRY MOSS, M.D.
Philadelphia, Penn.

Director of Medical Education, adjunct attending surgeon, cancer co-ordinator and director of Tumor Clinic and Tumor Board, Albert Einstein Medical Center, Northern Division; Diplomate, American Board of Surgery; Fellow, American College of Surgeons; M.D. from University of Pennsylvania, 1948.

Thursday Morning, October 8

7:30 a.m. Breakfast meeting of the Council, Parlor 3, fourth floor, Columbia Club.

8:30 a.m. Registration continues, lounge room, Murat Temple.

8:30 a.m. Technical and scientific exhibits, lounge and Egyptian rooms, Murat Temple.

GENERAL MEETING

(Murat Theater)

Kenneth L. Olson, M.D., South Bend, president, Indiana State Medical Association, chairman.

9:00 a.m. *Ulcerative Colitis.*

CHARLES W. MAYO, M.D., Rochester, Minn.

Abstract: Treatment is medical and symptomatic. Surgery is to be avoided unless essential. Surgical indications: malignancy, persistent polyposis, obstruction and fulminating ulcerative colitis. Colonic resection and end-to-end anastomosis.

Ileoproctostomy can be done when there is minimal rectal involvement. The usual operation is abdominoperineal co'ectomy and ileostomy in one stage.

The Tired Mother Syndrome.

LEONARD L. LOVSHIN, M.D., Cleveland.

Convalescence Following Illness and Surgery.

N. HENRY MOSS, M.D., Philadelphia.

Abstract: There is mounting evidence that uncomplicated surgical convalescence is unduly prolonged in current civilian practice. Metabolic and endocrine changes, the normal rate of wound healing or the socio-economic effects of accident and sickness insurance benefits do not account for the average current duration of surgical convalescence in uncomplicated cases in civilian life. In fact, the average duration of convalescence after surgery for personnel in the Air Force is approximately one-third that of civilian men for appendectomy, hemorrhoidectomy and inguinal herniorrhaphy.

The most important factor determining the duration of uncomplicated surgical convalescence is the expressed opinion of the attending physician or surgeon. A wide diversity of opinion, however, has been demonstrated by questionnaire surveys among surgeons, among industrial physicians, and among general practitioners regarding the duration of convalescence in the same hypothetical uncomplicated general surgical and gynecological cases. For the same case, the recommended interval for return to both light or heavy activity varied from three- to 24-fold.

Over 150 patients have been interviewed and examined during their convalescence after common surgical procedures and after their return to work. All factors influencing the duration of the convalescent period have been studied. Symtoms and signs of postoperative physicial disability have been evaluated for selected operative procedures for each patient prior to, at the time of and several weeks following the return to full activity. The disability scores are correlated to total convalescence time.

Empiric studies from the Air Force and other sources (to be discussed) indicate that considerably shorter periods of convalescence for uncomplicated common surgical procedures should be recommended.

Recent Advances in the Management of Diabetes Mellitus.

GLENN W. IRWIN, M.D., Indianapolis.

Abstract: A real contribution to the dietary management of diabetes mellitus was made several years ago by the introduction of the Meal-Planning system. Physicians and patients find this dietary plan to be understandable and effective.

Recently the Lente group of insulins were made commercially available. Lente insulin has been established as effective in the majority of patients requiring insulin. For the unstable and difficult problems of insulin management the addition of Semi-Lente insulin to Lente insulin is useful when a more rapid onset of insulin action is needed. When a more prolonged insulin action is needed the addition of Ultra-Lente insulin to Lente insulin may improve regulation.

The introduction of several oral compounds which reduce blood sugar has created much interest in the entire field of diabetes mellitus. Currently, Orinase, Diabenese and D.B.I. are commercially available. Each physician should be familiar with the indications, contraindications and side-effects of these new drugs before using them. It seems established that these agents have made an important contribution in the management of diabetes mellitus.

General Considerations in the Use of Steriods.

ROBERT M. SALASSA, M.D., Rochester, Minn.

Abstract: The chronic use of steroids in the management of nonendocrine diseases is frequently associated with certain adverse effects. Constant awareness of some of the fundamental facts concerning adrenocortical function as well as certain basic effects of all anti-inflammatory steroids will minimize these undesirable effects.

10:30 to 11 a.m. Time allowed to view technical and scientific exhibits.

11:00 a.m. Panel discussion, led by speakers of the morning session.

Thursday Noon, October 8

12:00 noon SECTION ON OBSTETRICS AND GYNECOLOGY luncheon meeting, Blue Room, Athenaeum.

Speaker: J. DONALD WOODRUFF, M.D., Baltimore.

Subject: *Premalignant Disease of the Vulva.*

Business meeting.

Election of section officers for 1960.

12:00 noon SECTION ON GENERAL PRACTICE luncheon meeting, East Room, Athenaeum.

Election of section officers for 1960.

12:00 noon Indiana State Society of Anesthesiologists and SECTION ON ANESTHESIA luncheon meeting, Veterans Room, Athenaeum.

Election of section officers for 1960.

12:00 noon SECTION ON MEDICINE luncheon meeting, Candidates Room, Murat Temple.

Speaker: ROBERT M. SALASSA, M.D., Rochester, Minn.

Subject: *Advances in Steroids.*

Election of section officers for 1960.

12:00 noon Indiana Association of Pathologists luncheon meeting, Ladies' Parlors, (large room), Athenaeum.

12:00 noon Nu Sigma Nu luncheon, Fraternity Room, Athenaeum.

12:00 noon Indiana Flying Physicians Association luncheon meeting, Directors' Room, Athenaeum.

Speakers: FRANK H. COBLE, M.D., Richmond.

Subject: *"The National Disaster Plan."*

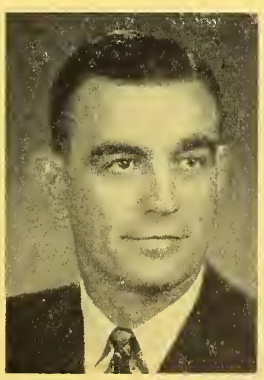
PAUL W. SPARKS, M.D., Winchester.

Subject: *"The Indiana Disaster Plan."*

THURSDAY'S SPEAKERS



GLENN W. IRWIN JR., M.D.
Indianapolis
Associate Professor of Medicine, Indiana University School of Medicine; born Roachdale, Ind.; M.D. from I. U. School of Medicine, 1944; specialty is in internal medicine.



ROBERT M. SALASSA, M.D.
Rochester, Minn.
Associate Professor of Medicine, Mayo Foundation, Graduate School, University of Minnesota; member of Section of Metabolic Diseases, Mayo Clinic; specialist in internal medicine. M.D. from Indiana University School of Medicine, 1939.

Thursday Afternoon, October 8

GENERAL MEETING

(Murat Theater)

Kenneth L. Olson, M.D., South Bend, president, Indiana State Medical Association, chairman.

2:00 p.m. *Carcinoma of the Lower Colon and Upper Rectum.*

CHARLES W. MAYO, M.D., Rochester, Minn.

Abstract: Reliable evidence is steadily accumulating to support preservation of the sphincters, resection and end-to-end anastomosis, coloproctostomy for malignancy where the lower border of the lesion lies at 9 cm. from the anal verge or margin or 6 cm. from the denrate margin. Obesity is the principle deterrant. Long and proper instruments are essential to the technic for a low anterior resection and anastomosis.

The Treatment and Care of Imperforate Anus.

ARTHUR DeBOER, M.D., Chicago.

Abstract: Imperforate anus is a rather common congenital anomalie often associated with a fistula to the perineum, vagina, urethra, bladder or uterus. The importance of discovering the fistula prior to surgery is paramount. The operative procedure and the elective time for surgery is determined by the presence or absence of the fistula and or the type of the fistula. The final goal of the surgery of this anomalie is to construct an anus that functions normally. A review of the cases that have been seen and treated at the Children's Memorial Hospital will be discussed. The pre- and postoperative complications will be reviewed, and a description of the surgical treatment of this anomalie will be developed. Improperly treated, the failure carries its impact for the entire life of this newborn child.

Headache.

LEONARD L. LOVSHIN, M.D., Cleveland.

Significant Findings in Patients with Cardiopulmonary Disease.

JOHN B. HICKAM, M.D., Indianapolis.

Abstract: This presentation will deal with the diagnostic meaning of some signs and symptoms which occur generally in cardiopulmonary disease, but which have special significance in certain combinations. An example is the development of exertional dyspnea in the absence of obvious cardiopulmonary disease as a symptom suggestive of pulmonary hypertension. Other signs and symptoms which will be discussed alone or in combination are Cheyne-Stokes breathing, ankle edema, cough syncope, exertional syncope, clubbing of the digits and cyanosis.

3 to 3:30 p.m. Time allowed to view technical and scientific exhibits.

3:30 p.m. Panel discussion, led by speakers of the afternoon session, and Mr. C. NAUNTON MORGAN, London.

2:00 p.m. Meeting of the SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE, Murat Candidates Room, Murat Temple.

Speaker: W. W. BAUER, M.D., Director, Department of Health Education, American Medical Association.

Subject: *The Changing Role of the Physician in Serving the School.*

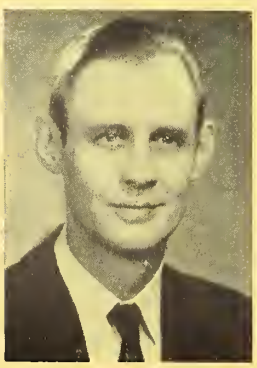
Abstract: The first school physicians were appointed in Germany about 1870 and in the United States in 1892, and were primarily sanitary inspectors and vaccinators. The idea of health examinations came much later. Prior to World War I, school health examinations were conducted mainly on a mass assembled basis, with children lined up before the doctor. They were often examined through several layers of clothing, since in many places the unbuttoning of even a single button without written parental permission was illegal. The inadequacy of such examinations caused great discontent among physicians, especially those required to perform these manifestly unscientific procedures. In addition, experience with getting parental action in response to recommendations based upon these examinations indicated an enormous amount of lost motion, waste of valuable professional time, failure to take advantage of educational opportunities, and a general discrediting of the whole system in the eyes of physician, educator, parent, and even the children who were old enough to understand. Meanwhile, the enactment of ill-considered laws froze this procedure into a required annual examination. In many areas this statuatory requirement was ignored because no funds were available; where it was observed, everyone was unhappy.

The new look in school health services visualizes, first of all, continuous teacher vigilance to identify children manifestly in need of help. Examination of these referrals plus routine examination of entering students, graduating students and those half-way through elementary schools, has made possible better examinations, better follow-through and more effective measures to meet demonstrated needs. Emphasis on the responsibility for health examinations has shifted from the school to the home, where such responsibilities rightly belong. The perfect method now is to have children examined in the physician's office at family expense; those unable to pay are either served by the profession gratis or get their examinations at public expense. The school physician now has become a consultant and a medical advisor rather than a routine inspector and examiner. He takes part in educational conferences, curriculum planning and counseling. He still exercises supervision over the sanitation in the school, but here, too, his interests have broadened to include the cafeteria, the pool, the gymnasium, the athletic field, the school bus and the emotional environment throughout the school.

These things have been brought about by conference, collaboration and cooperation between the medical profession, the educators and parents through organizations at all levels, and through individual contact at the local level where the child meets the four groups most interested in his welfare: his parents, his teachers, his physician and his nurses.

Election of section officers for 1960.

THURSDAY'S SPEAKERS



ARTHUR DeBOER, M.D.
Chicago, Ill.
Specialist in pediatric and cardio-vascular surgery; teaching connection with Northwestern Medical School; M.D. from Northwestern, 1945.



W. W. BAUER, M.D.
Chicago, Ill.
Director, Department of Health Education, American Medical Association; Diplomate, American Board of Preventive Medicine and Public Health; member, President's Citizens Advisory Commitee on the Fitness of American Youth; M.D. from University of Pennsylvania, 1917.

Thursday Evening, October 8

8:00 p.m. PRESIDENT'S NIGHT, Murat Theater.

Edward B. Smith, M.D., chairman, Convention Arrangements, Master of Ceremonies.

Address: KENNETH L. OLSON, M.D., South Bend, president.

Entertainment: Indiana University "Singing Hoosiers" and "Hoosier Queens."

Award of exhibitors' prizes for exhibit visitation.

Friday Morning, October 9

7:30 a.m. Breakfast meeting of the Council, Parlor 3, Columbia Club.

8:30 a.m. Registration continues, lounge room, Murat Temple.

8:30 a.m. Technical and scientific exhibits, lounge and Egyptian rooms, Murat Temple.

9:00 a.m. Final meeting of House of Delegates, Dining Room, basement, Murat Temple.

Meeting of Council and Executive Committee immediately following adjournment of House of Delegates.

Friday Noon, October 9

12:00 noon Annual trap-skeet shoot, Indiana Gun Club, E. 38th St. and Post Rd. Program calls for 50 16-yd. targets, 50 handicap targets and 50 skeet targets. Several prizes to be awarded in each event. Bring gun, come early! Luncheon served in club dining room.

Friday Afternoon, October 9

1:00 p.m. Annual golf tournament, Meridian Hills Country Club. (North on Meridian to 71st St.; west on 71st to Spring Mill Rd.; south on Spring Mill Rd. to the entrance of club.)

1:00 p.m. Organization meeting of 1959-1960 commission and committee members of the Indiana State Medical Association, Ballroom, Columbia Club. (Luncheon meeting.)

Convention Arrangements Committees

GENERAL CONVENTION ARRANGEMENTS: Edward B. Smith, Indianapolis, chairman; James M. Leffel, Indianapolis, vice-chairman; William B. Lybrook, Indianapolis, secretary; Ray H. Burnikel, Evansville; Irwin H. Scott, Sullivan; Jesse Benz, Marengo; George W. Ritteman, Franklin; Jack G. Weinbaum, Terre Haute; John H. Mader, Richmond; Howard E. Hill, Muncie; Robert H. Wiseheart, Lebanon; Michael Shellhouse, Gary; Harold S. Brubaker, Huntington; Donald G. Mason, Angola; Burton E. Kintner, Elkhart.

GOLF: J. M. McIntyre, Indianapolis, chairman.

TRAP-SKEET SHOOT: Clarence Laubscher, Evansville, chairman.

RECEPTION: John W. Hendricks, Indianapolis, chairman.

PUBLICITY: Harry Pandolfo, Indianapolis, chairman.

WOMEN PHYSICIANS: Josephine Van Fleet, Indianapolis, chairman.

WOMEN'S ENTERTAINMENT: Mrs. John H. Greist, chairman; Mrs. Wendell E. Brown and Mrs. J. Lawrence Sims, co-chairmen, reservations and registrations; Mrs. George S. Rader, Tuesday evening dinner; Mrs. Henry S. Tanner, Wednesday luncheon; Mrs. Howard S. Williams, Jr., Thursday tea and Art Institute tour; Mrs. Dwight W. Schuster, publicity.

FIFTY-YEAR CLUB RECEPTION: Clay A. Ball, Muncie, chairman.

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CONVENTION TELEPHONE MElrose 6-3406

1959 INSTRUCTIONAL COURSES
AND "BUZZ-SESSION" LUNCHEON

Order your tickets now!!

The complete schedule of classes for the 1959 Instructional Courses, offered as a special feature of the Annual Convention of the Indiana State Medical Association at Indianapolis, is published below. Classes will be held on Wednesday, October 7, 1959, at the Murat Temple.

The Indiana Academy of General Practice will give its members approval for Category No. 1 credit.

Admission to each class will be by ticket. Classes will be limited to 30 physicians. Cost, $1.00 per class, or $2.50 for all three classes. Plan your course to include all three classes, and indicate second choices. Enclose your check made payable to the Indiana State Medical Association.

A NEW FEATURE—A "buzz-session" luncheon will be held at noon Wednesday, Oct. 7, at the Athenaeum at which time there will be an opportunity to exchange views. Tickets for the luncheon, $2.50, includes gratuity.

Total cost, 3 classes plus luncheon, $5.00.

ORDER NOW — classes are filled early!

INSTRUCTIONAL COURSE SCHEDULE
WEDNESDAY, OCTOBER 7, 1959

FIRST PERIOD 8:00 to 8:20 a. m.	SECOND PERIOD 8:30 to 8:50 a. m.	THIRD PERIOD 9:00 to 9:20 a. m.
Course 1 Cardiac and Non-Cardiac Chest Pain DAN L. URSCHEL Mentone	**Course 7** Obstetrical Emergencies GORDON C. COOK South Bend	**Course 13** Tonsillectomy and Adenoidectomy —Accepted Procedure, Pre- and Post-Operative Care; Management of Hemorrhage RALPH V. GANSER South Bend
Course 2 Infant Feeding JOHN R. SCOTT Indianapolis	**Course 8** Allergy—When to Suspect It and What to Do About It BENNETT KRAFT Indianapolis	**Course 14** The Chronic Skin Rash Problem JAMES E. ENGELER Lafayette
Course 3 Office X-Ray Problems and Pitfalls LOUIS C. BIXLER South Bend	**Course 9** Office Laboratory for Every Doctor's Office ELGIN P. KINTNER Maryville, Tenn.	**Course 15** Efficient Office Management OTIS R. BOWEN Bremen
Course 4 Work-Up of an Abdominal Pain Problem JAMES M. LEFFEL Indianapolis	**Course 10** Diagnostic Problems of the Liver JAMES W. HURLEY Elkhart	**Course 16** Problems of the Urinary Stream TRUMAN E. CAYLOR Bluffton
Course 5 Foot Problems of Children MORRIS S. FRIEDMAN South Bend	**Course 11** Work-Up of a Back Problem GEORGE J. GARCEAU Indianapolis	**Course 17** Diagnostic Approach to the Patient with Shoulder Pain LELAND G. BROWN Muncie
Course 6 How to Do an Efficient Neurological Examination CHARLES W. CURE Indianapolis	**Course 12** Hypnotism in General Office Practice ELLIOTT A. HILSINGER Cheviot, Ohio	**Course 18** A Simplified Approach to a Complete Examination of a Gyn Patient EDWARD P. MININGER Elkhart

Application Blank

Instructional Course Committee
Indiana State Medical Association
1021 Hume Mansur Building
Indianapolis 4, Indiana

Enclosed find check for $_____. Please reserve tickets for the following Instructional Courses: Also_____tickets for "buzz-session" luncheon at $2.50 each.

Classes: $1.00 each, 3 for $2.50; Luncheon, $2.50.

WEDNESDAY, OCTOBER 7, 1959

	First Period 8:00 to 8:20 a. m.	**Second Period** 8:30 to 8:50 a. m.	**Third Period** 9:00 to 9:20 a. m.
First Choice_____	No._____	No._____	No._____
Second Choice_____	No._____	No._____	No._____

(Please insert course numbers plainly)

I will pick up my tickets at the Registration Desk at the convention.

Signed_____, M.D.

Address_____

Next year please include classes on these topics_____

Auxiliary Program

Mrs. John H. Greist, General Chairman.

Tuesday, October 6

12:00 noon Registration starts, lounge room, Murat Temple.

Purchase tickets for the dinner and luncheon at Auxiliary table, near registration desk, and obtain free ticket for tea and tour of Herron Art Institute.

7:00 p.m. "Hail to the Chiefs!" dinner in honor of former presidents of the Woman's Auxiliary to the Indiana State Medical Association, Auditorium, Indiana State Teachers Association Building (Northeast corner of Market St. and Capitol Ave.).

(6:00-7:00 Social Hour — cocktails available.)

Mrs. J. M. Black, Seymour, president, presiding.

Entertainment: Book review of "Dr. Zhivago" given by Dr. Allegra Stewart of Butler University.
Tickets for dinner must be purchased before 2:00 p.m.

Wednesday, October 7

8:30 a.m. Registration continues, lounge room, Murat Temple.

Purchase luncheon tickets before 10:00 a.m. at Auxiliary table near registration desk or during coffee hour between 9:00 and 10:00 a.m. Also obtain free ticket for tea and tour of Herron Art Institute.

9:00 a.m. Coffee Hour, Mural Room, Indiana State Teachers Association Building. Convention tickets available.

10:00 a.m. Board Meeting, Mural Room, Indiana State Teachers Association Building (county presidents, county presidents-elect, district councilors, state officers and chairmen). Members and guests are welcome.

12:30 p.m. "Petticoat and Pinafore Party with that Ayres Look"—luncheon and style show, Auditorium, Indiana State Teachers Association Building. Free tickets may be obtained for Thursday's tea and tour at Herron Art Institute.

Tickets for luncheon must be purchased before 10:00 a.m.

7:00 p.m. Annual dinner in conjunction with the Indiana State Medical Association, Ballroom, Columbia Club.

Thursday, October 8

8:30 a.m. Registration continues, lounge room, Murat Temple.

Tickets available for tea and tour at Herron Art Institute.

Morning open — for ladies to do their shopping!

3:00 p.m. Tea and tour at Herron Art Institute (110 E. 16th Street).

Mr. Wilbur Peat, speaker. All who attend will be guests of the State Auxiliary.

8:00 p.m. President's Night.

Entertainment in conjunction with the Indiana State Medical Association, Murat Theater.

Friday, October 9

Reserved for "Mi-Lady" for visiting with city or state friends—for shop—for sleeping.

ORDER YOUR TICKETS NOW

Woman's Auxiliary Dinner Reservation:

Mrs. J. Lawrence Sims, Treasurer
3723 N. Gale
Indianapolis 18, Indiana

Enclosed find my check payable to the Woman's Medical Auxiliary for $4.50 for the Tuesday evening dinner. I will pick up my ticket at the Indiana State Teachers Association Auditorium door.

Address:_____

Signed:_____

Woman's Auxiliary Luncheon Reservation:

Mrs. J. Lawrence Sims, Treasurer
3723 N. Gale
Indianapolis 18, Indiana

Enclosed find my check payable to the Woman's Medical Auxiliary for $3.25 for the Wednesday luncheon and Style show. I will pick up my tickets at the Indiana State Teachers Association Auditorium door.

Signed:_____

Address:_____

ENTERTAINMENT FEATURES

Annual Dinner and President's Reception

Wednesday Evening

October 7—6:15 p.m.

Indianapolis Athletic Club



Carl Winters, Ph.D., Detroit, Public Relations, GMC

A rare combination of inspiration and humor has won Carl S. Winters an audience of more than a quarter of a million people a year. He speaks from a broad background of human experience . . . former crime commissioner of Michigan . . . former Chicago Skid Row Commission chairman . . . advisor on Juvenile Board of Sheriff of Cook County . . . and a personal counsellor.

Presidents Night—with Indiana University "Singing Hoosiers" and "Hoosier Queens"



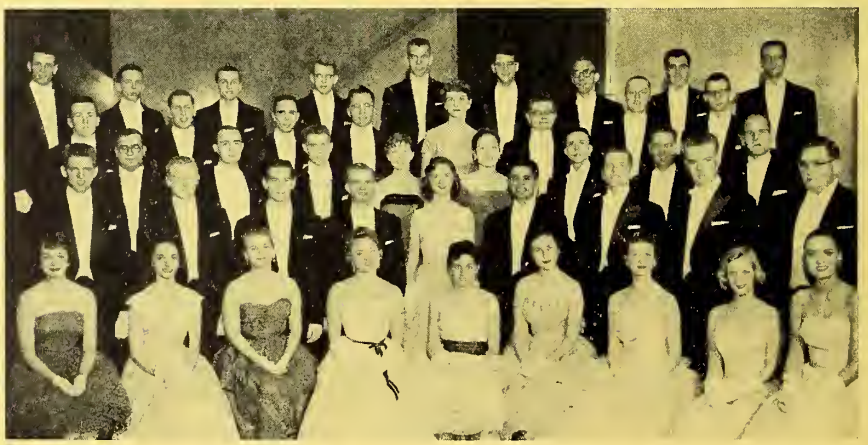
Prof. Krueger

Indiana University's globetrotting musicians are ambassadors of song—having entertained servicemen in Europe and the Far East during recent summer vacations. The group was organized in 1949 by their present director, George F. Krueger, associate professor of choral music, as a composite of men's and girls' glee clubs. Ninety per cent of them are not music majors, but students united in a common interest—a love for song. Some 50 girls and 75 men make up the "Queens" and the "Hoosiers"; distance traveling groups number about 45.

Thursday Evening

October 8—8:00 p.m.

Murat Theater



DOWNTOWN HOTELS IN INDIANAPOLIS

BREVORT HOTEL, 207 N. Illinois St.: 100 Rooms. Rates—Single $2.50 up; Double $3.50 up; Twin Bed Rooms $5.00 up.

CLAYPOOL HOTEL, Washington & Illinois Streets: 600 Rooms. Rates—Single $7.00 to $9.50; Double $9.50 to $14.00; Twin Bed Rooms $12.00 to $16.00; Studio Suites $13.50; Parlor Suites $20.00 to $34.00; Extra Beds $2.75.

CONTINENTAL HOTEL, 410 N. Meridian St.: 100 Rooms. Rates—Single $8.50 up; Double $11.00 up; Twin Bed Rooms, $12.00 up; Suites $14.00 up.

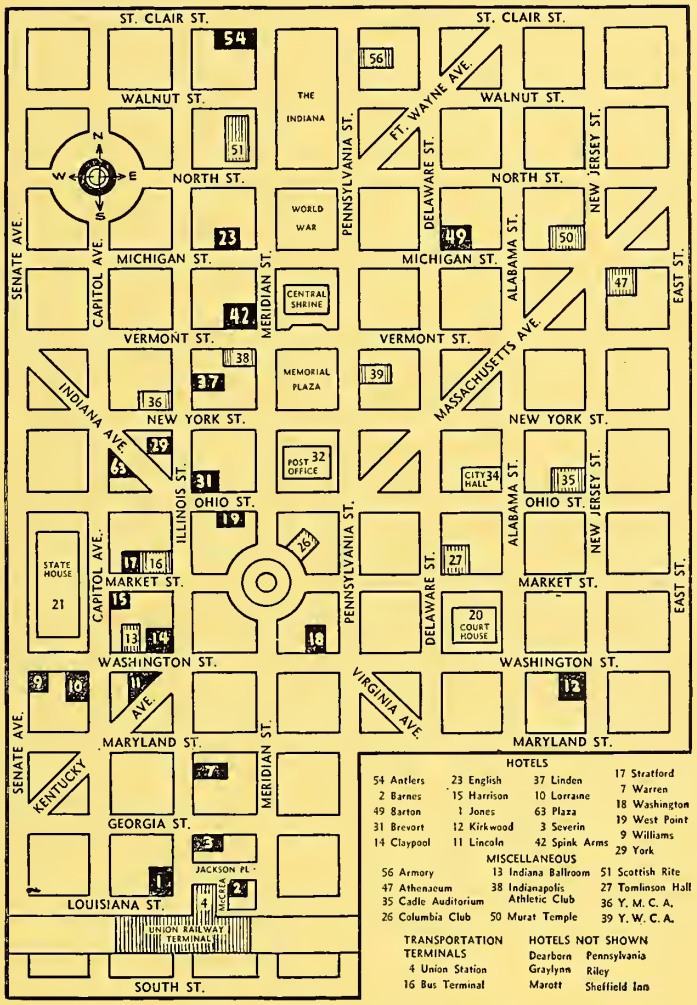
DRAKE MOTOR HOTEL, 1415 N. Pennsylvania St.: 60 Rooms. Rates—Single $7.50 to $10.00; Double $9.50 to $13.00; Twin Bed Rooms $10.50 to $13.50; Parlor Suites $18.00.

GRAYLYNN HOTEL, 1043 N. Pennsylvania St.: 75 Rooms. Rates—Single $7.50 up; Double $9.00 up; Twin Bed Rooms $11.50 up; Suites $13.00 up.

HARRISON HOTEL, 51 N. Capitol Ave.: 200 Rooms. Rates—Single $6.75 and up; Double $9.00 and up; Twin Bed Rooms $12.00 and up; Suites $20.00 and up.

MAROTT HOTEL, 2625 N. Meridian St.: 350 Rooms. Rates—Single $7.50 to $14.00; Double $10.00 to $13.00; Twin Bed Rooms $12.50 to $17.00; Suites $20.00 to $37.00.

DOWNTOWN DISTRICT OF INDIANAPOLIS



MERIDIAN PLAZA MOTOR HOTEL, 750 N. Meridian St.: 200 Rooms. Rates—Single $6.00 to $10.00; Double $8.50 to $13.50; Twin Bed Rooms $10.50 to $14.00; Suites $15.00 & $20.00.

MOHAWK HOTEL, 5855 E. Washington St.: 83 Rooms. Rates—Single $6.50 & $7.50; Double $9.00 & $10.00; Twin Bed Rooms $10.00 & $11.00.

PENNSYLVANIA HOTEL, 947 N. Pennsylvania St.: 60 Rooms. Rates—Single $5.50 and $6.00; Double $7.00 and $8.00; Twin Bed Rooms $9.00.

SEVERIN HOTEL, 201 S. Illinois St.: 400 Rooms. Rates—Single $5.50 up; Double $8.50 up; Twin Bed Rooms $11.00 up; Suites $27.00.

SHEFFIELD INN, 958 N. Pennsylvania St.: 125 Rooms. Rates—Single $5.00 up; Double $8.00 up; Twin Bed Rooms $8.50 up.

SHERATON-LINCOLN HOTEL, 117 W. Washington St.: 400 Rooms. Rates—Single $6.50 to $11.00; Double $9.50 to $15.00; Twin Bed Rooms $13.35 to $16.00; Suites $20.00 to $36.35.

WARREN HOTEL, 123 S. Illinois St.: 250 Rooms. Rates—Single $6.50 and up; Double $9.00 and up; Twin Bed Rooms $12.50 and up; Suites $25.00 and up.

WASHINGTON HOTEL, 34 E. Washington St.: 300 Rooms. Rates—Single $5.50 to $10.00; Double $7.50 to $10.00; Twin Bed Rooms $11.00 to $15.00; Suites $17.00 up.

NOTE: **Arrangements for the following private club facilities may be made only through members.**

COLUMBIA CLUB, Monument Circle: 130 Rooms. Rates—Single $7.00 to $10.00; Double $8.50 to $10.50; Twin Bed Rooms $9.00 to $13.50; Suites $25.00 to $29.00.

INDIANAPOLIS ATHLETIC CLUB, 350 N. Meridian St.: 135 Rooms. Rates—Single $4.75 to $7.25; Double $10.50; Twin Bed Rooms $12.00; Suites $17.50 and up.

NOTE: Many of these hotels offer air conditioned sleeping rooms.

Prepared and Provided by

Indianapolis Convention and Visitors Bureau
1201 Roosevelt Building—Indianapolis, Indiana

Reports of Officers

Executive Secretary

The following pages carry the reports of the various committees and commissions of the association for the past year. These reports review the work of these groups during the year and report their findings and recommendations for consideration of the House of Delegates and the membership at large.

The secretary will therefore not attempt to review these activities, for the sake of brevity, but urges the total membership carefully to review the work of the association's committees and commissions to become aware of the many activities carried on by these groups in the interest of the members, their findings which have a bearing upon the present-day practice of medicine, and their recommendations which will have a bearing upon the future of the medical profession.

This is the second year of the commission type of operation and, in the secretary's judgment, this type of organization will continue to grow in stature. While many of the commissions may be overloaded, it is quite evident from studying these reports that almost without exception their reports have a ring of interest and accomplishment, both of which are essential to develop functional, hard-hitting committee work.

I am sure the membership of the association will want to express to the members who have devoted countless hours and hard work in behalf of their colleagues in carrying on the responsibilities of association work, their appreciation for a job well done. While all may not agree with some of the reports, nevertheless these men have tried to do their best with the facts before them, and hope their activities have brought about a little more progress. Reference committee hearings will afford every member the opportunity to express his views upon any subject being heard by these committees, and I would like to urge every member to avail himself of this opportunity to "sit in" and listen to these discussions, and to participate in them. This is the only means we have of fairly expressing the views of the majority.

Needless to say, the past year has been a busy and active one for your association and its headquarters staff. Your secretary desires publicly to express his sincere appreciation for the spirit of cooperation, the sincere counsel, and the interest of the officers and members of the association. Had it not been for this, the work would have been much more difficult.

The management survey authorized by your Council promises to bring many improvements in the operation of your association offices.

Membership has continued to increase and is now at an all-time high of 4,218 members, a net gain of 525 during the last 10 years.

Medicare continues to be a major operation in the association office. For the first seven months of 1959, the office has handled 4,034 claims and has paid Indiana physicians $259,898.59 for services rendered to military dependents during this period.

The field staff surveyed all successful candidates for the state legislature prior to the meeting of this legislative body and made the acquaintance of all members. These contacts were discussed with the officers of the county medical societies, and a line of communication was developed between the societies, the headquarters office and the legislative halls. It has long been the policy to maintain a personal contact with the legislators by making at least two calls per year on each one. This gives us the opportunity to maintain friendly contacts and to discuss previous actions of the legislature and contemplated actions. As pointed out in the report of the commission on legislation, the cooperation of the component societies and the auxiliary was outstanding during the 1959 session and contributed largely to the successful results.

The field staff attended as many county society meetings as possible, and have attended the district meetings, offering their services to the officers in any way they might be useful. During the summer, they have been busy visiting every nursing home in the state to determine the population of those over age 65 in each, and to determine who is paying for their care. This was engendered by the problems of the aged, and it is interesting to note that the survey determined that personal or private funds were providing the care of the majority of these people.

We have also visited every newspaper in the state during the summer to discuss medicine's public relations program, and to learn how we might improve our press relations. This has resulted in many worthwhile suggestions which will be given to the Commission on Public Information for their consideration. At the same time, many newspapers requested the association to furnish them with the weekly health column for their local use.

The *Journal* has been the recipient of many compliments during the past year, one of which we are extremely proud being the praise accorded your publication by the International Council of Industrial Editors. Your *Journal* has been accorded "top-ranking" for state journals by every organization which has reviewed it. This opinion is further reflected by the confidence of the advertisers in placing their advertising with us. Dr. Ramsey, the editor, and his editorial board, have worked hard continually to improve the content of the *Journal*,

and I am sure those of you who have watched the progress of your publication will agree that many improvements have been made.

You will have noted another improvement by the time you read this report. Beginning with the September issue, there will be a change in the covers of the *Journal* and the use of more color throughout its pages. We hope you enjoy this publication as much as your editorial board and staff enjoy its preparation for your reading. Constant effort is being applied to continue the improvement of the *Journal,* and your staff would appreciate your suggestions for further improvements at any time.

Our records have now been centralized, our accounting has been centralized to provide more accurate control of the funds and budgets, and when the other departments become fully reorganized and implemented, we hope thereby to increase the facilities and services to the membership.

The tape library is fast becoming a most important means of quick distribution of the latest in scientific information. Popularity of this department continues to grow year after year, and the national publicity it has received has broadened the number of users of this service from the regulars to other physicians throughout the United States and many foreign countries. While it is supplied free of charge to the membership of the association as one of our services, a service charge is made to physicians who are not members by requiring a deposit covering the cost of the tapes and mailing. This is refunded with the return of the tape, less a deduction made for a service charge.

Inquiries by 'phone and mail and visitation by members of the association to the headquarters office are showing a marked increase. Your staff is happy to be of service to an ever-increasing number of the members, and again state that they are at the service of the members at all times.

All kinds of mail comes to your secretary's desk, much of which is received from the membership, and much more from various organizations and other medical groups. While time does not permit as close a perusal of all this material as might be desired, one fact is definitely noted. Physicians throughout the nation, and in our state, are becoming more cohesive in their interest in medical organization, and in developing solutions to the problems confronting them and answers to those who find fault. Physicians in other states are discussing many of the same issues as we in Indiana, and it has been particularly interesting to see the similarity of proposed legislation in the various states. It is evident that some group is developing suggested legislation which is being proposed in state after state. This makes it important that local legislative issues be considered very carefully lest we awaken some morning and find that someone has been successful in slipping legislation through, state by state, to accomplish a result which might meet failure if the legislation were attempted by the Congress with the attendant publicity and attention which would be drawn to the proposals.

While they say the West is still untamed, the physicians there are having their problems with insurance, cultists, etc. The recent *Bulletin* of the Los Angeles Medical Society is full of discussion over the attempt of the labor unions to enter into direct contracts with physicians and hospitals for supplying hospital and medical care for their membership. Physicians are strongly resisting this move inasmuch as they foresee that if successful, physicians and hospitals would be under the direct supervision and control of labor unions who, they fear, would in turn dictate the terms of supplying their services and those of the hospitals.

Advocates of broad social reforms have seized upon the word "health" as a vehicle to transport many of their ideologies which gather some support and at the same time attempt to discredit the great advancement which has been made by medicine in the improvement of the public health.

Long upheld at the last bulwark of free enterprise, medicine is looked upon as one of the last to be unregimented, but as others have fallen before the efforts of those who would regiment and control, our position becomes more hazardous and more effort is necessary to perserve our position.

Renewed interest, concern and discussion on the part of medical organization of matters of socio-economic importance are. therefore. of tremendous importance. With this interest, the physicians of Indiana and all other states will come up with intelligent answers and workable solutions to any problems thrown at them.

Your staff have endeavored to carry out the responsibilities assigned them by the officers, committees and commissions, and renew their pledge to serve the profession of Indiana to the best of their ability.

JAMES A. WAGGENER.

Treasurer's Report

Since Dec. 31, 1958 when the auditors submitted their annual report for the year 1958, the following additional investments have been made from the various funds:

THE GENERAL FUND

181-day United States Treasury Bills at 3.29% interest (maturity 8/13/59) will be automatically renewed if the General Fund does not require reimbursement ____$30,000.00

217-day United States Treasury Bills at 3.30% interest (maturity 9/21/59) will be automatically renewed if the General Fund does not require reimbursement ____ 20,000.00

Securities purchased prior to January 1959, and listed below on the auditor's report	251,000.00	
		$301,000.00
Premium on U.S. Treasury Bonds		210.11
Discount on U.S. Treasury Bills		(894.33)
Total investments General Fund		$300,315.78

MEDICAL DEFENSE FUND

217-day United States Treasury Bills at 3.30% interest (maturity 9/21/59) will be automatically renewed if the Medical Defense Fund does not require reimbursement	$ 2,000.00	
91-day United States Treasury Bills at 3.05% interest (maturity 6/11/59) — renewed 6/11/59, 3.26% interest for 91 days (maturity 9/10/59) ill be automatically renewed if the Medical Defense Fund does not require reimbursement	3,000.00	
Securities purchased prior to January 1959, and listed below on the auditor's report	23,000.00	
		$28,000.00
Premium on U.S. Treasury Bonds		86.53
Discount on U.S. Treasury Bills		(93.64)
Total investments Medical Defense Fund		$27,992.89

STUDENT LOAN FUND

The General Fund transferred to this fund on January 10, 1959	$ 5,000.00	
Cash in bank as shown by auditors statement 12/31/58	48.27	
		$ 5,048.27
Additional Student Loans:		
8 at $500	$4,000	
2 at 150	300	
1 at 400	400	
1 at 300	300	
		5,000.00
		48.27
Payment on Student Loans		820.02
Balance Student Loan Fund July 31, 1959		$868.29

Cash balances in the respective funds as shown on the books of the association:

General Fund	$19,959.70
Petty cash in office	5.00
Medical Defense Fund	1,434.26
Journal Fund	8,225.51
Petty cash in office	5.00
Student Loan Fund	868.29
Petty Cash Fund	1,500.00
Total cash on hand, July 31, 1959	$31,997.76

Following is a detailed report prepared by Wolf and Company, Indianapolis, showing the financial status of the association as of December 31, 1958.

OKLA W. SICKS, M.D., *Treasurer*

The Council,
Indiana State Medical Association,
Indianapolis, Indiana.

Gentlemen:

We have examined the financial records of the Indiana State Medical Association for the year ended December 31, 1958, maintained on a cash receipts and disbursements basis. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

The accounts of the association are maintained on a cash receipts and disbursements basis, except that the investments in United States Treasury obligations are carried at the principal amount, rather than at cost.

In our opinion, subject to the comment in the foregoing paragraph, the accompanying financial statements present fairly the position of the Indiana State Medical Association at December 31, 1958, and the results of its operations for the year then ended, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Respectfully submitted,

WOLF AND COMPANY,
Certified Public Accountants.

Exhibit A

INDIANA STATE MEDICAL ASSOCIATION

Statement of Assets, All Funds
At December 31, 1958

GENERAL FUND:			
Cash:			
Petty cash fund	$ 1,500.00		
General fund	$ 4,142.83	$ 5,642.83	
Loan to North Central District Blood Bank Clearing house		1,000.00	
Investments:			
U. S. Treasury bonds	145,000.00		
U. S. Savings bonds	96,000.00		
U. S. Certificate of Indebtedness	10,000.00	251,000.00	
		257,642.83	
Deduct:			
Note payable — The Indiana National Bank of Indianapolis		40,000.00	217,642.83
THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION:			
Cash on deposit—Exhibit D			4,152.96

MEDICAL DEFENSE FUND:			
Cash on deposit—Exhibit E		3,639.90	
Investments:			
U. S. Treasury bonds	14,000.00		
U. S. Savings bonds	9,000.00	23,000.00	26,639.90
STUDENT LOAN FUND:			
Cash on deposit—Exhibit F		48.27	
Notes receivable from medical students		15,245.02	15,293.29
MEDICARE FUND:			
Cash on deposit—Exhibit G		63,910.50	
Medicare claims paid—reimbursement receivable		18,089.50	
		82,000.00	
Deduct—advanced by U. S. Government		82,000.00	
			$263,728.98

Exhibit B

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Decrease in Assets, All Funds, For the Year Ended December 31, 1958

TOTAL ASSETS, DECEMBER 31, 1957			**$273,338.21**
TOTAL ASSETS, DECEMBER 31, 1958			
exhibit A			**263,728.98**
NET DECREASE			**$ 9,609.23**
Excess of operating cash disbursements over operating cash receipts, year ended December 31, 1958:			
General fund—Exhibit C:			
Disbursements	$287,158.85		
Receipts	276,677.39	$ 10,481.46	
Medical defense fund—Exhibit E:			
Disbursements	6,054.10		
Receipts	5,444.38	609.72	
Medicare fund—Exhibit G:			
Disbursements	598,475.31		
Receipts	598,463.81	11.50	11,102.68
Deduct excess of operating cash receipts over operating cash disbursements, year ended December 31, 1958:			
The Journal—Exhibit D:			
Receipts	69,661.18		
Disbursements	68,210.49	1,450.69	
Student loan fund—Exhibit F:			
Receipts	42.76		
Disbursements		42.76	1,493.45
NET DECREASE			**$ 9,609.23**

Exhibit C

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Cash Receipts and Disbursements

GENERAL FUND

CASH BALANCE (OVERDRAFT)**	For the Years Ended Dec. 31, 1958	Dec. 31 1957	Increase Decrease*
Beginning of year	$ 3,742.84	$ 686.99**	$4,429.83
RECEIPTS:			
Membership dues	143,865.00	112,055.00	31,810.00
Income from exhibits	21,875.00	12,225.00	9,650.00
Interest and discount on inventments	7,201.46	6,516.27	685.19
Instructional courses		391.00	391.00*
Collections on notes and scholarship agreements	200.00	292.05	92.05*
Interest income transferred from medical defense fund	37.50	75.00	37.50*
Tape recordings	489.50		489.50
Reimbursement of medicare administrative expense	15,933.95	5,839.52	10,094.43
Reimbursement of medicare claims	85,149.14		85,149.14
Reimbursement of travel expense	985.19		985.19
Refund of junior-senior dinner expense	940.65		940.65
Total	276,677.39	137,393.84	139,283.55
Transfer from student loan fund	100.00		100.00
Redemption of securities	50,000.00	60,000.00	10,000.00*
Transfers from medicare fund	1,000.00	2,974.89	1,974.89*
Proceeds of bank loan	40,000.00		40,000.00
Total receipts	367,777.39	200,368.73	167,408.66
	371,520.23	199,681.74	171,838.49

DISBURSEMENTS:			
Operating cash disbursements (Schedule C-1)	287,158.85	130,938.90	156,219.95
Purchase of securities	80,000.00	60,000.00	20,000.00
Refund to medicare, prior year administrative expense	218.55	------	218.55
Transfer to student loan fund	------	5,000.00	5,000.00*
	367,377.40	195,938.90	171,438.50
CASH BALANCE—END OF YEAR	4,142.83	3,742.84	399.99

Schedule C-1

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Operating Cash Disbursements

	For the Years Ended Dec. 31 1958	Dec. 31 1957	Increase Decrease*
Transfer applicable portion of dues to:			
American Medical Education Fund	$ 35,110.00	$ ------	$ 35,110.00
The Journal of the Indiana State Medical Association	11,856.00	11,820.00	36.00
Medical defense fund	4,695.00	4,722.50	27.50*
Commissions and committees:			
Medical education and licensure	4,423.02	1,427.70	2,995.32
Publicity	5,768.03	653.83	5,114.20
Legislation	3,307.63	4,815.34	1,507.71*
Public health	1,463.88	------	1,463.88
Voluntary health agencies	114.55	------	114.55
Government medical service	719.32	------	719.32
Medical economics and insurance	525.62	------	525.62
Constitution and by-laws	700.05	------	700.05
Interprofessional relations	158.95	------	158.95
Standing committes	221.60	------	221.60
Special committees	70.62	9,849.59	9,778.97*
Public relations	------	11,449.06	11,449.06*
Preceptorship	------	33.15	33.15*
Rural health	------	486.91	486.91*
Scientific work	------	105.30	105.30*
Grievance	------	80.11	80.11*
Fifty year club	352.26	197.69	154.57
Annual convention	25,178.35	12,202.88	12,975.47
Officers	8,101.71	3,542.36	4,559.35
Headquarters office expenses	75,619.08	56,114.38	19,504.70
Council	3,061.89	1,964.78	1,097.11
Contributions:			
Women's auxiliary	1,000.00	1,000.00	------
Hungarian relief	------	500.00	500.00*
Payroll taxes	727.90	617.21	110.69
Premium on purchase of securities	------	15.63	15.63*
Interest on bank loan to medicare	371.88	571.88	200.00*
Traveling and entertainment	605.00	799.00	194.00*
I.B.M. accounting service	2,833.53	933.44	1,900.09
Employes' retirement fund	5,561.87	6,036.16	474.29*
Administrative expenses — medicare	11,833.90	------	11,833.90
Funds transferred to medicare for claims	82,777.21	1,000.00	81,777.21
Total	$287,158.85	$130,938.90	$156,219.95

Exhibit D

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Cash Receipts and Cash Disbursements

The Journal of the Indiana State Medical Association

	For the Years Ended Dec. 31 1958	Dec. 31, 1957	Increase Decrease*
CASH BALANCE, BEGINNING OF YEAR	$ 2,702.27	$ 8,572.80	$ 5,870.53*
RECEIPTS:			
Subscriptions			
Members (Schedule C-1)	11,856.00	11,820.00	36.00
Nonmembers	157.50	213.00	55.50*
Senior members	141.00	------	141.00
Advertising	55,204.14	46,031.63	9,172.51
Sales:			
Single copies	143.52	337.93	194.41*
Reprints	1,752.10	1,646.10	106.00
Rosters	318.00	------	318.00
Scrap metal	88.92	------	88.92
Office equipment	------	50.00	50.00*
Total receipts	$ 69,661.18	$ 60,098.66	$ 9,562.52
	$ 72,363.45	$ 68,671.46	$ 3,691.99
DISBURSEMENTS:			
Salaries	$ 9,398.75	$ 10,711.44	$ 1,312.69*
Printing and reprints	50,755.16	48,420.59	2,334.57
Electrotypes	2,728.20	2,265.57	462.63
Photographs	496.79	126.00	370.79
Press clippings	220.60	141.00	79.60
Bulk mailing and addressing	1,248.47	940.72	307.75
Office expense and supplies	556.42	604.27	47.85*
Copyright fees	53.00	48.00	5.00

Rent and electricity	1,557.66	1,465.38	92.28
Telephone and telegraph	251.54	254.05	2.51*
Traveling and meeting expense	366.17	------	366.17
Payroll taxes	243.37	242.88	.49
Employe group insurance	57.48	102.00	44.52*
Purchase of office equipment	33.50	418.70	385.20*
Repairs and maintenance—office equipment	33.75	------	33.75
Miscellaneous	209.63	228.59	18.96*
Total disbursements	$ 68,210.49	$ 65,969.19	$ 2,241.30
CASH BALANCE, END OF YEAR	$ 4,152.96	$ 2,702.27	$ 1,450.69

Exhibit E

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Cash Receipts and Disbursements

MEDICAL DEFENSE FUND

	For the Years Ended Dec. 31 1958	Dec. 31 1957	Increase Decrease*
CASH BALANCE, BEGINNING OF YEAR	$ 1,249.62	$ 4,405.98	$ 3,156.36*
RECEIPTS:			
Transfer of applicable portion of dues from the general fund — Schedule C-1	4,695.00	4,722.50	27.50*
Interest on U. S. Government bonds	749.38	762.17	12.79*
Total	5,444.38	5,484.67	40.29*
Redemption of securities	3,000.00	12,000.00	9,000.00*
Total receipts	8,444.38	17,484.67	9,040.29*
	$ 9,694.00	$ 21,890.65	$ 12,196.65*
DISBURSEMENTS:			
Litigation costs	3,337.09	2,501.14	835.95
Attorney fees	2,627.37	3,090.00	462.63*
Interest earned transferred to general fund	37.50	75.00	37.50*
Miscellaneous operating expense	52.14	------	52.14
Total	6,054.10	5,666.14	387.96
Reimbursement of general fund for securities purchased in prior year	------	2,974.89	2,974.89*
Purchase of securities	------	12,000.00	12,000.00*
Total disbursements	6,054.10	20,641.03	14,586.93*
CASH BALANCE, END OF YEAR	3,639.90	1,249.62	2,390.28

Exhibit F

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Cash Receipts and Disbursements Student Loan Fund

	For the Years Ended Dec. 31, 1958	Dec. 31, 1957	Increase Decrease*
Cash balance (overdraft) beginning of year**	$ 374.47**	$3,688.38	$ 4,062.85*
RECEIPTS:			
Interest	9.76	162.15	152.39*
Donations	33.00	----------	33.00
Total	42 76	162.15	119.39*
Redemption of securities	5,000.00	20,000.00	15,000.00*
Collection of student loans	650.00	100.00	550.00
Transfer from general fund	----------	5,000.00	5,000.00*
Total receipts	5,692.76	25,262.15	19,569.39*
	$ 5,318.29	$28,950.53	$23,632.24*
DISBURSEMENTS:			
Operating disbursements	----------	----------	----------
Loans to students	$ 5,170.02	$ 9,325.00	$ 4,154.98*
Purchase of securities	----------	20,000.00	20,000.00*
Transfer to general fund	100.00	----------	100.00
Total disbursements	$ 5,270.02	$29,325.00	$24,054.98*
Cash balance (overdraft**), end of year	$ 48.27	$ 374.47**	$422.74

Exhibit G

INDIANA STATE MEDICAL ASSOCIATION

Comparative Statement of Cash Receipts and Disbursements Medicare Fund

	For the Years Ended Dec. 31, 1958	Dec. 31, 1957	Increase Decrease*
Cash balance, beginning of year	$ 26,012.84	----------	$ 26,012.84
RECEIPTS:			
Reimbursement of claims paid in current year:			
U. S. Government	497,851.15	168,546.41	329,304.74
General fund	82,777.21	----------	82,777.21
Reimbursement of administration expense	17,442.45	1,645.94	15,796.51
Refunds from physicians	393.00	185.00	208.00
Total	$598,463.81	$170,377.35	$428,086.46

Reimbursement of claims paid in prior years	$ 49,780.11	----------	$ 49,780.11
Refund of prior year's expense from general fund	218.55	----------	218.55
Funds advanced by U. S. Government	82,000.00	----------	82,000.00
Proceeds of bank loan	----------	75,000.00	75,000.00*
Transfer from general fund	----------	1,000.00	1,000.00*
Total receipts	$730,462.47	$246,377.35	$484,085.12
	756,475.31	246,377.35	510,097.96
DISBURSEMENTS:			
Medicare claims paid for which reimbursement has been received	$495,846.22	$168,719.91	$327,126.31
Reimbursement of claims transferred to general fund	85,149.14	----------	85,149.14
Reimbursement of administrative expense transferred to general fund	17,442.45	1,645.94	15,796.51
Interest charges on bank loan	37.50	----------	37.50
I.B.M. accounting charges	----------	218.55	218.55*
Total	$598,475.31	$170,584.40	$427,890.91
Medicare claims paid for which reimbursement has not yet been received—Exhibit A	18,089.50	49,780.11	31,690.61*
Repayment of bank loan	75,000.00	----------	75,000.00
Transfer to general fund	1,000.00	----------	1,000.00
Total disbursements	$692,564.81	$220,364.51	$472,200.30
Cash balance, end of year	$ 63,910.50	$ 26,012.84	$ 37,897.66

Chairman of the Council

The Council convened following the closing session of the 1958 session of the House of Delegates to transact the business at hand. Guy A. Owsley, M.D., of Hartford City was elected chairman. The Council then elected Don E. Wood, M.D., of Indianapolis, and Wendell E. Covalt, M.D., of Muncie, as members of the Executive Committee.

Inasmuch as detailed minutes of all the Council meetings have been printed in the *Journal* and copies supplied to the Reference Committee, I will only report some of the more important transactions of the Council.

Special Meeting—December 10, 1958

This meeting of the Council was for the purpose of considering proposed legislation which was coming before the State Legislature. At this time, representatives of the various departments of state government and the Commission on Legislation appeared before the Council to acquaint the Council with legislative proposals. This is the first time the Council has had this opportunity of hearing all proposed legislation which would have an interest to organized medicine, and as a result, being able to give our Commission definitive action which they could use in conducting their legislative program.

Also received at this special meeting was the recommendation of the Executive Committee for the employment of a management survey firm, which was approved.

Council Meeting—Jan. 18, 1959

The Council received a report from Dean Van Nuys concerning the establishment of a 2-year school of medicine on the Bloomington campus.

The president reported on the membership of the House of Delegates' Building Committee, as authorized by the 1958 meeting of the House of Delegates.

Also, the president reported that he had appointed the committee authorized by the House to study the feasibility of transferring the radiological and pathological fees from the Blue Cross to the Blue Shield certificate.

The Council gave the Editor of the *Journal* permission to publish the annual yearbook issue in May instead of July.

The Council approved the suggestion that the president and president-elect of the Medical Association be made members of the Blue Shield Board by virtue of their office.

The Council authorized the survey of the membership to determine ways to improve the Annual Meeting.

The Council received a report of the Commission on Medical Economics and Insurance, in which they recommended that the Indiana State Medical Association adopt the standardized insurance reporting forms as the form to be used in Indiana by the various insurance companies and the physicians. These forms were developed through the joint efforts of the Health Insurance Council and the American Medical Association. Upon motion duly made and seconded, the Council approved the adoption of these forms and recommended to the House of Delegates that they concur in this action.

The commission also submitted to the Council the following statement, which was approved by the Council:

"In support and furtherance of the efforts of the American Medical Association to effect a

proper and fair reduction in the cost of health care for the financially insecure, elder citizen;

The Commissions of the Indiana State Medical Association on Medical Economics and Insurance and on Public Health, in joint session, recommend by majority vote to,

Support a strictly basic hospitalization insurance policy, written by any acceptable insurance carrier, designed to cover basic hospital care at the lowest feasible premium to those recipients of Social Security payment for either retirement or total permanent disability benefits, and others with a comparable income, but who are otherwise indigent,

No medical or surgical care coverage is implied, as such care will be supplied by physicians on an individualized basis in accord with traditional professional policy."

The Council approved the following matters:

Disapproved the publicity stating doctors had been requested by the American Medical Association to cut their fees for people over 65;

Gave the Commission on Public Health authority to hold a public meeting on traffic safety;

Approved the holding of the annual Junior-Senior Medical Student Day;

Approved inviting Doctor N. Henry Moss of Philadelphia to appear on the convention program;

Approved the request of the Commission on Public Information that the association encourage participation by medical assistants in a course of training to be instituted at the Indiana University Extension Center, and that physicians be encouraged to assist in defraying the cost of this course for their employees, and that medical assistants, taking the course, be given some form of suitable certificate.

The Council interviewed representatives of various management engineering firms, and wound up contracting with the Wolf Management Engineering Company of Chicago to make a study of the operation of the Indiana State Medical Association and to fulfill the recommendations of the House of Delegates concerning the study relative to a building program.

The Council confirmed the nominations made by the districts for representatives on the Board of Directors of Blue Shield—confirming the nominations of R. R. Calvert, M.D., of Lafayette, who represented the 9th District—E. H. Clauser, M.D., of Muncie, who represented the 8th District—George W. Willson, M.D., of Evansville, who represented the 1st District—Mahlon F. Miller, M.D., of Fort Wayne, who represented the 12th District—Hubert T. Goodman, M.D., of Terre Haute, who represented the 5th District; and the Council nominated Dr. William H. Howard of Hammond as a member at large.

The Council approved a Tuberculosis Bed Survey to be made by the State Board of Health.

Meeting of April 5

The Council heard a report of the action of the Elkhart County Medical Society in which they favored the unit fee system.

The Council also heard a report stating that the majority of the doctors answered a poll in favor of being covered by social security.

The Council heard a report from the president in which he outlined his proposal for encouraging people to become immunized against polio.

The Council also heard reports from the chairman of the Grievance Committee and the chairman of the Building Committee.

The Council also heard the report of the Wolf Management Engineering Company, which was published in full beginning on page 1051 of the June, 1959, *Journal* of the Indiana State Medical Association.

The Council also heard a report from the Commission on Medical Economics and Insurance and the Conventions Arrangements Committee.

The Council approved the outline for the program of the 1959 Annual Meeting.

The Council was asked to interpret the policy of refunding dues of a deceased member, and by motion properly made, seconded and carried, it was decided that dues of a deceased member would not be refunded.

The Executive Committee called attention to Section 1, Chapter XXIX of the By-Laws, concerning the investment of surplus funds and the Executive Committee was given authority to select an investment counselor to advise the Committee on an investment program for the Association.

The Budget Committee reported on the 1959 budget, which was approved by the Council.

Meeting of July 12

The Council heard the reports of the delegates to the American Medical Association. The delegates reviewed the actions taken by the American Medical Association.

Nominations for members of the Editorial Board were received in which Dr. Franklin F. Premuda, of Hammond, was nominated to succeed Dr. George N. Lewis, of Gary, and Dr. S. R. Mercer, of Fort Wayne, was nominated to succeed himself.

The Council heard a report by the chairman of the Building Committee concerning the recent poll of the membership in which a large majority indicated they favored the building.

Also received by the Council was an invitation from Dr. Ochsner, on behalf of the Levey Memorial Foundation, inviting the association to consider occupancy, jointly with the Indianapolis Medical Society, of the building recently willed the Indianapolis Medical Society, located at 2902 North Meridian.

The Council heard a report from the officers and from the chairman of the Grievance Committee, concerning the activities of the respective committees.

Also reporting to the Council was the chairman of the Commission on Medical Economics and Insurance.

The Council appropriated five thousand dollars ($5000) for the Association's contribution to the 1960 Science Fair, which is to be held in Indianapolis.

The Council elected Dr. Maurice Kahler and Dr. Lawson J. Clark, both of Indianapolis, to succeed themselves on the Trust Committee of the Indiana Medical Education Foundation.

The Council discussed the membership of the Indiana State Medical Association and reviewed the efforts which had been made in the past to bring the membership of the Indiana doctors in the American Medical Association to a figure comparable to the number who are members of the Indiana State Medical Association.

By motion duly made and seconded the Council voted to submit the following Resolution to the House of Delegates:

"WHEREAS, organized medicine is faced with the necessity of being fully organized at all levels, and

WHEREAS, physicians, to present a united front, and to be fully aware of measures affecting them at all levels, and

WHEREAS, the Council is of the belief that every physician should wholly support, not only his County Society and his State Association, but also his national organization, and

WHEREAS, the physicians of many other states have banded themselves together to lend their support to their county society, State Association and American Medical Association, by declaring that all who are members of the county and State Medical Societies shall also be a member of the American Medical Association;

NOW, THEREFORE, BE IT RESOLVED, that effective with the next dues year no physician be granted membership by a county society nor the Indiana State Medical Association unless such membership also includes membership in the American Medical Association, and

BE IT FURTHER RESOLVED, that the Constitution and By-laws be amended to conform with this Resolution."

The Council also heard reports from the chairman of the Commission on Legislation and approved a study by the Board of Health on tuberculosis cases.

Dr. E. S. Jones reported on the Conference on Aging held in Atlantic City prior to the meeting of the American Medical Association and also on the Joint Conference on Aging which was held in Washington, D.C., immediately following the close of the American Medical Association.

We believe, from this report, and from the fully published minutes of the meetings of the Council, you will concur that the Council has had a busy and an important year. The chairman takes this opportunity to thank the members of the Council, the officers and all members of the Association for their fine cooperation which has permitted the handling of the business of the Council with dispatch.

GUY A. OWSLEY, M.D., *Chairman*

Reports From District Councilors

First Councilor District

The First District Society held its annual meeting at Evansville State Hospital on May 21, 1959.

The hosts were Dr. Milton Anderson, Superintendent of the Hospital, and the Mead Johnson Company.

The meeting was attended by Dr. Guy Owsley, Dr. Earl W. Mericle and Mr. James Waggener, executive secretary of the Indiana State Medical Association.

The principal problem in the First District has been the assimilation of osteopaths into the proposed Gibson County Hospital, and we believe that will be solved by the action of the House of Delegates of the A.M.A. and the Council at its last meeting.

The officers elected at the meeting were as follows:

President: Noel Neifert, M.D., Tell City.

Vice President: J. D. McDonald, M.D., Evansville.

Secretary-Treasurer: Gilbert Wilhemus, M.D., Evansville.

Alternate Councilor: P. J. V. Corcoran, M.D., Evansville.

(Doctor Challman was re-elected Councilor.)

WILLIAM B. CHALLMAN, M.D., *Councilor*

Second Councilor District

Medical progress has been good in the district the past year. Steps are being taken to improve the hospital facilities and attendance at staff meetings.

The District Medical Society met at the Country Club June 4, 1959, with an attendance of 42 members. Knox County invited the society to have the next meeting at Vincennes. Dr. Chattin of Vincennes was elected president of the District Society for next year. Dr. Ross was elected vice-president. Dr. J. S. Brown was elected secretary for the next year. Dr. Phillip Holland of Bloomington was elected alternate councilor of the district for the

term beginning Oct. 9, 1959. Dr. Fox of Washington was re-elected to the Blue Shield Board.

Dinner was served at the County Club at which time Dr. Earl Mericle, president-elect, gave a very interesting report on medical conditions in the state and nation. The speaker of the evening, Phil Eskew, gave a very interesting talk on the 'Good Old Days.'

J. H. Crowder, M.D., *Councilor*

Third Councilor District

The annual meeting was held at the New Albany Country Club on May 6, at which time nearly 100 members were present for a noon luncheon and a scientific program in the afternoon.

The scientific program was conducted by Dr. Robert L. MacLendon from Louisville, Ky., who spoke on office treatment for arthritis; and Dr. Grover B. Sanders of Louisville, who spoke on the management of diseases of the chest. Also present for the meeting were President-Elect Earl Mericle, Dr. Guy Owsley, chairman of the Council, and Mr. Waggener and Mr. Amick from the headquarters staff.

Doctor Mericle and Doctor Owsley gave a report to the meeting on what had been going on in our state organization in the last year.

The incumbent member of the Blue Shield Board was elected to succeed himself for a period of three years, and Dr. Donald Kerr from Bedford, was elected alternate counselor to succeed Dr. Lyle Havens of Jeffersonville.

The ladies auxiliary counselor group met under the direction of Mrs. Fontaine of Bedford and they had a very nice meeting which was well attended.

The present year has seen a start and almost the completion of two new hospitals in the district—one at Scottsburg and one at Paoli—and also, the hospital at Jeffersonville and the one at Salem have undergone programs of expansion and they are now in full operation. This indicates the growth of the population in the Third District, which is good for all concerned.

Things have run very well in the district this past year, and I, as the councilor, want to thank my colleagues for the loyal support and the courtesy that they continue to extend me as their representative in the Council.

John M. Paris, M.D., *Councilor*

Fourth Councilor District

The 55th annual assembly of the Fourth Councilor District was held at the Madison Country Club in Madison on May 20, 1959.

A group of hardy members braved the rain to play golf in the morning. The prizes were contributed by pharmaceutical and surgical supply companies and presented at the luncheon which was served at the Country Club.

At 1:30 the delegates met. Dr. Guy A. Owsley, chairman of the Council, Mr. James Waggener, executive secretary and Mr. Robert Amick, field secretary, represented the State Medical Association. Dr. Owsley brought the group up to date on association business, especially in regard to the building program. Mr. Waggener suggested that the next meeting date should be set so Dr. Dudding moved that it be the second Wednesday in May, 1960 in Columbus, Ind. New officers elected for the district are as follows: Dr. Robert M. Reid of Columbus, president; Dr. Harry R. Baxter, Seymour, vice president; Dr. David Adler, Columbus, secretary-treasurer; Dr. Joe Black, Seymour, district councilor. Dr. Robert Zink appointed the incoming officers as a committee to study the old constitution of the district, and to re-draft it, or to draft a new one for the consideration of the delegates at the next meeting. After this meeting was adjourned the scientific program was presented.

Dr. L. Douglas Atherton, Louisville, Ky., spoke on "Practical Aspects of Kidney Stone Formation and Prevention." Dr. Walter Coe, also of Louisville, spoke on "Vascular Disease, Dissection of the Aorta In Particular." Both papers were fully discussed.

The ladies were entertained with a tea at which Dr. Robert E. Bowers, chairman and professor of the Department of History, Hanover College, Hanover, Ind., spoke of his experiences in Russia.

In the evening, members and guests were entertained at dinner aboard the Johnson Party Boat on the Ohio River.

The affairs of the Fourth District are in good order.

J. E. Dudding, M.D., *Councilor*

Fifth Councilor District

Have attended all regular and special meetings of the Council during this period and participated in entire discussion. Also served on several minor committees of the Council.

During this time I visited the Parke-Vermillion Medical Society one time; the Putnam County Society twice and several meetings of the Terre Haute Academy of Medicine, but none of the regular business meetings of the Vigo County Medical Society.

Wrote an article on society activities in conjunction with Dr. Ken Neumann, councilor of the Ninth District. This article was published in the April issue of the I.S.M.A. *Journal*. I have attempted to improve relationship and understanding in my district by explaining the duties and responsibilities of a councilor, a fact that very few members understand even very remotely.

It is my hope that more active cooperation may be obtained in this district, particularly better liaison with the Parke-Vermillion group.

Professional and ethical situation is good except for a temporary local situation in one county, and that is being resolved at this writing.

Recommendations:

1. The meeting time should be changed for the district. It should not be in May or October. We have too many meetings during those two months.

2. Some districts are charging $1.00 per member per year, collected by secretaries of component societies and paid to the district secretary-treasurer. This should cover printing, postage and etc., for the annual meeting and the expenses of the delegates, councilors and alternate councilor meetings before the annual Indiana State Medical Association meeting.

3. The councilor, alternate councilor, delegates, alternate delegates and past presidents should meet to discuss business to be presented during the annual meeting.

4. Recommend that more attention be paid to arranging of auxiliary meeting, preferably at the same time as the district meeting, and the wives should be contacted directly.

5. In order to acquaint members of the component societies with affairs at a state level, the councilor should be notified by the county secretaries of regular monthly meetings, primarily those in the same month as regular Council meetings; January-April-July-October.

ROBERT K. WEBSTER, M.D., *Councilor*

Sixth Councilor District

This has been a year of concentrated activity for the betterment of conditions for the practitioner of medicine and its specialities. Every county in the district had representatives who never failed to respond when the need to contact individuals and groups was urgent. To mention names is impossible for lack of space for this report. To each who helped—my appreciation and thanks.

The annual meeting was held in New Castle in May. Officers elected were Dr. Kenneth G. Hill of New Castle, president; Dr. John H. Smith of Greenfield, vice-president; and Dr. John A. Davis of Flat Rock, secretary. The invitation to meet in Shelbyville May, 1960, was accepted.

Dr. Walter U. Kennedy of New Castle was elected as the choice of the Sixth District to be its representative on the Board of Directors of Mutual Medical Insurance, Incorporated.

It is with deepest regret that I pause a moment to remember Dr. Will A. Thompson of Liberty, Ind. Many will miss the gray hair, the red bow tie and the cane at the annual sessions. He was a friend of all.

HARRY PLUMMER ROSS, M.D., *Councilor*

Seventh Councilor District

The activity of the Seventh District Medical Society in the past year has been limited to its two regular meetings. The fall dinner meeting was held at 7 p.m. Wed., Nov. 19, in the Public Service Company building in Plainfield. We are very grateful to our president, Dr. Malcolm O. Scamahorn, who presided for all of the "extras" that made this meeting outstanding.

Election of officers was an order of business with the following results: president elect, Dr. Arthur W. Records, Franklin; secretary-treasurer, Dr. Herbert L. Egbert, Indianapolis; alternate councilor for 3 years, Dr. Charles A. Jones, Franklin (re-elected).

It was moved and passed to hold only one meeting per year. This meeting was to be either scientific or social, depending upon the wishes of the encumbent officers. This action was declared invalid later because it conflicted with the organizations by-laws, and will necessitate a change by vote.

Dignitaries present were: Dr. Earl Mericle, president-elect of the Indiana State Medical Association, who presented greetings from Dr. Kenneth Olson, president. Robert Amick, a field secretary for the Indiana State Medical Association, presented a capsule size digest of legislation pertinent to the profession that would be introduced during the 1959 General Assembly.

The evenings entertainment was high lighted by Charles G. Werner, editorial cartoonist for the Indianapolis Star.

The spring meeting was held jointly with the Marion County Medical Society, May 12, 1959 in the Western Electric Plant, 2525 Shadeland Ave. Our most sincere plaudits are extended to our members and the Western Electric officials who arranged a very delightful and delicious buffet dinner. An exciting tour of the plant was also made available for the membership.

RALPH V. EVERLY, M.D., *Councilor.*

Eighth Councilor District

The Eighth Councilor District meeting was held in Portland, Ind., on June 3, 1959, at the Country Club. The local committee with Dr. Keeling as chairman, arranged a luncheon meeting for the Executive Committee of the state association, and the regular monthly meeting of the Executive Committee was held during the afternoon. The business session was held before the dinner meeting and a separate program was arranged for the ladies. The councilor reviewed the activities of the state association during the past year and this discussion was followed by a question period.

District officers for the coming year were elected from Anderson where the 1960 district meeting will

be held. Dr. Richard C. Swan was elected president of the district, and Dr. Merriel P. Benoit, secretary-treasurer. Dr. Gordon B. Wilder was elected as alternate councilor, and Dr. Fletcher W. McDowell was chosen to fill the unexpired term of Dr. E. H. Clauser as director of Blue Shield. Recognition of Dr. Clauser's contributions to organized medicine was made a matter of record. Dr. Clauser's untimely death occurred just prior to the district meeting.

G. A. Owsley, M.D., *Councilor*

Ninth Councilor District

There have been no major organizational problems in the Ninth District this year. An increase in the activities of some of the societies has been encouraging. The councilor has met with eight of the 10 county societies during the year. All societies were contacted by mail at least twice during the year, plus telephonic communications during the Legislative session.

The White County Medical Society hosted the annual meeting at Monticello on May 21, 1959. A spirited business session was held with Dr. S. E. McClure of Monon presiding and Dr. David C. Beck acting as secretary-treasurer. No delegates appeared to represent three counties. Discussion on problems of state association activities, Relative Value Schedule and fee schedules, legislative activities, and the proposed building program occupied considerable time.

Dr. Kenneth Olson, president of the Indiana State Medical Association, attended and gave a resume of the year's activities of the state association and answered questions from the delegates. Mr. L. E. Converse gave a brief report of Blue Shield activities. Dr. K. O. Neumann gave the councilor's report for the year.

A proposed Constitution and By-Laws for the Ninth Councilor District Medical Society was adopted. By resolution, the delegates re-affirmed the desire of the Ninth District to elect the district representative on the Blue Shield Board at the annual district meeting every third year. The next election to be in 1961 for the term beginning in 1962. Dr. A. E. Stouder of Kempton, Ind., Tipton County, was elected alternate councilor for the term beginning October 1959 to October 1962. Dr. Thomas Hass of Lafayette spoke on Vaginal Bleeding and Dr. Paul W. Elliott of Lafayette discussed Catacholamines. Following a social hour and dinner, Dr. John Hicks of Purdue University gave the members and guests a look at "Collegiate Education in the Future."

Auxiliary members were entertained by the White County Auxiliary at a luncheon and bridge followed by boat trips on Lake Shafer.

The Ninth District meeting next year will be held in Lafayette on May 18, 1960. The Tippecanoe County Medical Society will be the host society. Dr. H. E. Klepinger of Lafayette will serve as president and Dr. F. J. Babb of Stockwell will serve as secretary-treasurer.

K. O. Neumann, M.D., *Councilor*

Tenth Councilor District

The Tenth Councilor District had two usually fine meetings during the past year. The first meeting was Sept. 10, 1958. The meeting opened at 4 p.m. at Phil Smidts restaurant in Whiting, Ind., with Dr. George Lewis, president, presiding. The afternoon session was scientific and consisted of two speakers: Dr. Alex Steigman, chairman, Department of Pediatrics, University of Louisville, who spoke on "Viruses in Cancer"; Dr. Donald Moore, Larue Carter Hospital, Indianapolis, who spoke on "New Developments in Psychiatric Treatment and Changing Committment Laws." Following the two talks, there was a short adjournment and the meeting resumed at 7 p.m. for dinner.

During dinner, Dr. Lewis acknowledged that the afternoon and evening programs were under the Indiana Academy of General Practice Road Show program supported by Eli Lilly Company, the Indiana Division of Mental Health and Indiana Cancer Society.

Mr. Jim Waggener, executive secretary of the Indiana State Medical Association, discussed the matters coming up at the October session of the House of Delegates and legislation which is expected at the 1959 General Assembly.

An election of district officers was then conducted with the following results: president: Dr. Ralph Hartsough, Remington; secretary: Dr. Kenneth R. Ockerman, Rensselaer.

A motion was made and adopted to establish annual dues for the district of fifty cents to defray the costs of the district meetings.

Dr. Lewis then introduced the afternoon speakers who presented as their evening discussions: "Paralytic Polio and the Family of Enteroviruses" by Dr. Alex Steigman and "Psychiatric Misconceptions" by Dr. D. Moore.

The district women's auxiliary held a separate meeting during the evening scientific session. One hundred members were in attendance at the evening meeting.

The spring meeting was held May 13, 1959 and was combined with the annual Parramore Hospital dinner. Ninety physicians attended the dinner at 7 p.m. at which Dr. Phil Becker, hospital superintendent, presided as host. Dr. Kenneth Olson, president of the Indiana State Medical Association spoke on a variety of subjects and particularly with regard to the state associations discussions concerning a new headquarters building.

Mr. Howard Grindstaff, field secretary for Indiana State Medical Association, Northern Indiana, was introduced.

Mr. James Waggener, executive secretary of the Indiana State Medical Association, discussed legis-

lation enacted by the Indiana General Assembly, and called the doctors' attention to the Simpson-Keough and Forand Bills pending in Congress.

Dr. J. Preston Vye, district councilor, presided in the absence of the president and the minutes of the April meeting were read and approved. Dr. Vye conducted an election of officers with the following results: president: Dr. Martin O'Neil, Valparaiso; secretary: Dr. J. R. Frank, Valparaiso; Councilor: Dr. J. P. Vye, Gary; Alternate Councilor Dr. Ralph Eades, Valparaiso. Mr. Waggener explained the new I.S.M.A. constitutional requirements requiring district societies to set dates for their annual meetings prior to January 1 of each year and to announce annual programs at least 30 days in advance. Accordingly, the dates for 1960 were established as May 11 and October 12. A motion was made and unanimously adopted supporting the candidacy of Dr. Harry R. Stimson of Gary for president-elect of the Indiana State Medical Association at the 1959 session of the House of Delegates.

At 8:30 p.m. the meeting adjourned to the auditorium where Dr. Mark H. Lepper, professor of Preventive Medicine and head of the Department of the University of Illinois, spoke on the subject of "Hospital Staph Infection Problems." Dr. Lepper's talk was illustrated by slides, and following the formal presentation many questions were raised and answered.

The meeting concluded with the showing of films of the March Grand Rounds sponsored by the Upjohn Company.

J. P. Vye, M.D., *Councilor*

Eleventh Councilor District

The spring meeting of the Eleventh Councilor District was held May 20, 1959, at Logansport with the Cass County Medical Society hosts. Dr. Robert Brown, district president, Marion, opened the meeting. The necessary business of the district was taken care of at this time.

The state society president, Dr. Kenneth L. Olson, gave a résumé of the accomplishments and problems of organized medicine in a short talk.

A medical panel from the faculty of Indiana University Medical School gave an excellent discussion on dianostic problems in which various representatives of the specialties took part.

A very entertaining and informative talk was given by the man in charge of a speech therapy clinic located in Bloomington near the I. U. campus.

Although the attendance was fairly representative of the district, the program certainly merited a much greater attendance.

The fall meeting is to be held at Roth Park in September, with the Carroll County Medical Society as hosts.

M. R. Adams, M.D., *Councilor*

Twelfth Councilor District

The annual meeting of the Twelfth District Medical Society was held in Ft. Wayne, Ind. at the Shrine Club House in conjunction with the regular meeting of the Fort Wayne Medical Society on May 5. Approximately 175 members attended. Honored guests were President Kenneth L. Olson, Mr. J. A. Waggener, executive secretary, and Mr. Howard Grindstaff, field secretary, of the Indiana State Medical Association.

Officers elected were: Harold F. Zwick, Decatur, president; Max M. Gitlin, Bluffton, vice-president; and Stephen C. Michaelis, Ft. Wayne, secretary-treasurer. Milton F. Popp of Ft. Wayne was elected alternate councilor for a period of three years.

President Olson gave a review of the activities of the headquarters office and of his own activities. He presented full and up-to-date information regarding activities of the building committee and urged all members to give serious thought to this problem and to actively participate in the forthcoming mail ballot regarding the building situation. The councilor gave a report concerning Council activities and requested any comments or suggestions as to the type of district meeting preferred by the members. Decision as to time and place of the next meeting was left to the officers with the provision that they should make this decision within the succeeding month so that the councilor can give timely notice to the headquarters office.

Following a cocktail hour and buffet dinner, Mr. Harry W. Ginty, vice-president of the Fort Wayne Medical Protective Insurance Company, gave a very instructive discourse on Medical Liability Insurance Problems. Mr. Ginty has had many years experience in this field and had a great fund of authoritative information regarding the background of this problem, the philosophy of the public, the insurance carriers, and the approach to the problem by members of the medical profession. Much excellent and sincere advice was given to our members and the program was well received.

Maurice E. Glock, M.D., *Councilor*

Thirteenth Councilor District

The annual meeting was held at the Spaulding Hotel in Michigan City on Nov. 19, 1958. The meeting was well attended.

R. L. Bender, M.D., president of the district, presided.

Problems facing organized medicine in general, and those of the state association were ably presented by Kenneth L. Olson, M.D., president of the Indiana State Medical Association, and James A. Waggener, executive secretary of the association.

The following will be officers for the coming year: R. W. Holdeman, M.D., South Bend, Ind., president; Thomas Elliott, M.D., Elkhart, Ind., vice president;

J. M. Wilson, M.D., South Bend, Ind., secretary-treasurer; G. O. Larson, M.D., LaPorte, Ind., councilor; and Ray Nelson, M.D., South Bend, Ind., alternate councilor.

The excellent scientific program consisted of a paper "Viruses vs. Cancer," by Thomas Ward, M.D., professor of Bacteriology, University of Notre Dame; "What is Adequate Surgery for Varicose Veins," by T. T. Myers, M.D., head of Section on Peripheral Vein Surgery, Mayo Clinic, Rochester, Minn.; "Management of Diabetes," by Charles E. Test, M.D., Indianapolis; "The Selection of Patients for Cardiac Surgery," a panel discussion by E. H. Fell, M.D., Clinical Professor of Surgery, and Oglesby Paul, M.D., Association Professor of Medicine, University of Illinois School of Medicine.

A meeting of the woman's auxiliary was held during the afternoon.

A cocktail and social hour was enjoyed by the doctors and their wives.

One of the finest evening programs we have ever heard was presented by Frank Rockwell Barnett, research director, The Richardson Foundation, New York City.

The next annual meeting of the society will be held in South Bend on Nov. 18, 1959.

G. O. Larson, M.D., *Councilor*

NOTES

Reports of Committees

Executive Committee

The Executive Committee has met each month during the past year to transact the routine business of the association.

The first meeting of the new year was held following the Council meeting at the end of the 1958 session of the House of Delegates, at which time the committee was organized, with Dr. Donald Wood being elected chairman of the committee for the year.

Minutes of all the meetings of this Executive Committee have been published in the *Journal* during the past year and copies have been supplied to the reference committee for their study, and the transactions of the Executive Committee have been previously reported to the Council.

We will review herewith some of the transactions of the Executive Committee during the past year.

November 1958 Meeting

The committee heard reports on the regional meetings conducted by the field staff on behalf of the Commission on Legislation and approved the omission in the Medicare contract of drugs under the Medicare Program, effective October 1.

The 1958 convention was discussed by the Executive Committee and Dr. Leffel came before the committee for discussion of the plans for the 1959 meeting. At this time the comments of the physicians and exhibitors both were reviewed and the plans for the 1959 meeting were tentatively developed. It was also decided to conduct an opinion survey of the members of the association to get their comments and counsel as to what could be done to make our annual meetings more attractive.

The Executive Committee heard the comments from Mr. Saylor, executive vice-president of Blue Shield, in which he sought permission to make an effort to maintain the group formed throughout the Medical Association limited to members of the association. He proposed that the plan would make an effort to determine who was eligible in the existing group and put the others on a direct billing so as to reflect a more accurate utilization of this group.

The Executive Committee agreed that the association should participate in a meeting concerning the Codification of the School Laws of the State of Indiana.

A full report was received concerning legislative proposals at the state and national level and plans for meeting some of these problems.

December 1958 Meeting

The committee discussed the employment of a management engineering firm and the secretary was requested to have several firms meet with the Excutive Committee at the January meeting.

The question of holding the annual meeting at the Indiana Theatre building or the Murat Temple was brought before the committee and it was decided to hold the 1959 meeting in the Murat Temple.

A notice of the renewal date for the Medicare contract was discussed.

The Committee requested the chairman of the Council, as a member of the Executive Committee, to report to the Executive Committee the policy actions taken by Indiana Blue Shield.

The secretary presented a digest of the actions taken by the AMA at its interim meeting in Minneapolis.

The association granted the Indiana Association of Medical Assistants permission to make a change in their bylaws.

The committee approved granting the medical officer of the United States Naval Ammunitions Depot, at Crane, Ind., permission to make use of the association's tape library.

The legislative review was given to the committee.

The Woman's Auxiliary was informed that the Executive Committee, as their advisory group, would meet with them in January to discuss the auxiliary's plans and program.

Dr. P. T. Lamey, secretary of the Medical Registration Board, came before the Executive Committee to discuss legislative matters in which the State Board of Registration had an interest.

Dr. Harry Pandolfo, chairman of the Commission on Public Information, requested the Executive Committee to approve and support a program to be started at the Indiana University Extension Center for medical assistants.

The chairman discussed the plans for the establishment of a 2-year medical school on the Bloomington campus of Indiana University.

The Executive Committee nominated Drs. Kenneth L. Olson, David L. Adler and James W. Crain, as the three representatives to the Hospital Advisory Council, to serve in relation to the administration of the Hill-Burton program in Indiana.

The Committee was notified of an increase in the cost of printing the *Journal*. The secreary was instructed to make a thorough study of the two proposals and to accept the one they would believe most economical to the association.

January 1959 Meeting

The committee met with representatives of the various management survey firms and selected two for appearance before the Council as candidates for

making a study of the Indiana State Medical Association.

Payment to the Board of Trustees of the Employees' Retirement Fund was approved.

Financial report of the 1958 Annual Convention was reviewed and accepted.

The report on the survey, as authorized by the Council, on the 1959 Annual Convention, was reviewed in detail and referred to the Council for their information and action.

The committee heard a report from Dr. L. G. Montgomery concerning his representation of the association at the meeting concerning the Codification of the Indiana Common School Laws.

Activities of the Legislature were reviewed by the chairman, Dr. Wood.

The attorney reported on the directive from the Council requesting him to procure from the Judicial Council of the American Medical Association clarification on the question of osteopathy. His report was presented and ordered submitted to the Council.

The president read a letter from the Lincoln National Life Insurance Company, in which the Association was requested to participate by supplying a liaison committee with the Indiana Chapter of the Health Insurance Council.

A request for a definition of permanent and total disability was received and the committee reaffirmed its previous definition prepared by the association on this subject.

The resignation of Dr. Walter L. Portteus as a member of the Grievance Committee was accepted, and it was recommended that Dr. M. C. Topping be appointed for the unexpired term.

Approval was given for the executive secretary to be a speaker before the National Blue Shield Professional Relations Conference in Chicago.

Mrs. E. W. Bailey and Mrs. J. M. Black, of the Woman's Auxiliary, appeared before the committee and reviewed their program and financial needs for the coming year.

The Executive Committee recommended that the auxiliary:

(1) Submit suggestions and help on the state meetings each year, and to encourage husbands to attend the annual convention;

(2) To take an active interest in medical organization; and

(3) To stimulate their husbands to become aware of what is going on in organized medicine and the importance of their active participation at all levels.

The committee allocated one thousand dollars to help the auxiliary with their program for the coming year.

February 1959 Meeting

Mr. Staunton, of the Wolf Management Engineering Company, the firm selected by the Council to do the management study, appeared before the Executive Committee and gave a progress report on their study, recommending that the association's headquarters offices be expanded and remodeled immediately.

Dr. Wood gave a progress report on the bills currently pending before the Indiana State Legislature.

Plans were completed for the meeting of the Indiana Congressional Delegation in Washington in April.

The request of the Professional Insurance Administrators, Inc., to be named agents of record of the Indiana State Medical Association, was studied and their request was referred to the Council.

Letters were received concerning the supplying of exhibits for various local meetings throughout the state. It was determined that component societies should be requested to assume this obligation for local programs.

The executive secretary discussed the proposal of some members of the Indiana Health Careers Committee for the establishment of a full-time office and staff—that he had appeared in opposition to this—and his stand was confirmed.

Dr. Emmett B. Lamb, chairman of the Commission on Public Health, presented material from the American Legion Community Service Department, and Dr. Lamb was authorized to seek the assistance of the Legion in any project which his commission might deem advisable.

Membership in the Joint Committee on Improvement of Patient Care for Indiana was renewed.

A letter from Dr. Martha O'Malley, director of the Division of Hospital and Institutional Services of the Indiana State Board of Health, was read, in which she suggested that the association might name a representative to sit at meetings of the Hospital Licensing Council during Dr. Clauser's illness. Dr. Mericle was asked to represent the association at these meetings.

The request of Dr. Glen Ward Lee, chairman of the Commission on Governmental Medical Services, that the association lend its name to the Workshop Planning Committee on the Care of the Mentally Ill Patients in General Hospitals was approved.

A subscription to *Today's Halth* for members of the Indiana State Legislature, to be sent through the auxiliary, was approved.

Dr. A. C. Offutt, health commissioner, appeared before the Executive Committee, discussing a problem he has in obtaining physicians to serve as county health officers in some areas of the state.

The committee authorized the preparation of a newspaper release, urging the public to obtain their fourth polio shot.

The committee appointed Dr. R. A. Solomon of Indianapolis to represent the association at the 1960 meeting of the United States Pharmacopoeial Convention, Inc.

March 1959 Meeting

Mr. Robert Bixbey, of the auditing side of the Wolf Management Engineering Company, appeared before the committee and presented the suggested budget for the coming year and recommendations concerning the accounting practices if the association.

Recommendations on the budget were approved and copies of the budget sent to each member of the Council.

The committee approved a letter to be sent to delinquent members of the Indiana State Medical Association.

Three contracts from Washington regarding Medicare—one, concerning the administration of the program for the period April 1, 1959, through March 31, 1960—the second, the final audit by the government and determination of the per claim rate for the period of July 1, 1957 through March 31, 1958—and the third, a contract modification, reducing the amount of advanced funds from $82,000.00 to $75,000.00 were approved for signature by the president.

In the absence of the chairman of the Commission on Legislation, the executive secretary gave a report on the legislative matters at a state and national level.

The report from the Wolf Management Company was discussed and the following action was taken:

Other rental sites were reviewed and the cost of making moves to other spaces were reviewed and the committee voted that the association should not move its headquarters office into other rental space at this time, but should attempt to procure more space in the Hume Mansur Building and remodel the present quarters. Proposed plans for remodeling were approved.

The recommendations of the Wolf Management Company for housing the membership records, and biographical and service records in fireproof files was approved and the purchase of the fireproof cabinets was authorized.

It was also authorized to microfilm the minutes of the Executive Committee, the Council and the House of Delegates, as well as old membership records.

The committee received a proposal from an investment counseling firm of Blont Ellis and Simmons; however, this was deferred pending further investigation.

The committee received a letter from the Chicago Medical Society, asking the Indiana delegation to support their candidate, Dr. Percy E. Hopkins, for the position of trustee of the American Medical Association, to fill the unexpired term of Dr. Warren W. Furey, deceased.

The minutes of the North Central District Blood Bank Clearing House were reviewed.

A letter from the French Lick-Sheraton Hotel was read, stating the only dates available for the 1960 meeting would be the last week in September; inasmuch as this would conflict with other state meetings the secretary was instructed to continue negotiations in an effort to find a date that would not conflict with adjoining state meetings.

The Savings Bond Department of the Government was given permission to distribute a flyer in the *News Flash*.

A request for $75.00 to assist the Indiana Chapter, Student AMA, was approved.

The president was instructed to write a letter to Dr. P. T. Lamey, secretary of the State Board of Medical Registration, expressing the views of the committee concerning the interpretation by the Board of the Attorney-General's opinion on the licensing of chiropractors.

The secretary was instructed to direct a letter to the State Board of Medical Registration for a definite statement concerning the necessity of interns and residents being licensed prior to taking training in this State.

April 1959 Meeting

The Executive Committee had reviewed in every meeting the membership report and noticed the number of physicians who were not members of the American Medical Association. The committee decided to call this to the attention of the Council and suggested that the Council consider the advisability of making AMA membership mandatory for all members of the Indiana State Medical Association and its component societies.

Mr. Staunton, of the Wolf Management Engineering Firm, presented his final report and recommendations which were referred to the Council for their action. The committee voted to recommend to the Council that the first two portions of the report be adopted. The third portion was referred without recommendation.

The executive secretary reported on the estimated cost of remodeling—informing the committee that the building management was not ready at this time to make a definite statement regarding this cost. The secretary also reported that negotiations were being conducted for the procuring of additional spaces.

As at all meetings, the committee received a report of the activities of the field staff, and at this meeting they were informed that in some of the counties there was apparently some agitation concerning the inclusion of physicians under a compulsory social security program.

As to the changes in the accounting of the association, the treasurer and the attorney were to investigate which employees should be bonded, and in what amounts, and to arrange for this bonding.

Recommendations of the Wolf Management Engineering Firm concerning the employment of an

investment counselor were discussed and the chairman of the Committee was asked to have representatives of these firms appear before the committee at a future date.

The chairman of the Commission on Legislation reported on the results of the State Legislative Program and on important legislation pending before Congress.

The president commented on the interpretation of the new law concerning T.B. testing of school teachers, and this matter was referred to the Commission on Voluntary Health Agencies for further study.

The chairman of the committee reported he and the executive secretary have done some preliminary work on investigating the establishment by the association of a plan to implement the Keogh Bill when it becomes a law.

Dr. P. T. Lamey, secretary of the State Board of Medical Registration, appeared before the committee and discussed the provisions of the new law concerning citizenship as a requirement for licensure in Indiana and the provision of the law concerning temporary permits for graduates of foreign medical schools.

Doctor Lamey also discussed the Attorney-General's ruling with respect to the opinion concerning the interpretation of the 1955 law governing licensure of chiropractors.

The attorney reported on his meeting with the attorneys for the Hospital and Osteopathic Associations concerning the osteopathic question.

Dr. G. O. Larson, councilor from the 13th District, appeared before the committee for a discussion of the osteopathic question.

A letter from Mr. K. L. Kaufman, chairman of the 1960 Science Fair, which will be held in Indianapolis, was read, in which he requested the association to financially support the 1960 fair. The president-elect was asked to discuss this with Mr. Kaufman and report back to the next meeting.

The executive secretary asked for a statement of policy concerning requests for refunds of dues of deceased members. This matter was referred to the Council for a policy statement.

The executive secretary and the chairman of the Commission on Public Health were requested to represent the association at a meeting of the Joint Council to Improve Health Care of the Aged in Washington, D.C.

Special Meeting, April 22, 1959

The executive secretary presented a letter and a 5-year lease from the Hume Mansur Company, calling for an annual rent of $9,756.00 with a liquidating damages clause, in the event the association cancelled the lease prior to the 5-year period. He also presented estimates for remodeling of the association headquarters—it was estimated to cost between seven and ten thousand dollars.

After fully reviewing all the figures, and discussing this matter, the committee voted that plans for remodeling and expansion be held in abeyance until the membership had been informed and given the committee some direction as to what action should be taken.

June 1959 Meeting

The report of the Building Committee and the results of the poll taken of the membership concerning the remodeling of the headquarters was received by the committee. The chairman of the Executive Committee was authorized to make a canvass of proposed building sites as recommended by the Building Committee.

As directed by the Building Committee, letters from architects concerning proposals for working relationships with the association were read and the chairman of the committee was authorized to negotiate with the architects in accordance with the recommendations of the Building Committee.

The signing of a contract agreement between Blue Cross and Blue Shield and the association was approved.

A letter was received from the Student AMA reporting fully the names of those who attended and participated in the Student AMA annual meeting and refunding the amount of $90.00 of unused money. The letter was read to the committee.

The committee authorized the secretary to request the president of the Indiana Chapter of the Student AMA to make a five-minute report of its activities before the House of Delegates meeting in October.

A letter from Mrs. J. M. Black, president of the auxiliary, was reviewed, in which she requested permission for the auxiliary to make an annual award to some individual who had made an outstanding contribution to the advancement of public health, and rules for the selection of the recipient were reviewed. The committee approved the recommendations of the auxiliary.

A letter from Mr. K. L. Kaufman concerning assistance of the association for the 1960 Science Fair was read, and it was agreed to request the Commission on Public Information to appropriate one thousand dollars of its funds for this purpose.

Letters of appreciation from students and teachers who participated in the 1959 Science Fair, thanking the association for making the trip to the National Fair possible, were read.

A letter from the North Central District Blood Bank Clearing House, asking the association to appoint a member to serve on the Board of Trustees of the Clearing House, was read, and Dr. Jene R. Bennett of South Bend was reappointed.

The request of Dr. Offutt for the association to recommend two representatives to serve on the Vision Advisory Committee was read and Drs. R. P. Good of Kokomo, and James V. Cassady of South Bend, were recommended.

A request from Dr. Offutt for a recommendation by the association of a physician for membership on the Commission for the Handicapped was reviewed and Dr. Neal E. Baxter of Bloomington was recommended as a member of this commission.

A request for financial support of the Farm City Week Program and the National Society for Medical Research were denied.

The chairman reported on a recent Board Meeting of Blue Shield and the committee recommended that the panel program be held at the 1959 Annual Convention, at which time members of the Blue Shield Board of Directors would be available to the entire membership for an open discussion of Blue Shield plans and policies.

The committee took action to request the auxiliary and the Commission on Public Health to institute a study of the over-65 age population in Indiana.

July 1959 Meeting

The AMA membership matter was again discussed and the committee voted to recommend that the Council prepare a resolution making AMA membership mandatory.

The executive secretary reported on the work of the field staff in compiling a census of people over 65 in Indianapolis nursing homes to determine who was providing financial support for their care. He also reported on contacts that were being made with the members of the State Legislature and all the newspapers in the state of Indiana.

The chairman reported that he and the executive secretary would appear before the House Ways and Means Committee in Washington on July 14 to file a statement of opposition to the Forand Bill. The proposed statement was reviewed and approved.

The chairman also called attention to the fact that Congressman Denton has introduced a resolution, known as H.R. 6644, which calls for the construction of an additional V.A. hospital in the Evansville area.

The chairman also called attention to the fact that the chiropractic group would again make an appeal in the 1961 Legislature for a separate board, and recommends that the association be giving some consideration and study to the preparation of legislation to create a basic science board in Indiana, and establishing separate licensing boards under the basic science board for licensure of practitioners in the individual fields of the healing arts.

The 1959 convention program was reviewed and accepted; the selection of a Fifty-Year Club recipient chairman, and many other matters dealing with the 1959 meeting, were discussed and the policies determined.

The committee referred to the Council the action of the American Medical Association concerning relationships with osteopaths.

The secretary reported that the renewal of the V.A. fee schedule for the period of July 1, 1959, through June 30, 1960, had been renewed, with the proviso that the association could re-open negotiations at any time during the life covered by the contract.

Authority was granted to the auxiliary to have a representative on the Nursing Careers Committee of the Indiana League For Nursing.

Dr. Earl Mericle was nominated as a representative of the association to serve on the Advisory Committee for the Indiana Section of the 1960 White House Conference on Children and Youth.

The secretary reported he had had a request from WFBM for supplying a speaker on Russian medicine to appear on their television program, and that he had procured Dr. Otis L. Anderson, the Medical Liaison representative in the Washington office of the AMA, who was a member of a team sent to Russia to study Russian medicine and health programs by the United States Public Health Service, as a participant on this program.

The secretary requested a clarification of the stand of the committee concerning the recommendation of the Wolf Management Company for changing the fiscal year of the association.

On motion, the secretary was instructed that the fiscal year should be changed to comply with the recommendations of the management survey firm.

A letter from the American Medical Association, requesting the executive secretary and the chairman of the Commission on Public Health to attend a planning conference to prepare for a Regional Conference on Aging was read and the secretary and the chairman authorized to attend.

The committee, sitting as a budget committee, approved an additional appropriation requested by the Commission on Constitution and Bylaws in the sum of $62.80.

The committee approved a request of $245.87 as an additional appropriation for the Commission on Medical Economics and Insurance.

The committee approved a request from the Commission on Inter-Professional Relations for an additional appropriation of $250.00.

The secretary called to the attention of the committee that the House of Delegates had created a Building Committee, which had expended $1,430.77, as of this date, but no funds had been incorporated in the budget for this purpose.

It was voted that the auditor revise the budget to include a contingency fund for *ad hoc* committees and that this amount be made a part of such revised budget.

Medical Defense Activities

1. **Malpractice Cases.** A year ago, at the time of this report, Aug. 1, 1958, the following 11 cases were pending before the committee, four of which were closed during the year, leaving seven cases still pending:

Case No. 200—(Closed). Filed February 12, 1932. Dismissed for lack of prosecution.

Case No.251—Filed September 25, 1942. Pending.

Case No. 285—Filed October, 1952. Pending.

Case No. 288—Filed November 12, 1954. Disposed of in Superior Court in 1956; plaintiff has appealed the case. Pending. Expense, $270.00, paid September 12, 1956, and $172.50, paid May 23, 1957.

Case No. 290—(Closed). Filed January, 1954. Settlement made by insurance company with consent of defendant.

Case No. 291—(Closed). Filed January 22, 1954. Settlement made by insurance company with consent of defendant. Expense, on above two cases, $1,211.61, paid January 16, 1959.

Case No. 296—Filed April 9, 1957. Pending.

Case No. 297—(Closed). Filed April 26, 1957. Case dismissed.

Case No. 298—Filed January 31, 1958. Pending.

Case No. 299—Filed May 13, 1958. Pending.

Case No. 300—Filed June 18, 1958. Pending.

Since Aug. 1, 1958, and up to Aug. 1, 1959, the following two new cases have come before the committee, making a total of nine cases pending at the present time as against 11 unclosed cases at the same time last year:

Case No. 301—Filed 1951. Pending.

Case No. 302—Filed July 30, 1957. Pending.

2. **Medical Defense Fund Statement from Aug. 1, 1958 to Aug. 1, 1959:**

Balance, August 1, 1958		$ 869.04
Receipts:		
Dues: 55—1958 members	$ 68.75	
3,776—1959 members	4,720.00	4,788.75
Interest on bonds		748.13
Matured Treasury Bills		3,000.00
		$9,405.92
Disbursements:		
Malpractice fees	$1,211.61	
Attorneys' salaries	1,817.50	
Printing	5.46	
		3,034.57
		$6,371.35
Purchase of U. S. Treasury Bills	$5,000.00	
Less discount on U. S. Treasury Bills	62.91	4,937.09
Balance, August 1, 1959		$1,434.26

Membership Report

County	December 31, 1958	July 31, 1958	July 31, 1959	Delinquent 1959	A.M.A. 1959
Adams	15	15	15	0	14
Allen	256	251	256	0	255
Bartholomew-Brown	40	39	39	0	38
Benton	8	8	8	0	8
Boone	20	20	20	0	21
Carroll	10	10	10	0	10
Cass	42	41	42	0	39
Clark	30	29	30	4	32
Clay	14	14	14	0	14
Clinton	23	23	22	0	22
Daviess-Martin	24	24	23	0	22
Dearborn-Ohio	13	13	14	0	14
Decatur	13	13	13	0	10
De Kalb	21	21	21	0	19
Delaware-Blackford	115	113	110	0	104
Dubois	24	24	22	0	19
Elkhart	101	100	103	0	96
Fayette-Franklin	22	22	20	0	19
Floyd	39	38	38	0	39
Fountain-Warren	16	15	16	0	16
Fulton	12	12	12	0	11
Gibson	17	17	17	0	17
Grant	60	60	62	1	63
Greene	18	18	18	0	10
Hamilton	20	20	22	1	11
Hancock	20	20	21	0	21
Harrison-Crawford	13	13	14	0	13
Hendricks	19	19	19	0	19
Henry	42	40	42	0	42
Howard	47	47	51	1	52
Huntington	23	23	22	0	22
Jackson	20	20	19	0	15
Jasper-Newton	15	15	14	0	14
Jay	17	17	18	0	16
Jefferson-Switzerland	30	29	29	0	27
Jennings	8	8	8	0	5
Johnson	26	24	31	0	32
Knox	42	42	41	0	39
Koscuisko	15	15	17	0	17
La Grange	8	8	8	0	8
Lake	394	373	392	2	353
La Porte	89	88	88	0	86
Lawrence	26	26	26	0	23
Madison	108	105	105	0	101
Marion	1,036	1,035	1,067	1	1,070
Marshall	23	23	22	0	22
Miami	21	21	21	0	19
Montgomery	28	28	29	0	29
Morgan	18	16	17	0	18
Noble	23	23	22	0	22
Orange	11	11	11	0	13
Owen-Monroe	54	54	54	0	49
Parke-Vermilion	22	22	20	0	22
Perry	12	12	13	0	13
Pike	3	2	3	0	5
Porter	21	21	24	0	24
Posey	11	11	11	0	12
Pulaski	6	5	7	0	6
Putnam	16	16	16	0	16
Randolph	21	21	21	0	19
Ripley	13	13	13	0	10
Rush	15	15	15	0	15
St. Joseph	224	222	217	0	217
Scott	3	3	3	0	3
Shelby	18	18	16	0	16
Spencer	8	8	8	0	5
Starke	6	6	6	0	6

County	December 31, 1958	July 31, 1958	July 31, 1959	Delinquent 1959	A.M.A. 1959
Steuben	13	13	14	0	14
Sullivan	16	16	14	0	12
Tippecanoe	101	99	103	0	103
Tipton	11	11	11	0	11
Vanderburgh	209	207	211	0	203
Vigo	115	113	115	0	114
Wabash	22	22	24	0	24
Warrick	13	11	11	0	13
Washington	7	7	7	0	7
Wayne-Union	82	82	81	0	73
Wells	35	35	34	1	34
White	11	11	11	0	11
Whitley	18	18	17	0	17
	4,201	4,143	4,221	11	4,096

THE JOURNAL

Advertising

This is a comparative report for the first six months of each year indicated.

State Journal Advertising	1956	1957	1958	1959
Bureau	$14,627.89	$20,884.69	$29,253.57	$40,978.58
Sold Direct by JOURNAL	5,298.24	5,016.54	2,692.19	3,083.18
Total	$19,926.13	$25,901.23	$31,945.76	$44,061.76

NOTE: July—1958 Local ads $1692.45

PRINTING COST

Year	Cost	No. of Pages (Inserts excluded)
1955	$33,648.28	1628
1956	38,415.57	1816
1957	46,211.34	1920
1958	50,093.16	1872
1959 (6 months)	32,163.72	1086

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Adv. Pgs. per Issue
1955	820	55	672	45	1492	124.3
1956	890	53	782	47	1672	139.3
1957	910	51	862	49	1772	147.7
1958	1055	52	969	48	2024	169

EXECUTIVE COMMITTEE

DON E. WOOD, M.D., *Chairman*
WENDELL E. COVALT, M.D.
KENNETH L. OLSON, M.D.
EARL W. MERICLE, M.D.
GUY A. OWSLEY, M.D.
OKLA W. SICKS, M.D.

The Journal

The staff of *The Journal* is happy to report on a successful year of publication, both from the scientific and financial viewpoints. Advertising revenues have increased sufficiently to offset any increased costs of production, and have also made it possible to enlarge the scientific content. Financial details are contained in the report of the Executive Committee.

The Journal adopted a newly designed cover one year ago with the 1958 convention issue. Scenic illustrations of outdoor Indiana and appropriate art work reproduced in color have featured the cover since that time. This has been well received and will be continued.

During the year we have inaugurated two new features. "Condensed Cardiology" is a brief discussion of the clinical aspects of cardio-vascular disease which is prepared under the guidance of the staff of the Robert M. Moore Heart Clinic. This presentation is designed to review in capsule form the most common conditions and to combine this discussion with the newer ideas in therapy. It will be a regular monthly feature.

The Indiana Association of Pathologists have agreed to furnish a short article—"Path-finder"—to inform the membership concerning the new diagnostic laboratory procedures, new applications for old procedures and new developments in clinical pathology. This will appear at intervals compatible with the supply of suitable material.

Recently *The Journal* was entered in the non-award classification of a magazine judging contest conducted by the International Council of Industrial Editors. Content, writing and appearance were all critically examined and graded. The report received was highly complimentary to our technical staff. A numerical grade of 82.85 was received. Constructive criticism will enable us to improve the format of *The Journal*. It is expected that a special category will be added to the competition in 1960, in which we may compete for an award.

The number of well written scientific papers which were submitted during the year has increased to a marked degree. We now have an adequate supply of papers from this source and from several of the scientific medical meetings and post-graduate programs over the state.

Student Loan

BALANCE in Fund, June 30, 1959		$ 515.27
Donation to Fund, 8/29/58, E. S. Jones, M.D.		33.00
Transferred from General Fund, 1/16/59, as authorized by House of Delegates in meeting, October, 1958		5,000.00
Payments on notes during year		1,020.02
		$6,568.29
EXPENDITURES		
Loans: 9 at $500.00	$4,500.00	
1 at $400.00	400.00	
1 at $300.00	300.00	
3 at $150.00	450.00	
		5,650.00
BALANCE in Fund, July 31, 1959		$ 918.29

Since the creation of the Student Loan Fund in 1956, 36 students have been granted loans totaling $20,995.02, $1,470.02 of which has been repaid. Nine students hold notes on which payments are due and are being made at this time. The balance of the notes are not due until after July 1, 1960.

At the time of this report eight applications for loans are pending.

HARRY PLUMMER ROSS, M.D., *Chairman*
KENNETH L. OLSON, M.D.
OKLA W. SICKS, M.D.
JOHN D. VAN NUYS, M.D.
NORMAN R. BOOHER, M.D.
SAMUEL E. BECHTOLD, M.D.

NOTES

Reports of Commissions

Legislation

The Commission on Legislation has completed what may be one of the most successful years in our existence. The commission was organized in November 1958 and immediately began work on preparation for the 1959 session of the State Legislature.

A survey was conducted by the field men who visited all successful candidates for the State Legislature, making their acquaintance, getting their views on proposed legislation and their feeling toward the medical profession. The results were then catalogued and component societies were informed of the impression our field staff gained of these men as to their cooperation with the profession. Also, while making the survey, names of the family physicians of the candidates were obtained and a mailing list to these physicians, as well as to the society legislative chairmen, was established.

We are happy to report that this past year saw the best cooperation from the members of the association with your commission in years, which was largely responsible for the success of our efforts in behalf of improved public health.

The Legislature saw fit to pass, amend as recommended by the Association, or refuse to pass as recommended by the Association, the bills in which we had a valid interest. Only two which we supported did not become law: (1) the bill authorized by the House of Delegates to provide for a physician to be a member of a county hospital board, and (2) the bill to provide that all registration fees paid the State Medical Board be for the exclusive use of the Board.

The chiropractic bill was back again and this session we had the chiropractic member of the House as author of the bill and as chairman of the Health Committee of the House, which was the committee to consider the chiropractic bill as well as all other health bills.

Through the cooperation of the auxiliary and the component societies, the Health Committee of the House received over 400 telegrams the morning the chiropractic bill was scheduled for consideration. All the committee accomplished was the opening of telegrams and, as a result, the bill was delayed from coming out of committee for over two weeks. Again through the assistance of the auxiliary and the societies, the chiropractic bill was defeated on the floor of the House by the greatest majority in years. This also marked the first time this bill has been killed in the house of origin.

The commission desires to thank the auxiliary, the component societies and the family physicians of members of the Legislature for the help and the time they devoted in making possible whatever success we had.

Even while the Legislature was in session, Congress convened and your commission was also busy contacting members of Congress concerning federal legislative proposals.

Two national issues have received active interest on our part, one the Simpson-Keogh bill, the other the Forand bill. Your commission was in almost constant contact with some of the key leaders in the House and the House did see fit to suspend the rules and pass the Simpson-Keogh bill. It is currently awaiting Senate action, and we are told there is a possibility the bill will pass this session of Congress.

The Forand bill, to amend the social security act to provide at government expense hospital and surgical care for recipients of social security, was a subject of a hearing by the House Ways and Means Committee of the Congress. On June 14, your commission entered a statement in opposition to the proposal before the committee. Testimony was heard from both opponents and proponents. The latest word is that this bill does not have much chance of passing this session, but it is anticipated it will be a major issue this next year.

On April 27 of this year, your commission conducted its annual dinner for the members of the Congress and their administrative assistants. We are happy to report that every senator and representative from the state of Indiana and their assistants were present. We believe this was one of the most successful meetings we have held and much was accomplished in discussing our views with our Indiana delegation on legislation having to do with public health. We recommend that this program be continued.

Your commission makes the following recommendations for consideration and approval by the House:

1. The chiropractic issue will again be an issue in the 1961 session. While we were successful in beating down their effort to lower their standards, there is an apparent growing feeling among some that separate licensing boards should be established, one for each branch of the healing arts. Much has been said that Indiana should have a basic science board which every person desiring to practice any phase of the healing art would be required to pass. Upon passing this board, he would then be examined by a medical board, an osteopathic board, a chiropractic board, etc. Some feel this would relieve the medical profession from criticism from other groups and from

the public for the acts and deeds of others. We, therefore, recommend that a special study be made of the advisability of introducing into the 1961 State Legislature such a bill, to create a basic science board and separate boards for the various branches of the healing arts.

2. We recommend that a study be made of our present licensing system in relation to the national Licensing Board. Should Indiana recognize the national board licensees for licensure by reciprocity?
3. We recommend that a study be made of our present provisions concerning foreign physicians as well as U. S. physicians who desire to come to Indiana for training and postgraduate work.
4. We recommend that the House of Delegates urge the component societies, councilor districts and the auxiliary to cooperate in establishing an effective action plan which will immediately go into action when needed in our legislative program.
5. We recommend that the House of Delegates strongly recommend that all component societies take an active part in contacting all candidates for the State Legislature and the Congress and other public offices to determine the position of the candidates on health legislation.
6. We recommend that the House of Delegates in turn urge the members of this association to urge qualified persons in their respective communities to announce for public office, and receive the support of the members in their candidacy.
7. We recommend that component societies develop a plan whereby physician members of their society might be provided with the time to serve in public office and actively participate in organizational activities. We believe the physicians of a community could do much to care for the practice of one of their members who is willing to devote his time to serving his profession in these fields.
8. We recommend that a study be made of the medical program of Civil Defense, and that physicians generally take a more active interest in this program.
9. We recommend that an *ad hoc* committee be established for an intensive study of all phases of medical services in Indiana, including the care of the needy and the aged.
10. We recommend that the meeting in Washington with the Indiana members in Congress, and active participation in the meeting of the U. S. Chamber of Commerce which is held at the same time, be continued.
11. We recommend that the association and all component societies actively participate in the state and U.S. Chambers of Commerce and the local Chambers of Commerce.

We submit the above for your consideration and request your approval of the recommendations.

Don E. Wood, M.D., *Co-chairman*
Walter E. Portteus, M.D., *Co-chairman*
Max R. Adams, M.D.
Joe M. Black, M.D.
P. J. V. Corcoran, M.D.
Kenneth O. Neumann, M.D.
Eugene F. Senseny, M.D.
James P. Vye, M.D.
Richard H. Woolery, M.D.
Robert O. Bethea, M.D.
Otis R. Bowen, M.D.
Paul T. Lamey, M.D.
William C. Stafford, M.D.
Paul R. Tindall, M.D.
Joseph G. S. Weber, M.D.

Public Information

The purpose of the Commission on Public Information is to collect and organize for dissemination to the public all matters of public interest within the field of medicine, including the activities of other commissions in which the public interest would be involved, and including the achievements in the advancement of medicine which would be of interest to the public, to develop and maintain the relations of the medical profession with the public in such a way as to give the lay public a better knowledge and understanding of the aims, objects and value of the profession to the public. In order to accomplish these objectives the commission was broken into committees. The remainder of this report will be the reports of these committees. All committee recommendations are condensed at the end of this report.

The commission, at their first meeting, was divided into sub-committees to deal with the many varied activities to be dealt with. These divisions were as follows:

(1) Science Fair

(2) Health Hints—Radio and T.V.

(3) State Fair Exhibits

(4) Coaches Conference—Athletic Injuries

(5) Medical Assistants Program

Three meetings were held during the year and the activities of the commission are hereby summarized in this report.

1. Science Fair

The National Science Fair was held in Hartford, Conn., May 6-9, 1959. As in the past, all Indiana Regional Science Fair winners and their escorts were provided with transportation from Indianapolis to Hartford and back. Three representatives of the Indiana State Medical Association accompanied this group. The chairman of this commission, Dr. Harry Pandolfo, Dr. Ralph Eades

of Valparaiso, and Miss Corki Wilson, of the ISMA *Journal*. A detailed report of this Science Fair, prepared by Corki Wilson, appears in the July issue of the ISMA *Journal*.

In 1960, the National Science Fair will be in Indianapolis and the ISMA will be among those sponsoring this national event at that time. The ISMA Council has approved participation in this event and the allotted substantial financial support to this important public relations activity.

The ISMA is represented on the local arrangements committee by Drs. Mericle and Pandolfo and Mr. James Waggener. Science Fair visitors to Indianapolis in 1960 will find that medicine will be prominent among the attractions planned for this event. The tours for visitors will include: The Indiana University Medical Center, Eli Lilly and Company, and Pitman-Moore Company at Zionsville. As in the past, the AMA awards banquet will be a highlight of the meeting.

This commission feels that continued participation in the Science Fair movement is a very desirable public relations venture.

2. Health Hints—Radio and T.V.

Health Hints: The column "Health Hints" was distributed to approximately 200 Indiana newspapers, as in the past. The field secretaries have called numerous newspaper editors and several newspapers have been added to the list of those printing "Health Hints" on a weekly basis. These columns are all reviewed by members of the commission for corrections or additions prior to publication.

Radio: County medical societies have received lists of available radio transcripts that can be used by radio stations in their respective areas. Many of the county societies have used these programs as part of their public relations activities.

T.V.: The committee arranged for Dr. Otis Anderson of Washington, D.C., to appear on WFBM-TV at 6:30 p.m., on July 19, on the program, "Vista." The subject was "Medicine in Russia." Dr. Anderson was a member of the United States Public Health Service Mission sent to Russia for an extensive study of Russian medicine and health programs.

He is the co-author of a report to the Department of Health, Education and Welfare of the U.S.P.H.S.

3. State Fair Exhibits

Exhibits for the Indiana State Fair will be sponsored by the ISMA, as in the past. The AMA Bureau of Exhibits reserved for our use at this fair the following exhibits:

(a) Choosing your Career in Medicine

(b) Immunization

Members of the Women's Auxiliary of the Marion County Medical Society will serve as attendants at this exhibit, as in the past. In addition, medical students will be employed for the purpose of taking blood pressure readings of visitors who wish this service.

4. Coaches Conference—Athletic Injuries

By previous action of the ISMA House of Delegates the Coaches Conference on a state-wide basis was discontinued. It was recommended that county societies continue this worthwhile project on a local level.

The AMA booklet on planning Coaches Conferences was distributed to all county societies to aid in planning this type of activity. Several county societies have conducted very fine conferences and continued activity in this area is recommended.

No progress was made in the matter of a study of athletic injuries in Indiana. A continued search for some qualified doctoral candidate to conduct this study is in progress. Continued activity in this project is recommended.

5. Medical Assistants Program

The Indiana University Extension Center in Indianapolis is in the process of instituting an in-service training program for medical assistants. This has been prompted by the requests for such a training program from many medical assistants in the state. This will be a pilot course to investigate the possibilities and if well received will be instituted at other Indiana University Extension Centers throughout the state. The course, as planned, will be a non-credit college level course covering six subjects, and will be given one night weekly. Two subjects will be covered each semester and three semesters will be necessary for completion of the total course.

This commission feels that the training course for medical assistants is a worthwhile endeavor and the following participation by the ISMA was recommended to the Council and approved; to be instituted when this course begins.

(a) That the ISMA, through this commission, encourage participation by medical assistants in this course;

(b) That adequate publicity be given this course, both to the medical profession and the medical assistants;

(c) That physicians be encouraged to assist in defraying the cost of this course to their employees who wish to attend these classes;

(d) That an advisory committee on a state level be set up to work with the Indiana Medical Assistants Association and the Indiana University Extension Center in Indianapolis. This is to be done in order to help formulate the program so that the courses offered can be of more value to those participating;

(e) That those medical assistants who complete a satisfactory portion of this total course be given some recognition. Possibly a certificate of completion, and notice of receipt of certificate in the ISMA *Journal*.

Recommendations

This commission feels that the preceding report in itself embodies many recommendations—briefly, these can be summarized as follows:

(1) Continued participation in Science Fair activities is desirable. The degree, nature and extent of this participation to be determined by the Council after study of this problem by this commission;

(2) Continued activity with Radio, T.V. and newspapers, as in the past.

(3) State Fair Exhibits should be conducted as in the past, varying the exhibits as has been done so that some important timely subjects may be covered.

(4) Continuation of Coaches Conferences on a county level, and continued efforts to complete a study of athletic injuries in Indiana.

(5) Participation in the training program for medical assistants, as outlined in this report.

HARRY PANDOLFO, M.D., *Chairman*
WILLIAM BANNON, M.D., *Vice-Chairman*
HARRY BAXTER, M.D., *Secretary*
HARRY PARMENTER, M.D.
R. L. KLEINDORFER, M.D.
B. E. SUGARMAN, M.D.
WILLIAM R. TINDALL, M.D.
EARL W. MERICLE, M.D.
SETH W. ELLIS, M.D.
JAMES M. KIRTLEY, M.D.
FRANKLIN F. PREMUDA, M.D.
HOWARD H. MARKS, M.D.
THOMAS HAMILTON, M.D.
JAMES F. RIMEL, M.D.
THOMAS D. ARMSTRONG, M.D.

Governmental Medical Services

The organizational meeting of your Commission on Governmental Medical Services was held Nov. 23, 1958, and sub-committees were appointed to study the various problems assigned the commission. This commission was assigned the following areas:

(1) Civil Defense
(2) Crippled Children and Rehabilitation
(3) Liaison with the State Department of Public Welfare
(4) Military Manpower
(5) Veterans Medical Care Program
(6) Medicare
(7) Liaison with the Indiana State Board of Health
(8) Continue the work of the Liaison Committee on Veterans Affairs

Your commission has held three (3) meetings during the past year and we shall report on the activities of this period.

Civil Defense

The activities toward Civil Defense have been limited this year since the state plan entitled "State of Indiana, Emergency Operation Plan, Annex N, Health, Medical, and Mortuary Services" was being rewritten and received approval only on June 1, 1959. This plan will be reviewed and your commission will continue to work toward a workable disaster plan for the state.

The commission was represented at the annual Conference on Civil Defense sponsored by the AMA in Chicago on Nov. 30—Dec. 1, 1958 and at the annual Civil Defense Program meeting in Atlantic City, June 6, 1959. This was without cost to the association.

There is continued study nationally on the problem of radiation hazards; and when a conclusion is final, we shall report these findings.

Department of Public Welfare

The liaison with this department has continued, and there has been a slight increase in the number of agreements between the local department of public welfare and county societies. There will be continued effort to work with the Indiana Department of Public Welfare during the next year. It is hoped that the Advisory Board to the Department of Public Welfare might be reorganized and be active as it was a few years ago. The commission also again recommends that there should be a liaison or review committee between the county medical societies and their local department of public welfare.

Veterans Care Program

The contract with the Veterans Administration was renewed with the understanding that negotiation could be reopened if the need arises.

There is still some conflict as to nomenclature and use of the standard code, but this is to be resolved as soon as possible.

Veterans Affairs

The Committee for Liaison on Veterans Affairs has met quarterly with like committees from the American Legion, Indiana Hospital Association and Indiana State Dental Association.

The various organizations rotate in chairing the meeting and acting as hosts. Problems such as the criticism of Veterans Administration residencies by the American Medical Association have been studied and the rationale of such discussed.

At the last meeting when administrators of the Indiana Regional Veterans Administration Medical Office and administrators of Veterans Administration Hospitals in Indiana were invited to attend, it was learned that present Veterans Administration policy requires the submission of a financial statement by a veteran with a nonservice connected disability when applying for hospitalization in a V. A. hospital. If the veteran's financial statement shows that he could afford private medical care, then he is not accepted for V.A. medical care.

In spite of this new limitation on medical care of veterans with non-service connected disabilities in V.A. hospitals, the President of the United

States and veterans administrators anticipate more utilization of Veterans Administration hospitals for N.S.C.D. cases in future years; and funds for building and staffing new Veterans Administration hospitals are continually being appropriated ($60 million for the next year).

These meetings, where there is constant emphasis by the American Legion representatives, to the thesis that every veteran deserves special consideration simply because he is a veteran, try one's patience; but the exchange of ideas is probably good and participation should be continued.

Medicare

The Medicare program in the state of Indiana, in spite of some restrictions and retrenchments, is still very much alive and an active portion of your Association's work. To give you some idea of the volume of the work handled relative to this program, there were 2,821 new claims received during the first six months of 1959 and during the same period of time $223,656.17 was paid out to Indiana physicians for services rendered military dependents under this program. Also, there is great possibility that this program will be expanded again.

Your committee again wishes to call to your attention that Medicare is not a pay-all program. Physicians participating in this program would do well to become better informed as to the coverage afforded by the program.

Also your committee feels that you should be informed as to the most common errors committed on your claims. As stated above, 2,821 claims were received during the first six months of 1959. Of this number, 1,297 or 45.97% were returned to the physician for correction or rejection. A record of the reasons for returning claims is not kept, but most of them are returned because they are improperly completed. Not more than 10% are returned because the services are not covered by Medicare.

The following are the major reasons for returning claims: Absence of dates of services performed and absence of permit or certification of acute emergency. Some are returned because the patient or accompanying parent has not signed the certification in item 14 and some because the charge physician signs item 30 or 31 rather than item 29. Also some because on the claims for prenatal care only the charge physician does not give the expected date of delivery. And there are some because of absence of medical authorization card and expiration date.

The above are some of the more common reasons that such a large percentage of claims must be returned for correction. Your committee feels that a large portion of these errors can be eliminated if the physicians over the state are better informed regarding the program. It is being proposed that we work through the local levels of county organizations with the field secretaries of the ISMA attending the county meetings and explaining the program.

Liaison With State Board of Health

An Institute for General Hospital Administrators and Nursing Supervisors on the Care of Mental Patients in General Hospitals was conducted at the Indiana State Board of Health on March 18-19, 1959.

The purpose—To encourage general hospitals to admit mentally ill patients for treatment of acute mental illness and to provide medical care until commitment to a mental institution, when indicated, can be arranged.

At the request of the Indiana State Board of Health, the Indiana State Medical Association participated in planning the program for this meeting and acted as co-sponsor, together with the Indiana League of Nursing, Indiana Association for Mental Health, Indiana Hospital Association and the Indiana Division of Mental Health.

The Tri-Kappa Sorority of Indiana underwrote all expenses for this meeting, as well as expenses for regional workshops for general duty nurses to be conducted this fall, to train nurses to handle mentally ill patients. The Tri-Kappa raised the money to pay the expenses of these meetings by their local chapters all over the state having "coffees."

The same sponsors have been asked to approve a statement of policy regarding the admission of the acute mentally ill patient to general hospitals as follows:

1. The mentally-ill or emotionally-ill person is a sick person in need of medical care and who may require hospitalization. The patient's own physician and the patient's own general hospital are the primary sources of general care which include mental and emotional illnesses for the patient and the patient's family. The general hospital in its ever-increasing role as the community health center should make available broader-type health services in co-operation with its medical staff to more completely serve the needs of the patient.

2. Patients with mental and emotional disturbances have varying degrees of illness and require as wide a range of services as the patient who is suffering from an acute physical ailment. Patients with many types of emotional disorders and mental diseases may be treated in the general hospital where adequate staff and facilities are available. The general hospital, in this instance, should serve as a diagnostic facility where the patient's own physician can direct the diagnostic and treatment program. The physician will determine the course to be pursued and prescribe the services that best meet the patient's needs, which may mean: (a) continued care in the general hospital where professional psychiatric direction may be available, after which the patient may be able to return home or may need to be transferred to a psychiatric hospital; (b) temporary care in

the general hospital where security quarters are available until appropriate arrangements for the patient are made.

3. In no instance will care in the local jail be considered proper care for a psychiatric patient. In communities where hospitals do not have security rooms or pyschiatric units, the Hospital Association, the Medical Association and the Association for Mental Health may work cooperatively to provide the type of service needed to meet the community's needs.

Mental Health

This problem has been discussed and as can be seen by the report on the above subject, some work has been done on it.

There are other problems in this field which we would like to refer to the Commission on Legislation for the study. While it is possible to commit an individual to a state institution on an involuntary basis, there is no law providing for the same legal procedure to a local county or general hospital, and members of this commission feel that this might be of great help in getting these people under care more rapidly.

Your commission was represented by Dr. H. Stimson at the Fifth Annual Conference on Mental Health Nov. 21-22, 1958. After his return and reporting to the commission, Dr. Stimson feels that a member of the psychiatric field should be sent to represent the association; therefore, the commission so recommends.

Military Manpower

There has been no problem in this field. It is reported that the Berry Plan has been of help in providing medical military manpower.

Recommendations

The commission wishes to recommend the following:

(1) The following activities be transferred to the Commission on Public Health:
 (a) Maternal and Child Welfare
 (b) Liaison with State Board of Health
 (c) Alcoholism

(2) Continuation of representation to the Liaison Committee on Veterans Affairs.

(3) A study of the committment laws in regard to mental patients to obtain some type of legislation for commitment to local, county or general hospital.

(4) Continued effort both on state and local levels for disaster planning.

(5) The setting up of a program by the ISMA for indoctrination and clarification on filling out Medicare forms. This will take cooperation from the physicians in the state to allow their staff time to attend these short meetings.

Your commission wishes to express their feeling of gratitude to the Commission on Legislation for their hard work on legislation both on state and national fronts.

We feel that more activity on the local level must be forthcoming to help this group in their endeavors.

The Commission on Governmental Medical Services wishes to thank Mr. Waggener and his staff for their assistance and guidance during the past year.

Glen Ward Lee, M.D., *Chairman*
V. Earle Wiseman, M.D.
Charles R. Alvey, M.D.
George Willison, M.D.
Frederick R. Smith, M.D.
I. E. Huckleberry, M.D.
William A. Johnson, M.D.
Robert E. Williams, M.D.
A. G. Popplewell, M.D.
Harry R. Stimson, M.D.
Stanley M. Mendelson, M.D.
Don F. Cameron, M.D.
James M. Wilson, M.D.
Guy A. Owsley, M.D.
Jean V. Carter, M.D.

Public Health

The Commission on Public Health met for its organizational meeting on Nov. 23, 1958.

The following officers of the commission were elected: Emmett B. Lamb, M.D., chairman, John A. Davis, M.D., vice-chairman and Howard T. Hammel, M.D., secretary.

The anticipated program for the year was discussed and the following committees were established:

Traffic Safety

Howard T. Hammel, M.D., Chairman
John C. Richter, M.D.
Robert K. Webster, M.D.
Forrest J. Babb, M.D.

Rural Health and Physician Placement

John A. Davis, M.D., Chairman
Joe Dudding, M.D., Assistant Chairman
E. S. Rifner, M.D.
Robert K. Webster, M.D.
Forrest J. Babb, M.D.
Betty Dukes, M.D.

Conservation of Hearing and Vision

Allan K. Harcourt, M.D., Chairman
Betty Dukes, M.D.
Richard C. Swan, M.D.
William Baughn, M.D., ex-officio

Industrial Medical Practices and Programs

Richard C. Swan, M.D., Chairman
Allan K. Harcourt, M.D.
E. S. Jones, M.D.
John C. Richter, M.D.
Lall G. Montgomery, M.D.

Preventive Medicine and Liaison with State Board of Health

Robert K. Webster, M.D., Chairman
Robert M. Lohman, M.D.
Joe E. Dudding, M.D.
Daniel M. Hare, M.D.
John A. Davis, M.D.

It was further decided at the organizational meeting that the problem of the aged and aging should be handled by the commission as a committee of the whole.

Following this organization meeting, three other meetings were held for the transaction of the business presented.

The last meeting, held July 1, was thought to be the last anticipated meeting for this year and was featured by a trip to the General Motors Technical Center at Warren, Mich. This meeting was interesting and informative for the commission.

All members were agreeably surprised to learn of the realistic research done by the General Motors Corporation along lines of industrial hygiene and community hygiene. Also, it was reassuring to note that the engineers of the corporation are sincerely attempting to build, not only efficient, modern automobiles, but safer automobiles. In further evidence of the effort for traffic safety, the study and research in the highway construction was demonstrated. Also, a very frank and informative discussion was had with Mr. Chayne, vice president of the General Motors Corporation, along these lines.

The committees of the commission send the following reports:

Aging and Aged

The work of the Committee on the Aged and Aging has been featured by discussion of problems presented at each committee meeting and numerous letters of information to the membership.

The Section for discussion of the problem of the aged and aging in the AMA Convention at Atlantic City was attended by Dr. E. S. Jones as a representative of this committee.

The National Conference for the Problems of the Aging, held in Washington, D.C., in June, 1959, was also attended by Dr. E. S. Jones, representing the Indiana Commission on Public Health.

Dr. Jones, reporting on these two meetings, indicated that many areas of the needs for aging people were being explored. He states that many of these seem to fall in a non-medical field, but the medical care of the aged and aging is still one of the important, primary factors. The social-economic phase seemed to take the most prominent part of these conferences.

Dr. Emmett Lamb represented the commission at the meeting of the State Commission for Care of the Aged on July 9, 1959. At this meeting, Dr. Robert Yoho presided and various phases were discussed by the state commission which had been established by the Indiana State Legislature. One of the particular areas of discussion was that of the nursing home problems, as to standards of fire protection, sanitation and medical care, with particular contrast of the private nursing home with the county nursing home.

I was then asked if the commission and its county committees could expect assistance from organized medicine and I advised that the Commission on Public Health would urge the county committees of the state commission to immediately establish liaison with the officers of the county medical societies.

I then arranged to supply Mr. Hunsucker with the names of the county society officers.

Recommendations:

It is recommended that the Commission on Public Health of the Indiana State Medical Association continue in its active representation in meetings concerning this problem; second, further attention should be called to this problem at the county level, and the county medical society officers be urged to cooperate with local organizations, and especially with the committees from the Commission of the State of Indiana for the Care of the Aging.

The following are the reports from the sub-committees of the commission:

1959 Report of the Rural Health and Physician Placement Committee:

This committee is a sub-committee of the Commission on Public Health. The first meeting was held on Nov. 23, 1958, at the Student Union Building, at which time it was decided to have another Junior-Senior Day, and to send the chairman to the National Rural Health Conference in Wichita on March 5, 6, 7. A report of this meeting was given at the Junior-Senior Day meeting held at the Columbia Club on March 21, which unfortunately fell on the same day as the State Basketball Tourney. A very fine program was presented to a fairly small group of medical students and their wives. While the number of students attending was small, those present were quite interested and in the small informal groups after the program asked many questions.

The refreshment and social hour after the program was furnished by Meade-Johnson Company and the banquet was sponsored by Blue Shield. However, it would be advisable next year to enlist the full cooperation of the dean of the medical school.

A meeting was arranged for early August with Mr. George Doup, president of the Indiana Farm Bureau, and Dr. S. F. Crockett, chairman of the AMA Council on Rural Health and allied farm leaders from the Purdue Extension for exploratory discussions on how the medical society can be

of more assistance to them in health education fields.

A meeting was also held at the Student Union Building on May 3 with representatives of the Indiana Heart Foundation and members of the Purdue Farm Cardiac Project, headed by W. H. M. Morris, Ph.D. At this meeting an attempt was made to coordinate the efforts of these three groups. A set of slides is being prepared suitable to be presented by the county rural health chairman as a program for the local medical society. Another set of slides is being prepared suitable for farmers' meetings. Pamphlets for distribution are also being prepared.

JOHN A. DAVIS, M.D., *Chairman*
JOE DUDDING, M.D., *Assistant Chairman*

Industrial Health

The Industrial Health Committee of the Commission on Public Health has met several times during the past year in committee and commission meetings.

Problems studied have been: 1) Medical Care for the Aged—Retired Employee; 2) H. & A. Insurance and Blue Cross-Blue Shield; 3) Workmen's Compensation Legislation; 4) Immunization of Industrial Employees.

Close contact was maintained with proposed changes in the Workmen's Compensation Law as they were considered by the 1959 Session of the Indiana Legislature. Letters were written to committees of the Legislature concerning medical problems in Workmen's Compensation.

Following are amendments to Workmen's Compensation and Occupational Disease Acts of Indiana, 1959, of interest to physicians:

SECTION 31—

Amputation of the leg below the knee 175 weeks instead of 150. The leg above the knee 225 weeks instead of 200 weeks.

Permanent loss of the sight of one eye 175 weeks instead of 150.

Loss of one testicle 50 weeks and loss of both testicles 150 weeks.

Note: No changes on the above benefits were made in the O.D. Act.

SECTION 40—

The average weekly wage of an employee on and after April 1, 1959, shall be considered to be not more than $65.00 and not less than $30.00. (This results in a maximum rate of compensation of $39.00 per week instead of $36.00.)

Amendments to Sections 31 and 40, of the Workmen's Compensation Act, and Section 11 of the Occupational Diseases Act, carry an emergency clause making them effective **April 1, 1959.**

Our final meeting was held at the General Motors Corporation Technical Center at Warren, Mich., where a part of the Corporation's Industrial Hygiene program was presented.

Methods of shielding employees from radiant heat sources were presented. Means of suppressing noise in industrial operations were demonstrated. A unique and ingenious device to sample and analyze the atmosphere within and without an automobile was shown. This apparatus was especially designed to study smog conditions and the re-circulated air inside of air-conditioned cars. Lastly, we observed the corporation's new means of rapid analysis of a blood sample for lead-using photospectography. Reports may now be given within a half hour of receipt of the sample; older methods took much longer.

The committee was also privileged to inspect the various excellent medical facilities provided for the center's 13,000 employees. Dr. S. D. Steiner, General Motors medical director, addressed the group.

R. C. SWAN, M.D., *Chairman*

Conservation of Hearing and Vision

The Committee on Conservation of Hearing of the commission is keeping alert to the increasing amount of literature on the subject in medical publications.

We observe that in industry, experience in other sections of the country regarding claims for hearing loss due to industrial noise should warn all industry to have accurate hearing tests and appraisals on employment, periodic tests on those workers subjected to increased noise, and reduce noise hazards when possible.

We approve the periodic testing of hearing in school children.

We have interest in the varying types of hearing aids offered the public.

We are happy to have had the consulting services, in the past year, of Dr. Baughn of Anderson, who has kindly consented to assist us as an expert in the field of Industrial Hearing Conservation.

A. K. HARCOURT, M.D.

Preventive Medicine and Liaison with State Board of Health

At the organization meeting of the Commission on Public Health and Traffic Safety, Nov. 23, 1958, it was agreed that the commission chairman, Dr. Emmett B. Lamb, appoint the Committee for Liaison with the State Board of Health.

A berief meeting was held on Jan. 4, 1959, as a portion of the joint meeting of the Commission on Public Health and the Commission on Medical Economics and Insurance. This meeting was also attended by Dr. A. C. Offutt and Dr. W. C. Anderson of the Indiana State Board of Health. There have been no more formal meetings of the commission.

The committee wishes to commend Dr. Offutt and his staff on their excellent cooperation. The State Board of Health under his able supervision is rendering the State of Indiana most efficient service and also assisting the medical profession of Indiana in giving more efficient care.

This committee has also served as part of the Study Committee on Aging which was undertaken by the commission as a whole.

ROBERT K. WEBSTER, M.D., *Chairman*

Traffic Safety

At the initial meeting of the Commission on Public Health held on Jan. 7, 1959, at the Student Union Building, Indiana University Medical Center, Indianapolis, Ind., the above named Committee on Traffic Safety was appointed for the purpose of investigating and promoting traffic safety.

At this meeting, as well as at the previous meeting, the Traffic Safety forum was suggested and accepted for promotion on Feb. 15th, 1959. Work was begun immediately and by January 21st all the positions on the forum were filled.

This Traffic Safety conference was to consist of a luncheon to be held before the conference. There was a portion on prevention of accidents to be presented by Seward E. Miller, M.D., director of the Institute of Industrial Health at the University of Michigan, on the "Medical Guide for Physicians Determining Fitness of Motor Vehicle," written by the American Medical Association.

The second portion was the "Indiana Licensing Law and Suggestion of Improvements," by Robert L. McMahan, Commissioner of Motor Vehicles of Indiana.

The third portion of the Prevention of Accidents was presented by Albert E. Huber, director of Traffic Safety of Indiana, on "Law Enforcement and Suggested Improvements."

The second portion of the program was on "Prevention of Morbidity and Mortality." It was presented in three parts: first, "Automative Engineering in the Prevention of Injury" by Howard K. Gandelot, engineer in charge, Vehicle Safety Section, General Motors Corporation.

The second portion was by Elmer C. Paul, first sergeant, Indiana State Police, and was "Automotive Crash Injury Research Program."

The third portion was "Recent Advances in Medical Care and Treatment of Patients to Prevent Morbidity and Mortality," presented by Homer M. Smathers, M.D., Detroit, who is immediate past state chairman of Trauma Committee of the American College of Surgeons. This program was a complete failure. There was a marked lack of attendance. Some of the people felt that this was because the program was not mailed until the 9th of February and most people did not receive these until the 12th or 13th and the program was held on the 15th.

Further work in traffic safety was held up pending another meeting of the Traffic Safety Committee. During the trip to Detroit for the conference on Industrial Health and Traffic Safety held at General Motors Institute the commission granted approval for the Committee on Traffic Safety to investigate the cost of becoming a sustaining member of the Indiana Foundation for Traffic Safety which is a non-political organization representing professions, business and industry for traffic safety and spans political changes for a smooth transaction in business of traffic safety. It administers the National Safety Council Annual Inventory and is approved by the President's Committee on Traffic Safety. It has a recognition program for smaller cities which are not covered by the National Safety Council.

It is felt that if we become a sustaining member we can do our part without such an elaborate exertion of effort and we feel that a sum of $300.00 each year should be set to maintain a position as representative of our profession in the promotion of Traffic Safety through the Indiana Foundation of Traffic Safety.

Also, at this last meeting in the General Motors Technical Center it was gratifying to the members of the Traffic Safety Committee to note that sincere effort is made on the part of the engineers of General Motors to build safe automobiles. It was also gratifying to note the extreme amount of study and engineering research that had gone into the highway construction problems, solely in the cause of safety on the highway. One of the demonstrations we witnessed especially was that of films where actual traffic conditions were shown, with especial emphasis upon the construction of highways, as to curves, visibility, obstructions on the shoulders and other factors which may predispose to accidents.

HOWARD T. HAMMEL, M.D., *Chairman*

In conclusion, we would recommend the continuance of the present committees for the year 1959-1960, perhaps with the establishment of a Committee for the Care of the Aged and Aging, rather than handling it by the commission as a committee of the whole.

We would further recommend that we encourage our state societies to establish close liaison with community efforts of lay organizations when those efforts can be guided for the betterment of community health or traffic safety.

EMMETT B. LAMB, M.D., *Chairman*

Voluntary Health Agencies

The Commission on Voluntary Health Agencies has met twice and discussed the matters which pertain to its liaison function between the recognized health agencies and the Indiana State Medical Association. In addition to the groups covered

last year, we have added some new ones so that the list now reads as follows:

Heart	Mental Health
Muscular Dystrophy	Cancer
Tuberculosis	Polio
Diabetes	

No problems or complaints were referred to this commission during its official existence to date, hence there are no reports of progress. To some extent it might be considered reassuring that we have had no problems referred to us either from the health agencies themselves or members of the Indiana State Medical Association. It is felt, however, that a somewhat closer relationship should be developed with these agencies and positive recommendations to this effect constitute the positive aspects of this report and unless instructed otherwise by the House of Delegates or the executive officers of the association, it is felt highly desirable that the commission, when it is established for the year 1960-1961, be urged to take positive steps to that end.

Respectfully submitted for the commission,

H. Glenn Gardiner, M.D., *Chairman*
Kenneth H. Brown, M.D., *Vice-chairman*
Dennis S. Megenhart, M.D.
R. Case Hammond, M.D.
Boyd A. Burkhardt, M.D.
John M. Sullivan, M.D.
Ralph O. Smith, M.D.
Robert M. Reid, M.D.
Wilson L. Dalton, M.D.
Thomas Botkin, M.D.
Charles E. Rutherford, M.D.
Wendell W. Ayres, M.D.
Karl R. Schlademan, M.D.
Louis C. Bixler, M.D.
James H. Gosman, M.D.

Medical Economics and Insurance

Your commission regrets the necessity of presenting to you such a lengthy and detailed report. However, we feel the material reported herewith deserves to be reported in detail in order that the facts and recommendations may be judiciously considered for definite action by this House.

We feel certain your review of the activities of this commission during the past year will leave no doubt in your mind that the year has been a busy and fruitful one. The chairman would call to your attention that every member of the commission has been active, accepted his responsibility and has been willing to devote countless hours of work during the year. As chairman, I wish to take this opportunity to express personally my thanks for their splendid cooperation.

The commission has now been in existence for two working years. We find after our two years of experience the following guiding principles are emerging:

1. Recognition and respect for the rights and privileges of the individual physician in private practice on a fee-for-service basis within his medical capabilities are of constant concern to your commission members.
2. The continued observation of the efforts of "Third Parties" which affect the medical care of the nation. When this influence appears to be against the best interests of the patient, we feel it is our obligation to acquaint the ISMA members of the dangers and to attempt to offer solutions for their consideration, through either the Council or the House of Delegates.
3. To carry out the mandates of the House of Delegates, the Council and the association officers.
4. To study and attempt to implement basic objectives of resolutions concerning socio-economic probems as adopted by the House of Delegates.
5. To solicit from members of the association suggestions and/or their reactions to topics under study by the commission in an effort to make our work accurately represent the physicians' views.
6. To act in a consulting capacity to both "Blue" plans and the commercial health insurance companies on matters of medical policy and procedure.
7. Recognizing the growing pressures for "service-benefits" throughout the nation from unions, governmental agencies, and most of the "Blue" plans, the commission realizes the "indemnity" principle is the best means of preserving the patient's own responsibility in financing health care at the most reasonable price.
8. The commission in meetings with the Health Insurance Council of Indiana is attempting to develop an enlightened sense of public responsibility on the part of the commercial insurance companies that they may provide adequate coverage at a reasonable premium for all persons, regardless of risk or age, who choose to purchase health insurance.
9. To make special studies, surveys or analysis necessary for basic policy recommendations on medical-economic and insurance problems.

We present our report in three parts—relative value study—double coverage and prepaid insurance.

RELATIVE VALUE INDEX STUDY

One of the projects of the commission during the past two years has been a study of the relative value theory now being used by many of the states. With the approval of the 1958 House of Delegates, the commission has spent the year in consultation with the representatives of the various branches of medicine in our state, requesting them to study the relative value theory and to submit to the commission their recommendations of point values or relationships of one procedure to another. Many of these groups have submitted their recommenda-

tions for relationships between the various procedures performed in their particular practice. While this idea is new to Indiana, many feel this should be given an opportunity to perform and to be tried before being accepted or condemned. Admittedly even though your commission and many others have worked hard in the preparation of this study, inequities will be found—but these may always be corrected at any time by additional study and as experience is gained. Therefore, a project such as this must necessarily be a continuing study.

Limitations in funds and publication facilities made it impossible to publish this portion of our report in *The Journal* and Handbook. However, we have published it in mimeographed form for your study and it is to be found as a separate publication which you received with your other materials.

Prepaid medical insurance was inaugurated by the physicians of Indiana with the establishment of Blue Shield in 1946. Since that time the medical profession has recognized the need for a guide or "rule-of-thumb" measurement which could be used to improve schedules of benefits used by the various insuring companies, including Blue Shield.

Each year since the formation of prepaid insurance, resolutions have been placed before the House which show dissatisfaction on the part of the membership in the coverage and the indemnity allowances of our Blue Shield. It is, therefore, evident some index is necessary.

Even though this House of Delegates in 1958 agreed that a relative value study, applying to Indiana, should be made and reported by our commission, we have the feeling that many hours of hard work and effort on the part of many physicians in our state may have been devoted to this project in vain. Inasmuch as many physicians apparently do not understand the philosophy, purpose or application of the relative value theory, we emphasize that this portion of our report be given judicious attention.

The medical profession having personal knowledge of the relative values of the procedures utilized in the practice of medicine and surgery, and in fact, having exclusive knowledge of these procedures, is in the unique position of being the only group able and qualified to determine the relation of one procedure to another. This imposes upon medicine the duty to ascertain such relationships in order that future benefit plans and even present benefit plans, may be geared to meet the need of the people and the desires of the profession.

A Relative Value Index, it Should be Understood, in No Way Sets Anyone's Fees or Anyone's Schedule of Fees. The Relative Value Index is in no Way a Fee Schedule!

The need for such standards has long been recognized. It has been next to impossible to evaluate and compare benefit schedules, one with another, without a listing of correct relative values. Health insurance schedules have inevitably paid too much for some procedures and not enough for others. Neither individual nor group purchasers of insurance have had understandable guides to follow to determine the adequacy of the coverage offered. Physicians have found it necessary to examine each fee on each new schedule issued by an insurance company in order to determine its degree of acceptability to them and the protection it really afforded their patients.

Our patients, who have purchased insurance with inadequate schedules which bear no relationship to the fee which might be charged, blame us when the insurance carrier does not pay in relation to our charge. This then gives us a means by which to work for the elimination of overpayment on some procedures which, some feel, allows the patient to make a profit on his illness, and for the upgrading of other allowances which do not even provide a decent token payment for the procedure performed.

Our profession has consistently pointed out irregularities and inadequacies in every benefit schedule yet produced. However, in the absence of standards, confusion and dissappointment with health insurance for the patient and economic injustices for the physician and the insurance company has been the rule.

You will note the relative value index is established in units and not in dollars. These relationships would have been misleading and incorrect for many areas if expressed in dollars. Expressed in units they are, at this writing, accurate and useful and at the same time are subject to review and constant study in order that alterations may be made at any time the economic forces make such alterations necessary.

Furthermore, a relative value index expressed in units, as this report of your commission has done, can readily be changed by the results of new surveys from time to time—thus the standards can be changed to reflect new facts of medical practice within our state. Changes in the point values can follow one by one.

The index, you will note, is divided into four separate classifications: (1) Medical Services; (2) Surgery; (3) Radiology; (4) Pathology. The relative values or relationships presented in this index exist only within each of the four separate sections. Relative values in one section must not be related or compared to those in any other section. For example, values in the section on medical services, including items such as office and home calls, hospital visits, mileage, etc., should not be related to values in any other section.

This index should be used by insurance companies and Blue Shield in establishing proper relationships in their indemnity allowances. Insured groups may find it useful in measuring the adequacy of coverage for which they pay their premiums. This index should make good, adequate medical coverage which allows free choice of physician, easier to produce, buy, sell and administer.

This index should be used to eliminate some of

the obvious inequities in all benefit lists and we hope that it will establish the exclusive right and the exclusive duty of medicine to establish and interpret its fees and the methods by which physicians will be paid. It can be an aid to protect the insured patient and to fairly compensate physicians.

This relative value index can be a significant contribution to health insurance and all who are concerned with it in our state—the physician, medical care plans and the people who purchase prepaid medical care insurance.

Dr. Murray Harden, chairman of the sub-committee which performed this Herculean task, and the members of his sub-committee, deserve the thanks of the association for performing this assignment well.

The commission also desires to express its appreciation to the California Medical Association and the many other state medical associations who gave us the benefit of their experience in developing their relative value studies.

The commission recommends that this index be published and distributed to all members, and further recommends that this be made a continuing study and that at periodic intervals it be critically analyzed and necessary adjustments be made.

Prepaid Insurance

At the organization meeting on 23 November 1958, this sub-committee was given the specific duties of (a) preparing a set of minimum standards for all health insurance policies, (b) preparing and recommending for adoption a set of standard insurance reporting forms and (c) a study of broadening coverage for medical care under Indiana Blue Shield. The later appearance of urgent problems connected with negotiation of the health insurance plan section of the United Steel Workers contract and the urgent problem of recommendations for means of providing care for persons over age 65 as a deterrent to the Forand Bill added greatly to the work of the committee and detracted somewhat from these original projects.

The sub-committee met with many difficulties in attempting to formulate a set of minimum standards for all health insurance policies, particularly with an attitude on the part of many of our members that we as a medical society had no authority to enforce conformity to such a set of standards once they were promulgated and that little precedent for propagandizing against non-conforming policies offered to the public existed.

A minority of our number felt that the ISMA might well proceed along the lines set up by Michigan State Medical Society in September 1957. Michigan established a set of minimum standards which would be used by a special state society commission in evaluating all health insurance policies, voluntarily submitted for its consideration and issuing a certificate of approval or evidence of conformity for those which met such standards. The entire sub-committee was in agreement that the Blue Cross-Blue Shield non-group certificates to be made available to Indiana citizens generally in September 1959 met with the minimum standards as we now regard them. The sub-committee did study resolution No. 22 on Standard Insurance forms which had been preparel by the Vanderburgh County Medical Society and adopted by that society for local use and which the reference committee on insurance favored. We also studied the set of Simplified Report forms prepared jointly by the Health Insurance Council and the American Medical Association. The sub-committee approved this latter set of forms and recommend to the reference committee that they be favorably reported upon and adopted at the next meeting of the House of Delegates as the standard form for use in Indiana. These are titled Simplified Claim Forms, and a set is attached. This recommendation was presented to the ISMA Council at its meeting on 18 January 1959 and was approved.

The sub-committee and the Commission on Medical Economics and Insurance in joint meeting with members of the Commission on Public Health formulated the following resolution:

"In support and furtherance of the efforts of the American Medical Association to effect a proper and fair reduction in the cost of health care for the financially insecure, elder citizen;

"The Commissions of the Indiana State Medical Association on Medical Economics and Insurance and on Public Health, in joint session, recommend by majority vote to:

"Support a strictly basic hospitalization insurance policy, written by any acceptable insurance carrier, designed to offer basic hospital care at the lowest feasible premium to those recipients of Social Security payments for either retirement or total permanent disability benefits, and others with a comparable income, but who are otherwise indigent.

"No medical or surgical care coverage is implied, as such care will be supplied by physicians on an individualized basis in accord with the traditional professional policy."

This resolution was presented to the ISMA Council on 18 January and approved.

A proposal from W. H. Scoins, M.D., of the Lincoln National Life Insurance Company and the Indiana Health Insurance Council was transmitted to us through Dr. Olson recommending the formation of a joint ISMA-Indiana Health Insurance Council Committee to carry out grass roots public relations campaign similar to an A.M.A.-H.I.C. committee program. The program has the following aims: to exchange ideas and information about health insurance problems; to rely upon the ISMA to handle abuses of the system by individuals or groups of physicians; to cooperate with the "Blues,"

to avoid controversy; to keep the discussions and proceedings on the highest possible plane of medical ethics and good public relations, keeping in mind the overall objective and our obligation to the greatest number of people of this state. The sub-committee did meet with the Indiana Health Insurance Council Committee on one occasion and enjoyed a mutually pleasant and beneficial meeting. It is recommended that such liaison be continued with regular scheduled meetings.

The committee studied a number of compulsory temporary disability insurance programs and concluded that a need for such was not existent in the state at this time.

The sub-committee studied and made itself familiar with the apparently successful and long-standing arrangement whereby physicians of the State of Washington through their physician sponsored plans are caring for all welfare or public assistance cases, and the recent undertaking by Colorado Blue Shield Plan for state action program for the care of public welfare pensioners. Such plans seem a more reasonable method of handling the health problems of public aid recipients and the committee recommends continued observation and study of such plans.

The sub-committee also studied Michigan Blue Shield's new M-75 Service Contract as a matter of information.

The sub-committee examined complaints from physicians concerning the apparently growing practice of some insurance carriers of soliciting detailed information from past medical records of patient-applicants for insurance. We felt that in many instances this was a device for avoiding an insurance examination, placing the burden for payment for such information on the patient or providing a nominal secretarial fee. The use of information culled from past treatment records as a basis for insurability in the place of a current insurance physical examination was felt to be an improper basis, capable of injustice to both the patient-applicant and the carrier. It was further felt that placing responsibility for payment for such information on the patient-applicant was improper, untraditional and capable of abuse by, and embarrassment to, all parties concerned.

The sub-committee condemns such practice and recommends:

1. That the House of Delegates officially condemn the practice on the above grounds and

2. That the Indiana Health Insurance Council be informed of the committee action and any action by the House of Delegates.

The sub-committee spent an entire session with representatives of Indiana Blue Cross-Blue Shield studying the problem of health insurance coverage for persons over the age of 65. It was emphasized that Indiana Blue Cross-Blue Shield from its inception had never had an age limit on subscribers. It was further demonstrated that Indiana Blue Cross-Blue Shield now covers 26% of the Indiana citizens over age 65. The relatively heavy burden of this class of subscriber to Indiana Blue Cross-Blue Shield was demonstrated to us.

It was determined, also, that it had been the practice of Indiana Blue Shield from its inception to set aside from younger age group coverage premiums a subsidy for the over 65 age group. Indiana Blue Cross-Blue Shield, therefore, has had an excellent and unparalleled experience in the coverage of this age group. It was the opinion of the sub-committee that the current plans offered by Blue Cross-Blue Shield and the non-group certificate planned for offer in September of 1959 has the problem in Indiana under reasonable control and is not a matter of immediate concern. We do need to be concerned about our over 65 group now and in the future. Our best approach to this problem is by emphasis on continuation of group coverage after age 65 and the development of individual, non-selective coverage through commercial carriers or Blue Cross-Blue Shield.

Several members of the sub-committee have joined with those from Lake County in familiarizing themselves with the problems of the current steel contract medical plan negotiations and have participated in two seminars in Pittsburgh and several at the local level. The sub-committee feels that these negotiations are vital to the practice of medicine and to industrial relations in Indiana, and vital, also, to Indiana Blue Cross-Blue Shield. The steel union's Bargaining Committee's position was seen to be:

UNION COMPLAINTS

1. Cost of coverage is too high because of surcharges, e.g., Blue Shield.

2. Unnecessary or over hospitalization for treatment which could be done in the home or office.

3. Inadequate preventive medical service, e.g., vaccinations.

4. Inadequate provision for prepaid home and office care including ordinary drugs.

ULTIMATE OBJECTIVES OF THE UNION:

1. Total government health care.

2. Total prepaid medical care at company expense or if joint company and union expense, the two will share administration and control of medical care.

3. Comprehensive medical care at company expense (Kaiser Permanente Plan) or "joint union-company expense and control."

PROBABLE STEEL UNION DEMANDS IN 1959:

1. Group practice treatment and diagnostic clinic as a means of expanding benefits at a reasonable cost.

2. More adequate coverage for non-surgical medical care in hospital, office and home.

3. Controls of fee schedule abuses (additional charges over insurance benefits).

4. Controls to be sure that qualified doctors carry out surgical and medical diagnosis and treatment.

5. Compromise in improving present plan with better benefits. Similar to H.I.P. of N.Y.

HIGH ON THE LIST OF UNION COMPLAINTS AGAINST PRESENT ARRANGEMENTS AND FREQUENTLY VOICED WERE:

1. High cost because of overutilization of hospitalization, in-patient x-ray and laboratory procedures which they lay directly at the door of the medical profession.

2. Lack of means of any control by anyone of the quality of medical care given under the existing contracts.

They—the union negotiators and their advisors —are convinced that these inadequacies can be controlled under a union or union-management administered closed panel system and the statistics they present in support of this position are impressive and difficult of controversion.

The sub-committee undertook a survey of state medical associations and various Blue Shield plans across the country concerning double coverage or the concurrent coverage of medical and surgical problems in-patient, coverage of consultation fees and coverage of fees for surgical assistants with the following results:

SURVEY CONCERNING "DOUBLE COVERAGE" UNDER BLUE SHIELD-BLUE CROSS CONTRACTS

At the suggestion of President Olson in his letter to the commission dated 30 December 1958 as follows: "I would suggest that they appoint a committee to find out if it is possible to pay medical consultation in surgical cases as was advocated at the state meeting and again recently brought up by the Indianapolis Medical Society. I would suggest that they write to other states and other state medical societies and also other Blue Shield companies in various parts of the country as well as some of the private companies to find out if such policies are available and what their experience is." Such a survey was undertaken by the Sub-committee on Prepaid Insurance.

A questionnaire as per attached Table 1 was addressed to each of the state medical associations, and a similar questionnaire as per the attached Table 2 was addressed to the Blue Shield organization in the United States, including Hawaii, through the appropriate executive officer. A total of 77 replies were received. One of these could not be used in tabulations because its source could not be identified. The 76 replies are tabulated in the attached Table 3. Thirty-five replies were received from state medical society association presidents or their executive secretaries. These are tabulated in the attached Table 4. Three state medical societies reported no physician sponsored plan operating in their respective states. These are Idaho, Louisiana and Nevada. Forty-one replies were received from Blue Shield executive officers covering data from 52 different Blue Shield organizations in 36 different states including Hawaii and the District of Columbia. These replies are tabulated in the attached Table 5.

Part one of our questionnaire did not carry any explanation of our terminology "double coverage" and is doubtlessly open to criticism as being ambiguous. Nevertheless, only two replies had sufficient misinterpretation of the question to make them useless for our purpose. The purpose was to determine whether, in addition to the regular scheduled surgical fee allowance, there was additional allowance from Blue Shield to cover concurrent medical care by another physician or coverage allowing payment to the general practitioner or referring physician for pre-surgical work-up or medical care and post-operative care. Part number two was perfectly clear in its definition of information requested and yet the replies, particularly to part "B," demonstrated a most universal misunderstanding. But in no case did the reply prohibit its proper usefulness to us. Comparison of Tables 4 and 5 demonstrate only an occasional disagreement between medical society executive officers and Blue Shield executive officers as to the coverage of Blue Shield. It is therefore proper to utilize for our analysis the information from Table 5.

Forty-four of the 52 Blue Shield organizations reported having no such "double coverage" as we had in mind; that is, no concurrent coverage of medical and surgical problems during the same admission. The Maryland Blue Shield executive officer reported having no such benefits but in his remarks reported "Medical benefits in connection with a surgical admission covered only if an additional medical condition clearly requires medical management." The Michigan Blue Shield executive officer reported no such benefits but in his remarks reported "15th to the 30th days postoperative doublecoverage on an individual consideration basis on contracts having medical coverage." The St. Louis, Mo., Blue Shield executive officer reported no such benefits but in his remarks reported "Diagnostic work or care prior to surgery covered. Also if surgical procedure is minor and scheduled benefit is less than the allowance per medical care covered for severe medical condition or complication." The Richmond Va. Blue Shield executive officer reported no "double coverage" but in his remarks reported "Concurrent medical service at discretion of association when required by unusual and grave complications; individual consideration only." The Charleston W. Va. Blue Shield executive officer reported no "double cover-

age" but in his remarks reported "Exception made in case where medical visits are not related to surgical condition. **Referral fees are often billed in guise of a consultation.**" It is seen therefore that of the 44 Blue Shield plans reporting no "double coverage," 16 of these plans by their remarks and qualifications indicated that actually such "double coverage" did exist under their plans. Actually then, of the 52 plans reporting, 24 of them do have some form of coverage for medical conditions arising during an admission in which interval surgery is also performed and a scheduled surgical fee paid.

Of the eight Blue Shield organizations reported as having "double coverage," all of them indicate that it is predicated on the patient having in-patient medical coverage in the contract. There apparently is no exception to the requirement that to qualify for such benefit the services must be rendered by a physician other than the operating surgeon, that they must be billed separately and that the service must be for other than the routine post-operative management. **New Jersey makes a notable exception which seems a wise conclusion which might be followed by other Blue Shield organizations, even those interested only in surgical coverage—any medical care in addition to surgery in any patient under 1 year of age.**

Of 54 plans reporting concerning coverage of consultation fee in addition to scheduled fee for surgery, eight reported an unqualified "yes," 19 reported an unqualified "no," nine reported "yes," but with the following qualifications: California Physicians Service covered pre-surgical consultation if the contract carried in-patient medical coverage. Surgical consultation during and after-surgery automatically covered. Florida Blue Shield reported "yes" on "A" contracts only, "no" on "F&J" contracts. Columbus, Ga., Blue Shield reported $5.00 consultation fee coverage on low benefit contracts only. Hawaii Medical Service allows up to $10.00 consultation fee if patient does not continue under the care of the consultant. Iowa Medical Service reported coverage of consultation on new contracts only. Maine Blue Shield reported coverage of consultation only on individual case consideration. Michigan Blue Shield reports coverage of consultation under new M-75 series contracts as class two services, which require patient contribution of $5.00 or 10% of the schedule whichever is greater, according to subscribers certified annual income. Montana Blue Shield reports coverage for consultation only if for condition unrelated to that for which surgery is performed. New Jersey Blue Shield covers consultation service if rendered at least seven days prior to surgery but limits to one per year. North Dakota Blue Shield limits consultation to one per year. Richmond, Va. Blue Shield reports a maximum $15.00 consultation fee but no limit otherwise. Charleston, W. Va. Blue Shield reports coverage of consultation and notes that **referral fees are often billed in the guise of consultations.** Milwaukee, Wisc. Blue Shield reports consultation covered but deducted from total surgical fee.

Eighteen Blue Shield plans reported no coverage of consultation but with qualifications as follows: The eight West Virginia Blue Shield plans note consultation is available as a special rider. Utah, South Carolina and the eight New York Blue Shield plans report no coverage of consultation but note that it can be covered under special board consideration of individual claims. St. Louis, Mo. Blue Shield reports no coverage of consultation but does report the diagnostic work or care prior to surgery is covered when patients have in-patient medical coverage. Actually, of the 54 plans reporting, only 19 show no method of coverage for consultation fees, but few leave any doubt that what is intended is actually a necessary and bona-fide consultation and most have set limits to the dollar value involved, and the number, and do require that patients also carry in-patient medical coverage in their contracts.

Of the 54 plans reporting, 22 report that they have no coverage for a fee to a surgical assistant in addition to the regular scheduled allowance for surgery. Eleven plans—the eight New York Blue Shield plans and the Blue Shield plans of New Mexico, North Dakota and Oregon—report that they do have such coverage without any qualifications. California Physicians Service reports such coverage on a regular schedule basis based on per hour time spent. Florida, Pennsylvania, Utah, Milwaukee, Wisc., and eight West Virginia Blue Shield plans report that they do have such coverage but it is by reduction of the scheduled surgical fee as indicated by the operating surgeon and require his authorization for such payment and require him to set the proportion of such scheduled fee to be paid to the assistant. Therefore, these 12 plans should properly be classified with the 22 as reporting no coverage in addition to that allowed for surgery. Hawaii Medical Service pays up to $25.00 to surgical assistant if there is no regular house staff available in hospital and gives special consideration for special supplementary surgical skills which might be required; i.e., payment to both neurosurgeon and orthopedist cooperating in disk surgery. Iowa covers surgical assistants allowance on percentage basis where required under a plan called "the cooperative care of the surgical patient" based on Iowa Index Fee. Maine Blue Shield pays the assistant at major surgery a $20.00 minimum or 12% of the scheduled surgical benefit, whichever is greater.

Maryland Blue Shield pays an assistant at major surgery in those hospitals not having resident staff. Massachusetts Medical Service in major cases (fee $75.00 or over) deducts 15% for payment to the surgical assistant and 15% for payment to the local physician for aftercare, but does require specification from the operating surgeon. These provisions apply only to service contract patients where the surgical benefit ceiling is $75.00. Michigan Blue Shield covers surgical assistants

under class two benefits in their new M-75 contract which require patient contribution of $5.00 or 10% of the schedule, whichever is greater according to the subscribers certified annual income. Minnesota deducts 15% of the scheduled surgical fee benefit for supplemental care or for the surgical assistant when scheduled fee is more than $75.00 if so designated by the operating surgeon. New Jersey Blue Shield makes no additional payment for the surgical assistant but does make apportionment on certification of the participating surgeon with separate payment to each and notification to the patient of such apportionment. North Carolina pays surgical assistant by deduction of 15% of the scheduled surgical benefit.

It is evident then that, of the 54 plans reporting, only 18 have made a definite provision for coverage of fee to surgical assistant on a definite schedule which does not require the operating surgeon to designate that a portion of the scheduled benefit be paid and what portion of that scheduled benefit should be paid.

Of those Blue Shield plans reporting coverage of consultation fees and/or surgical assistants fees Hawaii alone reports as covering under strict indemnity basis. All of the others are covering under a service basis or service basis under certain income limits.

We take the liberty of attaching as Table 6 a report of the Board of Directors of Blue Shield Medical Care plans to the American College of Surgeons dated 15 September 1958 which report covers a survey similar to the one we have just completed. The two differ somewhat in this regard: Table 6 demonstrates a higher incidence of apportionment of services by the plans than does ours, while ours indicates a rather higher incidence of pro-ration of fee.

Our own Indiana Blue Shield Plan in actual performance seems to have in those contracts which include in-patient medical care adequate mechanism for coverage of concurrent medical problems and surgery. This is not so of those contracts which do not include in-patient medical care. Neither contract seems to have satisfactory mechanism for coverage of necessary bonafide consultations in either strictly surgical or strictly medical problems. It is well at this point again to emphasize the wisdom of the New Jersey Blue Shield organization in providing for the co-operative medical-surgical care of all patients under the age of 1 year. It would seem wise to expand this age level for these difficult problems. We in Indiana should concentrate on the replacement of all Blue Shield contracts carrying strictly surgical coverage with those including in-patient medical care as well as surgery. There would then exist the means for providing coverage for the co-operative care of the surgical patient, ethically and on an actuarily sound basis. Indiana Blue Shield, at the direction of the House of Delegates in 1952, set up a provision whereby the surgical assistant could be paid by separate check, and directly, a portion of the scheduled surgical fee benefit when designated by the operating surgeon to whom and in what percentage amount should be paid. By this mechanism in 1958 Blue Shield paid 775 doctors a total of $174,180.24 out of a total of $13,599,026.27 in claims. The utilization expressed in dollars was less than 1½% and the utilization varied widely in the different counties.

This experience of low utilization is consistent with that reported from other Blue Shield organizations wherein it was required that the operating surgeon designate the amount and to whom a portion of the scheduled surgical fee should be paid. Apparently, the operating surgeon regards this as onus of the fee split or as beneath his dignity. Certainly it is inconsistent with the principles as laid down by the Board of Regents of the American College of Surgeons. Inasmuch as the Joint Board of Accreditation requires a surgical assistant for all major procedures which assistant must be a physician and inasmuch as few Indiana hospitals are provided with a resident house staff available to act as assistants at major surgery, it would appear that the current practice or methods provided Indiana Blue Shield is inconsistent with the requirements. It would appear within reason to suggest to the Indiana Blue Shield Board that a separate schedule of benefits be set up for direct payment to the assistant at major surgery or lacking that a definite percentage—15% or 20%—of the current surgical benefits schedule be set aside for payment to the assistant at major surgery and in such cases where supplemental skills are required.

TABLE I

Answer to Questionnaire Concerning,
"Double Coverage"

Report of the State Medical Association of . . .
.

1. The physician sponsored plan in our state (does) (does not) Provide "double coverage" under its plan.

2. Does your plan, in addition to payment of a surgical allowance, pay for the following?

 (a) Consultation (yes) (no)

 (b) Surgical Assistants (yes) (no)

 (c) If these are paid, is it on an indemnity or service basis

.
(signed)

COMMENTS:

TABLE II

Answer to Questionnnaire Concerning, "Double Coverage"

Report of the Executive Officer of the Blue Shield Plan of

1. The physician sponsored plan in our state (does).....(does not)..... provide "double coverage" under its plan.
2. Does your plan, in addition to payment of a surgical allowance, pay for the following?
 (a) Consultation (yes).....(no).....
 (b) Surgical Assistants (yes).....(no).....
 (c) If these are paid, is it on an indemnity or service basis?

(signed)

COMMENTS:

TABLE III

Tabulation of Replies

Questionnaire Survey ISMA Commission on Medical Insurance

Concerning Multiple Coverage

of

Professional Fees—By

"Blue Shield"

Blue Shield or Physician Sponsored Plan Reporting*	1	2	3	4	Remarks or Qualifications
Ala. SMA**	No	No	No		
Ala. B.S. Exec.	No	No	No		
Arizona SMA	No	Yes	Yes	S.	Surgical assistant's fee 20% of schedule for major surgery. Service basis if subscriber under income limitation.
Ark. B.S. Exec.	No	No	No		
Ark. SMA	No	No	No		
California Physician Service	Yes	Yes	Yes	S.	Required med. services only if supplemental skills required. Additional payment for after care beginning 3 to 6 wks. P. O. Medical & surgical only if contract has medical coverage. Pre-surgical consult if contract has med. coverage. Surgical consult during & after surgery automatically covered. Surgical asst. paid hourly A/C fee schedule on service basis is under stated income ceiling.
Colo. SMA	No	Yes	Yes	S.	
Conn. SMA	No	No	No		Believe future contracts will do so.
Conn. Med. Svs. Inc.	No	No	No		No provision for division of maximum scheduled surgical fee but customary to submit remainder of unused maximum for subsequent care when initial care rendered away from home.
Dela. SMA	No	Yes (In-Patient)	No	I.	
D. of C. SMA	No	No	No		
Wash. D.C. B.S. Exec.	No	No	No		No charge to be made for an after care during period of hospitalization.
Fla. SMA	Yes	Yes—New A Contract No—Old Contracts	"A" Yes "F&J" No	I. A—Over $5000 F&J—over $3600 Income	"Double coverage" on individual claim necessity basis but not for routine care. May pay 3 or 4 MD's. Surg. asst. fee paid directly as part of total schedule when requested by surgeon but seldom used.

Fla. B.S. Exec.	Yes	Yes—A Contracts No—Type F&J	Yes—A Con.	I. As Above	Remarks as above.
Atlanta, Ga. B.S. Plan	No	No	No		
Columbus, Ga. B.S. Plan	No	Yes	No		Low benefit contract $5.00 consultation fee except in O.B. cases. No consultation or surg. asst. fee in high benefit contracts.
Savannah, Ga. B.S. Plan	No	No	No		
Hawaii Med. Svs. Assoc.	Ques. Misunderstood	Yes	Yes	I.	Allow up to $10. Consultation fee if patient does not continue under care of consultant. Up to $25. surg. asst. fee if no regular house or special consideration for special supplementary skills.
Idaho SMA	No Physician Sponsored Plan				
Ill. SMA	No	Yes	No	I.	Consultation fee on individual consideration only.
Iowa SMA	No	Yes	No	S. Basis for Those Under Income Limits	Surgical asst. fee included in surgery fee scheduled and not separate.
Iowa Med. Svs.	Yes	Yes	Yes	S. Under Income Ceiling $3600	Concurrent med. surg. coverage and surg. asst. fee via special joint billing form dividing total B.S. liability on service basis for contracts below $3600 ceiling. New contract separate consultation allowance, percentage surg. asst. allowance & concurrent med. serv. when required under "cooperative care of surgical patient" based on Iowa unit fee index.
Kans. B.S. Exec.	Yes	Yes New Contract $10 Limit In-Patient	No		Double coverage special medical cases on individual basis.
Ky. SMA	No	No	No		
Ky. B.S. Exec.	No	No	No		
La. SMA	No Physician Sponsored Plan				
Maine B.S. Exec.	Yes	Yes	Yes	"Double Coverage" I. Others S. Basis	Coverage of med. services and either surg. or O.B. during one stay entirely at discretion of board. Same is true of consultation. Surg. asst. (major surg.) $20. minimum or 12% of surg. benefit, whichever greater.
Md. SMA	Yes	Yes	No	I.	Double coverage when patient condition specifically warrants but on individual consideration basis.
Md. B.S. Exec.	No	Yes	Yes	S.	Med. benefits in connection with surg. admission only if an additional med. condition clearly requiring med. man. Benefits for up to 3 consultations if by different physician. In-patient only. Benefit for surg. asst. available in those hospitals not having resident staff.
Mass. Med. Soc.	No	No	No	S.	Major case (fee $75 or over) 15% deducted for payment to surg. asst. & 15% deducted for after care by local physician. Requires specification by operating surgeon. Applies only to service patients $7500. ceiling.
Mass. Med. Svs.		No	Yes	Both	Major case (fee $75. or over) 15% deducted for payment to surg. asst. & 15% deducted for after care by local physician. Requires specification by operating surg. Applies only to service patients $7500. ceiling.

Mich. SMA	No	Yes	Yes	S.	
		Applies to both Columns 2 & 3			
Mich. B.S. Exec.	No	$2500-$5000, M.S. Contract No	M-75 Series Contract Yes	M-75 Partial S.	15th-30th day P.O. double coverage individual consideration on contracts having med. coverage. Consultation & surg. asst. included as class 2 services under M-75 contracts require patient contribution of $5 or 10% of schedule, whichever greater according to subscribers certified annual income.
Minn. SMA	Yes			S.	Special consideration in serious med. condition in addition to surg. for family dr. or internist or family dr. participating in P.O. care as part of scheduled surg. benefit.
Minn. B.S. Exec.	Yes	Yes	Yes	S.	15% of scheduled surg. fee deducted for supplemental care or for surg. asst. when scheduled fee more than $75. If designated by surg., one bona fide consultant per policy year per subscriber. Allow on serv. basis.
Miss. SMA	No	No	No		
Miss. B.S. Exec.	No	No	No		
Mo. SMA	No	No	No		Pays med. visit to date of surg., also med. care on per visit basis for complications following surg. when cared for other than by surg.
St. Louis, Mo. B.S. Exec.	No	No	No	I.	Diagnostic work or care prior to surg. covered, also if surg. procedure is minor & scheduled benefit less than allowance per med. visit basis, payment on latter scale.
Mont. B.S. Exec.	No	Yes	No	S.	Pays med. care in addition to surg. where 2 MD's render care for conditions which are unrelated, but will not pay 2nd physician for care of condition for which surg. was performed.
Neb. SMA	No	No	No		House of Delegates Resolution 1953 permits apportionment or pro-ration of fees.
Nev. SMA	No Physician Sponsored Plan				
N. H. SMA	No	No	Yes	I.	Double coverage on individual consideration basis only.
N. J. B.S. Exec.	No	Yes	No	S.	Double coverage a. Another physician caring for P.O. complication b. Another physician treating condition other than that for which surg. performed c. Any med. care in addition to surg. in patient under 1 yr. old Consultation service covered if rendered at least 7 days prior to surg. Limit one. No additional payment for surg. asst. but apportionment on certification of participating surg. Separate payment for each and notification of patient to same.
N. Mex. Phys. Svc. Exec. Sec.	No	No	Yes	S. If Within Income	In 14 yrs. no request for such service from physicians or patients.
Albany, N.Y. B.S. Exec.	No	No	Yes	S.	Concurrent in-hosp. med. care at sole discretion of Plan Board.
N. Y. SMS Bureau of Med. Care Ins.	No				7 B.S. plans non-reporting any instance where general practitioner paid for P.O. care.
N. C. SMS	No	No	Yes	S. If under $4200 Income Limit	Div. of benefit to allow compensating med. fee in concurrent attendant of physician & surgeon.
N. C. B.S. Exec.	No	No	Yes	S. If Under Income Limits	75% as scheduled medical allowance for concurrent med. care, surg. asst. fee by deduction of 15% of surg. allowance.

N. D. B.S. Exec.	Yes	Yes	Yes	S. If Under Income Level	Payment for extraordinary med. complication treated by other than attending surg. or by attending surg. beyond usual P.O. term consultation maximum $15. Limit one per year.
Ohio SMA	No	No	No		
Ohio Med. I.O.	No	No	No		
Okla. B.S. Exec.	No	No	No	I.	
Okla. SMA	Reg. B.S. No Yes	Columns 2 & 3 Same as No. 1 Extended Benefit B.S.			
Ore. B.S. Exec.	Question Misinterpreted	Yes	Yes	S.	
Penn. SMA	No	Yes	No	S.	Subscriber permitted one consultation per admission. Surg. may designate portion of scheduled fee to be paid an asst. No additional fee allowed.
Penn. B.S. Exec.	No	Yes	No	S.	Surg. may assign part of fee to asst.
R. I. SMA	No	No	Yes	Both	
S. C. B.S. Exec.	Yes	No	No		Coverage on a very limited and controlled basis for services of another physician when required by complications.
S. D. SMA	No	No	No		
S. D. B.S. Exec.	No	No	No		
Tenn. SMA	No	No	No		
Tenn. B.S. Exec.	No	No	No		
Tex. SMA	No	No	No	I	
Tex. B.S. Exec.	No	No	No		
Utah SMA	No	No	Yes	S	Portion of surg. allowance as designated by operating surg. may be paid to asst.
Utah B.S. Exec.	No	No	Yes	S.	Concurrent med. care covered for severe med. condition or complications portion of scheduled surg. Fee as designated by operating surg. may be paid to asst.
Va. SMA	No	Yes	No	S.	Consultation provided in surg. cases with complications.
Richmond, Va. B.S. Exec.	No	Yes	No	S.	Concurrent med. service at discretion of assn. when required by unusual and grave complications. Individual consideration consultation fee maximum $15. No limit except consultant must reside in community where hospitalization occurs.
Roanoke, Va. B.S. Exec.	No	No	No	S.	No med. coverage under any circumstances.
Wash. SMA	No	Yes	Yes	S.	
W. Va. B.S. Exec. 8 Plans	No	Yes	Yes	S.	Physician in charge advises plan reduction in scheduled fee with difference being sent to surg. asst. Consultation service available by special rider.
Charleston, W. Va. B. S. Exec.	No	Yes	No		Exception made in case where med. visits are not related to surg. Referral fees are often billed in the guise of a consultation.
Huntington, W. Va. B.S. Exec.	No	No	No		
Milwaukee, Wisc. B.S. Exec.	No	Yes	Yes	S.	Consultation & surg. asst. fees deducted from total scheduled surg. fee.
Wyo. SMA	Yes	Yes	Yes	S.	Concurrent med. surg. care only by adjudication in cases of complication. One consultation only. One surg. ass't. fee all in addition to scheduled surg. fee.

Key to Tables III, IV and V.

Columns

1 "Double Coverage" medical and surgical coverage paid at same time.
2 Consultation fee paid in addition to surgical allowance.
3 Surgical assistants fee paid in addition to surgical allowance.
4 Indemnity or service (Indemnity-I.) (Service-S.)

****Abbreviations Used**

SMA State medical association
B.S. Blue Shield
EXEC. Executive Officer
I.O. Indemnity officer
P.O. Post operative

TABLE IV

Tabulation of Replies From State Medical Societies

Questionnaire Survey ISMA Commission on Medical Insurance

Concerning Multiple Coverage

of

Professional Fees—By

"Blue Shield"

Blue Shield or Physician Sponsored Plan Reporting	1	2	3	4	Remarks or Qualifications
Ala. SMA	No	No	No		
Ariz. SMA	No	Yes	Yes	S.	Surgical asst. fee 20% of schedule for major surg. Service basis if subscriber under income limitation.
Ark. SMA	No	No	No		
Colo. SMA	No	Yes	Yes	S.	
Conn. SMA	No	No	No		Believe future contracts will do so.
Del. SMA	No	Yes (In-Patient)	No	I.	
D. of C. SMA	No	No	No		
Fla. SMA	Yes	Yes—New A contract No—Old Contract	"A" Yes "F&J" No	I. A—Over $5000 "F&J" Over $3600 Income	Double coverage on individual claim necessity basis but not for routine care. May pay 3 or 4 MD's, surgical asst. fee paid directly as part of total schedule when requested by surgeon, but seldom used.
Idaho SMA	No Physician Sponsored Plan				
Ill. SMA	No	Yes	No	I.	Consultation fee on individual consideration only.
Iowa SMA	No	Yes	No	S. Basis for Those Under Income Limits	Surgical asst. fee included in surgery fee scheduled and not separate.
Ky. SMA	No	No	No		
La. SMA	No Physician Sponsored Plan				
Md. SMA	Yes	Yes	No	I.	Double coverage when patient condition specifically warrants but on individual consideration basis.
Mass. SMA	No	No	No	S.	Major case (fee $75. or over) 15% deducted for payment to surg. asst. and 15% for after-care by local physician. Requires specification by operating surgeon applies only to service patients $75. ceiling.

Mich. SMA	No	Yes	Yes	S.	
Minn. SMA	Yes			S.	Special consideration in serious med. condition in addition to surg. for family dr. or internist or family dr. participating in P.O. care as part of scheduled surg. benefit.
Miss. SMA	No	No	No		
Mo. SMA	No	No	No		Pays med. visit to date of surg., also med. care on per visit basis for complications following surg. when cared for other than by the surg.
Neb. SMA	No	No	No		House of Delegates Resolution 1953 permits apportionment or pro-ration of fees.
Nev. SMA	No Physician Sponsored Plan				
N. H. SMA	No	No	Yes	I.	Double coverage on individual consideration basis only.
N. Y. SMS-Bureau of Med. Care Ins.	No				7 B.S. plans non-reporting any instance where general practioner paid for P.O. care.
N. C. SMA	No	No	Yes	S. If Under $4200 Income Limit	Division of benefit to allow compensation of med. fee in concurrent attendant of physician and surgeon.
Ohio SMA	No	No	No		
Okla. SMA	Reg. B.S. No Extended Benefit B.S. Yes	Reg. B.S. No Extended Benefit B.S. Yes	Reg. B.S. No Extended Benefit B.S. Yes		
Penn. SMA	No	Yes	No	S.	Subscriber permitted one consultation per admission. Surg. may designate portion of scheduled fee to be paid an asst. No additional fee allowed.
R. I. SMA	No	No	Yes	Both I&S	
S. D. SMA	No	No	No		
Tenn. SMA	No	No	No		
Tex. SMA	No	No	No	I.	
Utah SMA	No	No	Yes	S.	Portion of surg. allowance as designated by operating surg. may be paid to asst.
Va. SMA	No	Yes	No	S.	Consultation provided in surg. cases with complications.
Wash. SMA	No	Yes	Yes	S.	
Wyo. SMA	Yes	Yes	Yes	S.	Concurrent med. surgical care only by adjudication in cases of complication. One consultation only. One surg. asst. fee all in addition to scheduled surg. fee.

TABLE V

Replies From Blue Shield Executive Officers

Questionnaire Survey ISMA Commission on Medical Insurance

Concerning Multiple Coverage

of

Professional Fees—By

"Blue Shield"

Blue Shield or Physician Sponsored Plan Reporting	1	2	3	4	Remarks or Qualifications
Ala. B.S. Exec.	No	No	No		
Ark. B.S. Exec.	No	No	No		
Calif. Physician Service	Yes	Yes	Yes	S.	Required med. services only if supplemental skills required. Additional payment for after care beginning 3 to 6 wks. P.O. Med. & surgical only if contract has med. coverage. Pre-surgical consult if contract has med. coverage. Surg. consult. during and after surg. automatically covered. Surgical asst. paid hourly A/C fee schedule on service basis it under stated income ceiling.
Conn. Med. Svc. Inc.	No	No	No		No provision for division of maximum scheduled surgical fee, but customary to submit remainder of unused maximum for subsequent care when initial care rendered away from home.
Wash., D.C. B.S. Exec.	No	No	No		No charge for any after care during period of hospitalization.
Fla. B.S. Exec.	Yes	Yes—A Contracts No—Type "F&J"	Yes—A Contracts	I. A—Over $5000 "F&J" over $3600 Income	Double coverage on individual claim necessity basis but not for routine care. May pay 3 or 4 MD's. Surg. asst. fee paid directly as part of total schedule when requested by surgeon but seldom used.
Atlanta, Ga. B.S. Plan	No	No	No		
Columbus, Ga. B.S. Plan	No	Yes	No		Low benefit contract $5.00 consultation fee except in O.B. cases. No consultation or surg. asst. fee in high benefit contracts.
Savannah, Ga. B.S. Plan	No	No	No		
Hawaii Med. Svc. Assn.	Question Misunderstood	Yes	Yes	I.	Allowed up to $10 consultation fee if patient does not continue under care of consultant. Up to $25. surg. asst. fee if no regular house or special consideration for special supplementary skills.
Iowa Med. Svc.	Yes	Yes	Yes	S. Under Income Ceiling $3600.	Concurrent med. surg. coverage and surg. asst. fee via special joint billing form dividing total B.S. liability on service basis for contracts below $3600 ceiling. New contract separate consultation allowance percentage, surg. asst. allowance & concurrent med. services when required under "Cooperative care of surgical patient" based on Iowa fee index.
Kans. B.S. Exec.	Yes	Yes New Contract $10 Limit In-Patient	No		Double coverage special med. cases on individual basis.
Ky. B.S. Exec.	No	No	No		

Maine B.S. Exec.	Yes	Yes	Yes	Double Coverage I Others S. Basis	Coverage of med. services and either surg. or O.B. during one stay entirely at discretion of board. Same is true of consultation surg. asst. (major surg.) $20 minimum or 12% of surg., benefit whichever greater.
Md. B.S. Exec.	No	Yes	Yes	S.	Med. benefits in connection with surg. admission only if an additional med. condition clearly requiring med. management. Benefits for up to 3 consultations if by different physician. In-patient only. Benefit for surg. asst. allowance available in those hospitals not having resident staff.
Mass. Med. Svc.		No	Yes	Both	Major case (fee $75 or over) 15% deducted for payment to surg. asst. & 15% deducted for after care by local physician. Requires specification by operating surg. Applies only to service patients; $75 ceiling.
Mich. B.S. Exec.	No	No $2500-$5000 M-S Contract Yes M-75 Series Contract	No $2500-$5000 M-S Contract Yes M-75 Series Contract	M-75 Partial Service	15th-30th day P.O. double coverage individual consideration on contracts having med. coverage. Consultation & surg. asst. Included as class 2 services under M-75 contracts require patient contribution of $5 or 10% of schedule, whichever greater according to subscribers certified annual income.
Minn. B.S. Exec.	Yes	Yes	Yes	S.	15% of scheduled surg. fee deducted for supplemental care or for surg. asst. when scheduled fee more than $75. if designated by surgeon. One bona fide consultation per policy year per subscriber. All on service basis.
Miss. B.S. Exec.	No	No	No		
St. Louis, Mo. B.S. Exec.	No	No	No	I.	Diagnostic work or care prior to surgery covered, also if surg. procedure is minor and scheduled benefit less than allowance per med. visit basis, payment on later scale.
Mont. B.S. Exec.	No	Yes	No	S.	Pays med. care in addition to surg. where 2 MD's render care for conditions which are unrelated, but will not pay 2nd physician for care of condition for which surgery was performed.
N. J. B.S. Exec.	No	Yes	No	S.	Double coverage a. Another physician caring for P.O. complication b. Another physician treating condition other than that for which surgery was performed c. Any med. care in addition to surgery in-patient under 1 year old Consultation service covered if rendered at least 7 days prior to surgery. Limit one. No additional payment for surg. asst. but apportionment on certification of participating surg. Separate payment for each and notification to patient of the same.
N. Mex. Phys. Svc. Exec. Sec.	No	No	Yes	S. Income Limit If Within	In 14 years no request for such service from physicians or patients.
Albany, N.Y. B.S. Exec.	No	No	Yes	S.	Concurrent in-hospital medical care at sole discretion of plan board.
N.C. B.S. Exec.	No	No	Yes	S. If Under Income Limits	75% as scheduled medical allowance for concurrent med. care surg. asst. fee by deduction of 15% of surgical allowance.
N. D. B.S. Exec.	Yes	Yes	Yes	S. If Under Income Level	Payment for extraordinary medical complications treated by other than attending surg. or by attending surg. beyond usual P.O. term consultation maximum $15. Limit one per year.

Ohio Med. I.O.	No	No	No		
Okla. B.S. Exec.	No	No	No	I.	
Ore. B.S. Exec.	Question Misunderstood	Yes	Yes	S.	
Penn. B.S. Exec.	No	Yes	No	S.	Surgeon may assign part of the fee to asst.
S. C. B.S. Exec.	Yes	No	No		Coverage on a very limited and controlled basis for services of another physician when required by complications.
S. D. B.S. Exec.	No	No	No		
Tenn. B.S. Exec.	No	No	No		
Tex. B.S. Exec.	No	No	No		
Utah B.S. Exec.	No	No	Yes	S.	Concurrent med. care covered for severe med. condition or complication portion of scheduled surg. fee as designated by operating surg. May be paid to asst.
Richmond, Va. B.S. Exec.	No	Yes	No	S.	Concurrent med. service at discretion of assn. when required by unsual & grave complications. Individual consideration consultation fee maximum $15.00. No limit except consultant must reside in community where hospitalization occurs.
Roanoke, Va. B.S. Exec.	No	No	No	S.	No medical coverage under any circumstances.
W. Va. B.S. Exec. 8 Plans	No	Yes	Yes	S.	Physician in charge advises plan reduction in scheduled fee with difference being sent to surg. asst. Consultation service available by special rider.
Charleston, W. Va. B. S. Exec.	No	Yes	No		Exception made in case where med. visits are not related to surg. Referral fees are often billed in guise of a consultation.
Huntington, W. Va. B.S. Exec.	No	No	No		
Milwaukee, Wisc	No	Yes	Yes	S.	
B.S. Exec.	No	Yes	Yes	S.	Consultation & surg. asst. fees deducted from total scheduled surg. fee.

TABLE VI

BLUE SHIELD
MEDICAL CARE **The National Association of BLUE SHIELD Plans**
PLANS 425 North Michigan Avenue, Chicago 11, Illinois

September 15, 1958
American College of Surgeons
40 East Erie Street
Chicago 11 Illinois

Attention: Robert S. Myers, M. D.
Assistant Director

Gentlemen:

A survey has been made on the subject of payment of surgical fees in accordance with a request in a letter from Dr. Myers, Assistant Director of the American College of Surgeons, dated June 3, 1958.

This letter stated:

1. The College wants the information on pro-ration solely for the information of the officials of the College.
2. The College will not use this information as the basis for a publication or for a press release.
3. The College agrees that it is the responsibility of the medical profession to set its own patterns of ethics and its adherence to these.

The survey followed discussion between your representatives and ours, and its results were reported to our Board of Directors. The Board has directed that I inform you as follows:

Many plans have an over-all fee for surgery which includes pre-operative, operative and post-operature procedures. The word "pro-ration" is meant to cover only those cases where different procedures or functions are necessarily performed by two or more physicians and not pro-ration of a fee for a single service.

A summary of the reports received indicates the following:

Plans apportioning fees for services of more than one physician number 39.

Services Apportioned	No. of Plans
Post-operative care	27
Assisting at surgery	20
Pre-operative care	15
Consultation	1
Medical care rendered by a second doctor for the condition for which surgery performed	1
For complication and a specialist is called in or when two surgeons work together to obtain a single result such as a bladder excision by one and formation of a new bladder by another	1

Plans not apportioning fees number 29. However, as indicated below, many of these plans pay a separate schedule fee for the following services:

Services not apportioned, but paid as separate schedule fee	No. of Plans
Consultation	13
Assisting at surgery	8
Pre-operative care	7
Post-operative care	4
Medical visits prior to surgery for a separate condition	4
Concurrent medical care	3
Radiology and pathology	1
Services by more than one physician when condition of patient so requires	1

This survey on the matter of apportionment has not revealed that there is a trend toward the encouragement of fee splitting. Very careful regulations have been drawn up by plans to govern cases of apportionment to prevent abuse or violation of the Code of Ethics. In nearly every instance these regulations have been submitted to and have been approved by the sponsoring medical society of the state in which a given plan operates. Information reported to our Board indicates the number of cases of so-called pro-ration is not only infinitesimal compared with the total number of claims paid, but that this proportion is decreasing rather than increasing, thereby demonstrating that the carefully guarded procedures now in operation are actually sound and acting as a protection to medical ethics.

Furthermore, Blue Shield wishes to invite attention to the fact that it does not establish policies in this area of operation, but that such policies are directed by its sponsoring medical societies.

We believe the charge that Blue Shield is contributing to the practice of fee splitting is entirely unfounded.

Sincerely yours,
Donald Stubbs M.D.
Chairman of the Board

The sub-committee feels that all members of ISMA should be informed that in the recent renegotiation of the UAW-CIO contract Blue Shield was unsuccessful in selling the proposed in-patient medical care—4.00/da—rider because union and management found this indemnity above the usual charges made for such care by local physicians and they refused to be party to anything which might serve as an impetus to an increase in the level of medical fees. Instead they paid more money to buy an out-patient diagnostic service rider. The sub-committee feels that basic to the securing of proper indemnities for in-patient non-surgical professional care is a proper valuation being placed on that care by the physicians who are providing such services.

The sub-committee urgently recommends that Blue Cross-Blue Shield be authorized or instructed to find means whereby indemnities for x-ray and laboratory services be paid through Blue Shield to the physicians rendering those services as are the indemnities for physician-administered anesthesia.

The sub-committee recommends that the following resolution supplant the House of Delegates resolution on issuance of two checks by Mutual Medical Insurance, Inc. adopted by the Permanent Study Committee on Medical Care Insurance in 1952.

WHEREAS the board of Regents of the American College of Surgeons have endorsed the following principles concerning medical care insurance plans as being in the best interest of the patient, the profession and the public: (1) every physician involved in the care of the patient is entitled to compensation commensurate with both the value of indicated and necessary services rendered, and with the reasonable ability of the patient to pay; (2) the fee designated for the service of one physician should not be shared with any other physician; (3) insurance plans should not pay to one physician the fee earned by another; (4) medical care insurance plans should not establish fee schedules which interfere with the obligation of the physician to give the best possible care to his patient; (5) the

fee schedule for physicians' services, if established by any medical care insurance plan, should not fix the physicians fee for all patients in that locality and

WHEREAS the Joint Commission on Accreditation of Hospitals disproves nurses, or others who are not graduates of medicine, acting as first assistants on a major surgical case and

WHEREAS the Joint Commission on Accreditation of Hospitals further holds that inasmuch as the surgeon should consider both the safety of the patient and his responsibility for the education of junior surgeons, he should, when performing major surgery, have a capable physician assistant who is competent and ready to continue the operation at any moment in case of necessity. In this instance, major surgery should be considered as any procedure in which there is considered to be hazard to life or any procedure in which a major body cavity is opened, and

WHEREAS few of the hospitals in Indiana where major surgery is performed have a resident house staff of medical graduates available to serve as assistants at major surgical procedures, such necessary surgical assistants must be enlisted from the rolls of local private practicing physicians. Therefore,

BE IT RESOLVED that the Board of Directors of Indiana Blue Shield be instructed to issue a new schedule of indemnities wherein the indemnities for major surgical procedures are set up as "Schedule of Indemnities for the Cooperative Care of the Surgical Patient" listing in separate columns (1) the total indemnity payable for the procedure, (2) the indemnity (75% or 80%) of the total indemnity payable jointly to the certificate holder and the operating surgeon on submission of the proper claim form by the operating surgeon, and (3) the indemnity (20% or 25% of the total indemnity) payable jointly to the certificate holder and the "cooperating physician"—for his services as surgical assistant or physician providing a necessary supplemental skill—on submission by the "Cooperating Physician" of proper and separate claim form. Further,

BE IT RESOLVED that the Board of Directors of Indiana Blue Shield take steps promptly to bring their schedule of indemnities into conformity with the ISMA Relative Value Schedule just as soon as such a schedule is prepared and adopted.

Subcommittee on Medical Economics

1. The commission recommended that the Indiana State Medical Association not endorse or underwrite any individual or group plan of insurance for life, health and accident, office expenses, etc., pending evidence of greater demand from the membership of the association that such was desired. The commission recognized that many specialty groups already had such coverage.
2. The Council is to be advised again of our recommendation to adopt the H. I. C. Simplified Claim Forms in Indiana. The doctors and insurance companies are to be so informed.
3. In answer to the AMA request regarding the questions on "free choice" and "panel practice" as posed in Doctor Blasingame's letter, the commission recommended the adoption of Doctor Benoit's statement on "free choice" which reads as follows:

FREE CHOICE OF PHYSICIAN

Definition

Free choice of physician is the right of the responsible adult individual to select whoever he chooses, of his own free will and accord, to contract with to provide him with medical care, treatment or recommendations.

(No one questions this right when the individual is responsible directly for the payment of the services. It is equally true in those cases where, 1) through the selection of an insurer, he delegates the responsibility for such payment by furnishing cash premiums to the insurer or, 2) where the individuals' employer agrees to receive contributions from the individual, in the form of withholdings from wages or as payment in lieu of wages; the employer thus acts as the insurer or the insurers agent.)

Remarks and Explanations

1. Where the premiums are paid entirely by the individual, either directly to the insurer or indirectly in the form of withholding from wages, there can be no question as to his freedom of choice of physician.
2. Where the employer contributes a portion of the premium payment, in lieu of wages, there can be no question as to the individuals' freedom of choice of physician.
3. Certain categories of individuals are, by law, not expected to exercise free choice of physician. For these persons someone else stands responsible. Examples of these are:
 1) Minors.
 2) Members of the Armed Services.
 3) Persons to whom someone stands *in loco parentis.* These are persons serving prison terms, persons committed to mental institutions, or other persons whom the courts have designated incompetent.
 4) Persons, who by virtue of their employment, come under the Workmen's Compensation Laws, which laws make the employer assume responsibility for the occupational injury or disease, the costs of treatment, the loss of wages and any resultant permanent disability.

(Accepted by the Indiana State Medical Association Commission on Medical Economics and Insurance, March 22, 1959.)

It further recommended the following regarding Closed Panel Systems of medical care:

Closed panel systems within the practice of medicine have existed for many years in many hospital staffs (community, private and university) and in many clinics with outpatient departments. These systems do not restrict free choice of physician in our opinion. It is deemed proper that other legally constituted bodies may also organize closed panels on the basis of accepted medical professional standards, evaluation and direction. Physicians so included are judged to be practicing fully within the principles and ethics of the medical profession. No panel which involved (a) incompetent medical care, (b) economic exploitation of the patient, or (c) a deficiency of professional direction of the panel's administrative operations is acceptable to the profession.

We ask your concurrence in these actions.

COMMISSION ON MEDICAL ECONOMICS AND INSURANCE

EDWARD T. EDWARDS, M.D., *Chairman*
JOHN L. ARBOGAST, M.D.
JOHN W. BEELER, M.D.
MERRILL P. BENOIT, M.D.
ROBERT N. BILLS, M.D.
RICHARD P. GOOD, M.D.
HUBERT T. GOODMAN, M.D.
MURRAY E. HARDEN, M.D.
JOHN LANGHOR, M.D.
GEORGE E. PAINE, M.D.
JOHN M. PARIS, M.D.
WILLIAM SCHARBROUGH, M.D.
WENDELL C. STOVER, M.D.
LOWELL I. THOMAS, M.D.
MORRIS D. WERTENBERGER, M.D.,

Inter-Professional Relations

Three meetings of the commission were held: Feb. 11, April 29 and June 24, 1959. In concurrence with the recommendation of the House of Delegates, the commission continued its study of the ethical relationship with osteopaths, optometrists and chiropractors. There was no active contact with organizations representing either the optometrists or chiropractors.

The osteopathic question was discussed at all meetings and a joint conference with the representatives of the osteopathic organization, headed by Dr. D. H. Wolf, was held on the occasion of the June 24 meeting.

The sense of this discussion was that the osteopaths have held off any legal or other abrupt action in regards to obtaining hospital privileges in county hospitals to which they would be entitled by state law. They stated since they have not received the cooperation of the Indiana State Medical Association, it would be necessary for them to approach the Council on Hospital Licensure, and possibly then the courts, to obtain their privileges. They are reluctant to do this and would prefer that the medical association assist them in the approach to the hospitals.

The commission was not fully informed of the then very recent action of the House of Delegates of the American Medical Association. The osteopathic representatives were assured that the Inter-Professional Relations Commission would be interested in maintaining liaison with their group but that we could make no comment or relay any idea as to policy until the meeting of the Executive Committee of the Indiana State Medical Association clarified the standing of the association.

A resolution was adopted by the commisison to the effect that the Indiana State Medical Association and its constituent organizations be guided by the state laws in regard to osteopathic privileges in hospitals.

The executive secretary was requested by the commission to write appropriate letters to the various professional organizations in the state with which organized medicine should maintain contact. These included the organizations representing hospitals, nurses, pharmaceutical houses, dentists, veterinarians, osteopaths and optometrists. This letter was to appraise these state organizations of the availability of this commission to consultation should any appropriate matter be brought to our attention. No replies suggesting the need for such conferences have been received.

Dr. Nathaniel Ewing has been serving as liaison with the nursing profession and nursing educational activity in the state. Your commission is well informed on the changes in nursing educational patterns and a resolution has been adopted requesting that the Indiana State Medical Association appropriate a sum not to exceed $500 for the Joint Committee for the cost of nursing education, to be used in furthering the establishment of nursing courses in colleges and universities in this State.

"BE IT RESOLVED, that the House of Delegates authorize the Budget Committee to appropriate a sum not to exceed five hundred dollars ($500) from any balances of the Association for the use of the Joint Committee for financing and expanding nursing education for the purpose of conducting a conference designed to further the establishment of courses in nursing in the colleges and universities of the State of Indiana."

Dr. Russell Spivey heads a subcommittee to meet with the State Anatomical Board and representatives of Indiana University to investigate the manner by which the Indiana State Medical Association and its component societies can help to alleviate the anatomical material shortage through contact with morticians and their state organization.

It is felt considerable progress has been made in this area and the receipt of cadavers from local funeral homes has improved greatly in the past year.

The commission again goes on record as recommending that all efforts be made to influence the legislature to revise the state law to provide for more than one physician member of the Council on Hospital Licensure. The difficulties encountered in the most recent legislature are known; however, the recommendation is again repeated well in advance of the next session of the legislature.

JOSEPH B. DAVIS, M.D., *Chairman*
FRANK H. GREEN, M.D.
ROBERT H. RANG, M.D.
JOSEPH D. MCDONALD, M.D.
WILLIAM PAYNTER, M.D.
KENNETH D. SCHNEIDER, M.D.
PAUL E. HUMPHREY, M.D.
FLOYD A. BOYER, M.D.
C. V. ROZELLE, M.D.
ELI B. HARTER, M.D.
MILTON B. GEVIRTZ, M.D.
C. JULES HERITIER, M.D.
F. R. NICHOLAS CARTER, M.D.
NATHANIEL D. EWING, M.D.
RUSSELL J. SPIVEY, M.D.

Medical Education and Licensure

The work of this commission this year represents a continuation of the policies started last year; namely, an extension of the tape library and its supervision, cooperation with the teaching profession, the Indiana State Board of Medical Registration and Examination, the Indiana State Board of Health and the Indiana University School of Medicine, the Mental Health Group, and continuing our work on supervision of the elementary school health text-books in the State of Indiana.

Three meetings were held of the commission as a whole. The first meeting was at the general organizational meeting of the entire Indiana State Medical Association, held Sunday, Nov. 23, 1959, at the Columbia Club, Indianapolis. This meeting was an organizational meeting, resulting in re-election of the officers for another year, viz:

Chairman: Elton R. Clarke, M.D., Kokomo

Vice-Chairman: Harry E. Klepinger, M.D.. Lafayette

Secretary: Kenneth G. Kohlstaedt, M.D., Indianapolis

Chrmn., Comm. on Medical Education: Ralph C. Eades, M.D., Valparaiso

Chrmn., Comm. on Licensure: Joseph H. Clevenger, M.D., Muncie

Resolutions passed at this year's state convention, namely Nos. 9, 14, 15 and 20, were discussed, of which No. 14 was presented in modified form and passed. This resolution was one presented by the Vanderburgh County Medical Society in opposition to "Invasion of Private Medical Practice by Teaching Hospitals."

The next general meeting of the commission was held on Sunday, Feb. 1, 1959, in Indianapolis. The meeting was chiefly an "in progress" meeting of sub-committee reports and reports of guests. Of these, the following spoke: Dr. John VanNuys on curriculum changes at Indiana University, and the current status of Medical Education in Pakistan. Dr. P. T. Lamey discussed the bill for the licensing of foreign doctors and a bill for issuance of temporary training permits to them; also the chiropractic bill. Dr. A. C. Offutt discussed the nursing home problem and the care of the aged, immunization of first grade pupils in school, poison registry of household products, poison information centers and the radiation health act. Dr. Robert Seibel presented a "School Health Policy" compiled by Bob Yoho, Ph.D. Doctor Bacastow of the Methodist Hospital, Indianapolis, reported on problems of foreign students and their permits, also programs of education for the intern. The Indiana State Medical Association should support education programs for interns, and this could be done through the annual convention of the association.

The third meeting of the commission was held at the headquarters office, Wednesday, June 17, 1959.

Sub-Committee on Internships

"I am terribly sorry that I am not able to submit a better report for the Sub-Committee on Internships. I made an honest effort to organize a panel discussion on internships and residencies either as a part of the refresher course, or as a separate meeting, but met with no success at this time.

"The person I was most anxious to get was Dr. Ed Turner, who has been secretary of the Council on Medical Education, but at the time I wrote to him, his title had just been changed, and he had new duties. The man who has taken over his job, Dr. Nunamaker, said that he was too busy getting into the swing of his new job, and consequently could not guarantee attendance at our meeting. It would seem to me most desirable to have someone who occupies an important position in the Council to take part in this discussion, and consequently I have let the matter drop. We could, of course, get other people, but one would need the benefit of a "name" to attract an audience. Perhaps next year something can be done about this: our Dr. Bacastow is certainly anxious to participate in any way he can. He, too, tried to get people to help in a panel discussion and met with failure. Aside from these abortive efforts, we have done nothing."

HAROLD C. OCHSNER, M.D.

The third meeting of this commission was held in the State Headquarters, Wednesday afternoon, June 17, 1959. In the absence of Chairman Elton Clarke, Dr. Harry E. Klepinger, vice-chairman, was in charge.

This meeting was attended by Mr. James Waggener, state secretary, who was very informative and helpful in giving the committee a realistic picture of what occurred at the Atlantic City meeting of the House of Delegates only a few days before.

Each committee and sub-committee was represented and the meeting was very helpful in attempting to set forth problems and ideas for consideration of the new commission which will be named at the coming convention in October.

Some of the problems which might well be considered include such pertinent ones as:

1. The establishment of a mid-winter scientific (only) meeting at French Lick.
2. Further study of the problems pertaining to osteopathy in our state.
3. Closer liaison with teaching profession with view to examining medical and scientific teachings prior to adoption as a prophylactic measure.
4. A thorough study of internships in Indiana.
 a. How long should they be?
 b. What should be included, excluded in their program?
 c. We should support the Land Resolution presented to the AMA House of Delegates.
 d. We should interest our profession more with regard to teaching in the medical schools and their curricula.
5. Consideration of types and content of residency training in our hospitals.
 a. All post-graduate work should be evaluated.
6. Study the varieties of nursing school teachings offered in our hospitals.
 a. How badly, if at all, is an outpatient department needed?
7. What should be the relationship of our Indiana State Board of Registration to national boards?
8. What should we do about temporary training permits, especially for foreign doctors?
9. Methods of publicizing medical ethics.
10. The art of medicine should be present both within and without the profession.
11. Scientific medicine, *per se*, should be evaluated.
12. Better liaison with University Chapter, Student AMA.
13. Interest the doctors in getting practice of medical principles over to their patients.
14. Invite M.D.'s to attend various committee meetings.
15. We should "re-think" our position and assert ourselves in a more positive way, concertedly.
16. The district meetings need to be studied, evaluated and given a thorough overhauling.
 a. Stimulate attendance.
 b. Better programs.
 c. Better, more efficient organization.

These and many other educational problems face our profession. Many overlap with other commissions. They should be studied and, when needed, the combined efforts of two or more commissions should be available.

Sub-Committee on Education

Report of Committee on Textbooks for Health Teaching in Public Schools.

The purpose of our committee was to find the answer to two questions regarding the texts that children in our schools are to study:

1) Is the material factual and accurate in light of current scientific and medical knowledge?
2) Does it contain any subject matter that tends to promote socialistic trends in our society—medical or otherwise?

The committee did not concern itself with the presentation of or arrangement of the material and subject matter of the books.

With this in mind, the following textbooks were reviewed and the committee did *not* find any material that conflicted with present and accepted medical facts nor did they promote socialistic ideology.

A.B.C. Health Series—American Book Company
- All Day—Every Day
- Blue Skies
- Come Rain—Come Shine
- Among Friends
- Broad Streets
- Cross Roads
- About Your Health
- Building Better Health

Winston Health Series—The John C. Winston Co.
- From Head to Toe
- Side By Side
- How We Grow
- Bigger and Bigger
- Getting Acquainted
- Knowing Yourself
- Adventures in Living
- New—Wider Horizons

Health Series—J. B. Lippincott Co.
- Building Health
- Enjoying Health
- Health for You

Henry L. Holt Co.
- Modern Health

Harcourt, Brace & Company
- Your Health and Safety

The committee is deeply appreciative of the assistance and cooperation of Dr. Robert Yoho in procuring the textbooks for this study.

Supplementary Report of Committee on Textbooks for Health Teaching in Public Schools.

The following books were received subsequent to the first report and have been reviewed:

Health — Happiness — Success Series —Lyons & Carnahan:
- Awake and Away
- Growing Day by Day
- Keeping Fit for Fun
- All Aboard for Health
- Better Health for You
- Safeguards for Your Health
- You and Your Health
- Good Health for All

It was noted by the committee that in the text *You and Your Health* suggestions as to treatment were given, i.e., p. 19, "2. Name some new drugs now being used in the treatment of certain diseases." An error not noted by the proofreader on p. 57, "Irradiated milk has been enriched with vitamin D by submitting it to *infrared* rays." (The text had discussed irradiation by the ultraviolet ray correctly on p. 53.) In the text *Good Health for All*, p. 253, "Physicians today have effective drugs to use, such as penicillin, which help to reduce the seriousness of pneumonia."

It is the belief of the committee that there should be no presentation of a drug as treatment for any disease entity except in those cases where specific therapy is universally accepted as—diphtheria antitoxin for diphtheria. These are not things to present to the grade school student, as they may well cause him to question the family M.D. when such drugs may not be used by the M.D. in cases noted by the textbook—and the textbook is *right* to the student at that age.

ELTON R. CLARKE, M.D., *Chairman*
HARRY E. KLEPINGER, M.D., *Vice-chairman*
KENNETH G. KOHLSTAEDT, M.D.
MELL B. WELBORN, M.D.
WILLIAM C. REED, M.D.
DANIEL H. CANNON, M.D.
ROBERT SEIBEL, M.D.
BASIL M. MERRELL, M.D.
NORMAN F. RICHARD, M.D.
HAROLD C. OCHSNER, M.D.
JOSEPH H. CLEVENGER, M.D.
ROBERT A. HEDGCOCK, M.D.
RALPH C. EADES, M.D.
LINUS MINICK, M.D.
LOUIS E. HOW, M.D.

Constitution and Bylaws

This is the annual report of the Commission on Constitution and Bylaws to the House of Delegates of the Indiana State Medical Association. Various subjects were considered and noted under the following headings:

Reference Committees

The matter of specifying in the Bylaws that members of the reference committees of the House of Delegates be members of the House of Delegates was discussed. The recommendation of this commission is expressed in the following resolution:

BE IT RESOLVED, that the first sentence of paragraph 3 of section 1 of Chapter XXIV of the bylaws of the ISMA which now reads, "Each committee shall consist of five members, the chairman to be specified by the President," be amended to read, "Each committee shall consist of five members, at least three of whom shall be members of the House of Delegates. The chairman shall be named by the President from among those who are members of the House of Delegates."

County Society Constitution and Bylaws

On Feb. 22, 1959, the commission requested (through ISMA headquarters office) legal counsel of ISMA to prepare amendments to the Bylaws having the effect of requiring composite county medical societies to file, annually, an up-to-date copy of their Constitution and Bylaws not later than May 1 of each calendar year, or a certificate certifying no change, and providing that any county society not complying will have its delegates to the State Convention declared ineligible for seating at the next Annual Convention. To carry out this proposed change, we submit the following:

"BE IT RESOLVED, That Sec. 15 of Chapter XXV of the by-laws, which now reads as follows:

'Sec. 15. Each component society shall have its own Constitution and Bylaws, not in conflict with the Constitution and Bylaws either of this Association or of the American Medical Association, a copy of which shall be filed with the Executive Secretary of this Association; and furthermore, the Executive Secretary shall be notified at once of any changes or amendments that may be made from time to time.'

be amended to read as follows:

'Sec. 15. Each component society shall have its own Constitution and Bylaws, which shall not be in conflict with the Constitution or Bylaws either of this Association or of the American Medical Association. An up-to-date copy thereof shall be filed with the Executive Secretary of the Indiana State Medical Association not later than May 1 of each calendar year, or where such copy is so on file and no change has been made, then it shall be sufficient to file a certificate to that effect with said Executive Secretary.'"

It has been proposed that any component society not meeting this requirement be ineligible to have its delegates seated at the next annual convention. In this connection we call your attention to Article V of the Constitution, which provides in part as follows:

"The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) delegates elected by the component county societies;"

Since the Constitution expressly provides that delegates elected by component societies shall be members of the House, we seriously doubt if restrictions could be placed thereon in the bylaws or if by bylaw, an elected delegate could be made ineligible for seating without amending this section of the Constitution. Such an amendment could be accomplished by adding to the above quotation the following:

"which have met all requirements of this Constitution and of the Bylaws of this Association."

The amendment would then read as follows:

"Article V. The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) delegates elected by the component county societies, which have met all requirements of this Constitution and of the By-Laws of this Association; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be ex-officio members: the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote."

For this reason we have not added such a clause to the amendment of Sec. 15 of Chapter XXV of the Bylaws. Should such a penalty be desired, then Article V of the Constitution should be amended as above suggested. Such an amendment could not be finally adopted until the annual convention in 1960, and concurrently therewith there could be submitted a further amendment to Sec. 15, of Chapter XXV of the Bylaws, as follows:

"Any component society which has not complied with this section shall not be eligible to have delegates elected by such society seated at or participate in the proceedings of the House of Delegates at the next succeeding annual convention. Provided, however, that any such delinquent component society, upon presenting satisfactory evidence of having filed such Constitution and Bylaws or such certificate of no change before the next succeeding meeting of the House of Delegates, may have its elected delegates seated at such meeting upon a two-thirds (⅔) vote of the qualified delegates."

Fiscal Year

On Feb. 22, 1959, the commission requested legal counsel of ISMA to prepare amendments to the Constitution and Bylaws to bring them into conformity with any change which might be made by the Executive Committee and the Council concerning the fiscal year of the association. In January, the Council received a report from Wolf Management Engineering Firm recommending that the fiscal year of the association be changed from October 1 to September 30. In order to accomplish this, we propose the following changes:

In order to change from a calendar year to a fiscal year, it will be necessary to amend Sec. 2 of Chapter IX of the Bylaws and to also amend Chapter XXV, Section 12 of the Bylaws.

Said Section 2 of Chapter IX, referring to the Executive Committee, provides "It shall prepare a budget for the ensuing calendar year;" This should be amended by changing the word "calendar" to "fiscal."

Sec. 12 of Chapter XXV is a lengthy section and provides that the fiscal year shall be the calendar year. It then ties the payment of dues to a calendar year. Consequently, this section would have to be rewritten and if the principle of paying dues by the first of the fiscal year be retained, this would make dues payable by October 1. If it be desired to accomplish this result, then the following two resolutions should be adopted:

"BE IT RESOLVED, That Sec. 2 of Chapter IX of the Bylaws, which presently now provides in part as follows:

'It shall prepare a budget for the ensuing calendar year;'
be amended to read as follows:

'It shall prepare a budget for the ensuing fiscal year;' "
and a further resolution as follows:

"BE IT RESOLVED, That Sec. 12 of Chapter XXV of the By-Laws, which presently reads as follows:

'Sec. 12. The fiscal year of the Association shall be the calendar year, and all dues shall be for the year and payable in advance.

'The secretary of each component society shall forward the dues for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Secretary of this Association the dues for such new members.

'The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only. Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay $10.00 as dues for the remainder of that year. Interns and residents shall pay $10.00 a year annual dues during their term of service in the hospital.

'In the event the county society remits a member's dues for good cause, the secretary of the county medical society shall recommend in writing to the councilor of his district the remission of the state association dues of said member of the society, showing good cause why such recommendation should be granted. The councilor in turn may present the recommendation to the Council, which shall have the power to remit such dues.'
be amended to read as follows:

'Sec. 12. The fiscal year of the Association shall be from October 1 to September 30 of the succeeding year. All dues shall be payable for the year and payable in advance. The secretary of each component society shall forward the dues for his society, together with a roster of officers and members, and list of non-affiliated physicians of the county, to the Executive Secretary of this Association on or before October 1 of each year and he shall promptly report thereafter the names of any new members elected to membership in his society and promptly forward to the Executive Secretary of this Association the dues for such new members.

'The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the fiscal year only. Provided, however, that physicians elected to their first membership in this Association during the first nine months of any fiscal year shall pay the regular annual dues for that year and those elected to their first membership after the said first nine months of any fiscal year shall pay $10.00 as dues for the remainder of that year. Interns and residents shall pay $10.00 a year annual dues during their term of service in the hospital.

'In the event the county society remits a member's dues for good cause, the secretary of the county medical society shall recommend in writing to the councilor of his district the remission of the state association dues of said member of the society, showing good cause why such recommendation should be granted. The councilor in turn may present the recommendation to the Council, which shall have the power to remit such dues.'"

It will also be necessary to amend Sec. 13 by changing the date "February 1" in said section to "November 1." There should, therefore, be a third resolution as follows:

"BE IT RESOLVED, That Sec. 13 of Chapter XXV of the By-Laws be amended to read as follows:

'Any county society which fails to pay its dues or make the report required by November 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.'"

A fourth amendment to the Bylaws will also be necessary in that Sec. 7 of Chapter XXVIII relating to medical defense should be amended by changing the date therein of "January 1" to "October 1" and the date "February 1" to "November 1," and insert the word "fiscal" ahead of the word "year," as follows:

"BE IT RESOLVED, That Sec. 7 of Chapter XXVIII of the Bylaws be amended to read as follows:

'The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on October 1, and become delinquent on November 1 of each fiscal year. The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only bona fide evidence of payment of dues or membership in this Association.

'The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.'"

Model Constitution and Bylaws

A sub-committee of this commission has been established to prepare a draft of a model constitution and bylaws for the guidance of component societies of the ISMA. This work is in progress now and should be ready for consideration by the commission this fall. Certain unexpected technicalities have delayed processing this project.

Members in Federal Service

It is the feeling of this commission that all members of the ISMA who have made a *career* in any branch of the defense establishment, the federal public health service, or the Veterans Administration, should pay the full dues to the ISMA, interns and residents excluded.

Representation on Council

Consideration was given to the matter of proportional representation on the various councilor districts on the Council of the ISMA. This matter was presented pursuant to action of the House of Delegates on the Reference Committee Report on Resolution No. 11. After long discussion of this matter from all angles and viewpoints, this commission has found no convincing reasons to advise changing the representation of the councilor districts on the Council of the ISMA.

Allocation of Delegates

It is the feeling of this commission that for the purpose of determining the number of delegates authorized a component medical society, no distinction should be made among members with respect to the particular dues category an individual member may enjoy.

Election in Absentia

Dr. E. S. Jones of Hammond has informed this commission of his opinion regarding the provision of Section 3, Article IX of the Constitution of the ISMA, concerning elections wherein ". . . no person shall be elected . . . who is not in attendance on that Annual Convention, and who . . .". This provision of the Constitution has been studied by this commission. It was agreed by this commission to request the attorney of the Association to prepare an amendment to Section 3, Article IX of the Constitution of the ISMA, to read, in substance, as follows:

BE IT RESOLVED, that that part of Section 3 of Article IX of the Constitution of the ISMA which now reads "and no person shall be elected to any such office who is not in attendance on that Annual Convention and who has not been a member of the Association for the preceding two years," be amended by substituting therefor the following: "and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years."

Meetings of this commission were held at Indianapolis on Nov. 23, 1958 and Feb. 22, 1959. The terms of office of 1 or 2 or 3 years dating from the annual convention of October, 1958, are indicated by the numeral placed after the name of each member.

A. W. Cavins, M.D., *Chairman*, 1
William B. Challman, M.D., 3
J. H. Crowder, M.D., 1
James Y. McCullough, M.D., 1
Gordon S. Fessler, M.D., 2
Howard E. Sweet, M.D., 1
Charles A. Jones, M.D., 3
Irwin S. Hostetter, M.D., 2
William M. Sholty, M.D., 3
Philip J. Rosenbloom, M.D., 2
Lowell J. Hillis, M.D., 2
Truman E. Caylor, M.D., 3
John B. Cleveland, M.D., 2
G. O. Larson, M.D., 3
Robert M. Hansell, M.D., 1

Special Activities

The Commission on Special Activities has continued its primary effort in American Medical Education Foundation. The 1958 total of $50,259.97 was a gain to 2½ times that of 1957. For this Indiana received a special "Merit Award" at the Atlantic City (1959) Annual Meeting. The dues increase of $10 has apparently been accepted with rank and file.

Contributions from auxiliary and individuals continue during the year. The other efforts for AMEF are monthly advertisements in our state *Journal*, which have been only fairly effective.

Plans are underway now for talk on AMEF to juniors and seniors in Indiana University; this is an attempt to educate students regarding this fund. Mr. William Armstrong of I. U. Foundation has been contacted to discuss a joint fund-raising effort among I. U. School of Medicine graduates. Facts show that most M.D.'s have loyalty to nearby schools in addition to their Alma Mater, should they be different schools. The commission and auxiliary plan an exhibit at 1959 State Association Meeting.

The second concern of our Special Activities Commission has been a survey regarding blood banks. This problem has been acute in some two or three areas of the state. The questionnaires were mailed to presidents and secretaries of each component society, as well as administrators of each licensed hospital in the state. These questionnaries have been summarized.

The commission feels that an investigation of physicians' activities in civic affairs and interest in medical organizations would be of great interest and help to public relation committees. Such will be their suggestion to the Council.

Malcolm O. Scamahorn, M.D., *Chairman*
Earl W. Bailey, M.D. *Vice-chairman*
Robert L. Parr, M.D., *Secretary*
Forrest R. LaFollete, M.D.
Joseph E. Coleman, M.D.
C. Philip Fox, M.D.
Eli Goodman, M.D.
Jack Shields, M.D.
Sturart R. Combs, M.D.
H. N. Smith, M.D.
E. H. Clauser, M.D.
T. A. Dykhuizen, M.D.
Jack L. Eisaman, M.D.
Edward W. Sirlin, M.D.
Guy B. Ingwell, M.D.

Amendments to the Constitution and Bylaws

To be Voted on at Indianapolis Session, 1959

At the 1958 annual convention at Indianapolis, the House of Delegates adopted the report of the Reference Committee on Amendments to the Constitution and Bylaws, which contained the following recommendation:

"The part of the report of the Commission on Constitution and Bylaws titled, 'Speaker of the House of Delegates,' involves an amendment to the Constitution which cannot be voted on until the next annual convention. As there is no purpose in changing the Bylaws until the Constitution is amended in regard to a Speaker of the House of Delegates, we present this part of the report and recommend it be held over for vote until the next annual convention."

Resolution on Speaker and Vice-Speaker of House of Delegates

BE IT RESOLVED, that Article IX, Section 1, of the Constitution of the Indiana State Medical Association be amended by inserting in Line 3 of Section 1, after the word "Treasurer" and before the word "and" the following words: "a Speaker and a Vice-Speaker of the House of Delegates";

BE IT FURTHER RESOLVED, that Chapter VI, Section 1, of the Bylaws of the Indiana State Medical Association be amended by deleting the first sentence of Section 1;

BE IT FURTHER RESOLVED, that Chapter VI of the Bylaws of the Indiana State Medical Association be amended by adding a new section, to be designated as Section 4, to read as follows:

"SECTION 4. The Speaker of the House of Delegates shall preside at all meetings of the House of Delegates and shall appoint all Reference Committees. He shall organize and conduct the business of the House of Delegates, but shall not have a vote therein except in case of a tie. He shall be an officer of the Association with the right to participate in the discussion in the meetings of the Council and of the Executive Committee but without power to vote in either of such meetings. If the Speaker is absent or unable to perform his duties, the Vice-Speaker shall perform them";

BE IT FURTHER RESOLVED, that the Bylaws of the Indiana State Medical Association be amended by renumbering the sections of Chapter VI of the Bylaws, so that the present Section 4 of Chapter VI shall be numbered Section 5 of Chapter VI, and that the present Section 5 of Chapter VI shall be numbered Section 6 of Chapter VI;

BE IT FURTHER RESOLVED, that the Bylaws of the Indiana State Medical Association be amended by changing Section 4 of Chapter V to read as follows:

"SECTION 4. The President, President-elect, Treasurer, Speaker and Vice-Speaker shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect and Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates";

BE IT FURTHER RESOLVED, that the Bylaws of the Indiana State Medical Association be amended by substituting the word "Speaker" for the word "President" whenever the word "President" occurs in Sections 1 and 2 of Chapter XXIV of the Bylaws.

Resolutions

Resolution No. 1

Introduced by: THE MADISON COUNTY MEDICAL SOCIETY

Subject: RESOLUTION OPPOSING THE RELATIVE VALUE SCALE

WHEREAS, the determination of a physician's fees is an individual matter, to be arrived at by mutual understanding between the physician and his patient, and

WHEREAS, any attempt by any other party, including organized physician-groups, to influence the conduct of the individual patient-physician relationship, in the matter of arriving at a satisfactory charge for service, is unjustified and endangers personal liberty, and

WHEREAS, there has been devised and promulgated, by organized physician-groups, a coding of weights of several medical and surgical procedures, known as the Relative Value Scale, and

WHEREAS, the use of the Relative Value Scale, in conjunction with a conversion factor, to be determined by the organized physician-groups in given geographic or political areas, results in creating a Fixed Fee Schedule, and

WHEREAS, such a Scale and its companion, the conversion factor, which are announced by organized physician-groups themselves, serve the interests of unions, insurance companies and other groups both as a club to promote their insistence on the acceptance of a fixed set of physicians' rates and as a wedge to divide those physicians unwilling to participate from their colleagues, and

WHEREAS, such a Scale, with its conversion factor, in the face of organized group and general public pressures against justifiable rate increases, would impose undesirable economic restrictions, which with continuing inflationary trends, would prove to be a financial hardship to physicians from which the only hope for relief would be in the direction of bargaining with representatives of labor, the insurance companies and others,

THEREFORE BE IT RESOLVED, that the Madison County Medical Society condemns the Relative Value Scale as a dangerous device capable of doing great harm to patients, physicians and the medical profession, and

BE IT FURTHER RESOLVED, that a copy of this Resolution be sent to the Indiana State Medical Association for presentation to the House of Delegates at the annual meeting, October, 1959.

Resolution No. 2

Introduced by: THE VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: SPECIALTY JOURNALS AS BENEFIT OF AMA MEMBERSHIP

WHEREAS, The AMA has this year included in the annual dues a subscription to one of its specialty journals as an added benefit of membership, and

WHEREAS, The primary function of the AMA is not the publishing of journals, and

WHEREAS, Anything which fosters the glut of medical writing which already inundates the profession should be critically appraised, and

WHEREAS, The portion of annual AMA dues thus diverted to subsidize such journal publishing might be devoted to other constructive purposes, now therefore be it

RESOLVED, That the Indiana State Medical Association urge the American Medical Association to reconsider its decision to include specialty journals as a benefit of membership and to ascertain the preference of members generally, and be it

FURTHER RESOLVED, That this resolution be introduced in the House of Delegates of the Indiana State Medical Association in Indianapolis, October 1959, and presented at the Clinical Session of the AMA House of Delegates in Dallas, December 1959.

Resolution No. 3

RESOLUTION No. 3

Introduced by: THE TIPPECANOE COUNTY MEDICAL SOCIETY

Subject: CONSTRUCTION OF BUILDING TO HOUSE THE INDIANA STATE MEDICAL ASSOCIATION

BE IT RESOLVED, that the Tippecanoe County Medical Society wishes to go on record as favoring the construction of a building to house the Indiana State Medical Association on or adjacent to the medical campus in Indianapolis.

Resolution No. 4

Introducted by: THE LAKE COUNTY MEDICAL SOCIETY

Subject: DETERMINATION OF CAUSE OF DEATH

WHEREAS, the present laws of the State of Indiana governing the determination of cause or causes of death involving violence are inadequate, and

WHEREAS, there is reason to believe that violent deaths, including homicide and suicide, can and do occur in the State of Indiana without detection, and

WHEREAS, there is further reason to believe that undetected criminal cases in the State of Indiana provoke more criminal acts of violence and the perpetrators are unpunished, and

WHEREAS, there is sufficient reason to believe that "natural deaths" are signed unknowingly by health departments as heart disease or cerebral hemorrhages instead of homicides or suicides, now therefore

BE IT RESOLVED, that the Indiana State Medical Association seek the adoption of appropriate legislation in the 1961 General Assembly requiring a more thorough medical investigation of all deaths from violent causes, suspicious deaths, or deaths without medical attendance, and

BE IT FURTHER RESOLVED, that unattended natural deaths and those deaths which the attending medical doctor deems investigation is necessary be delegated to the respective county coroner.

Resolution No. 5

Introduced by: THE LAKE COUNTY MEDICAL SOCIETY

Subject: IMMUNIZATION OF SCHOOL CHILDREN

WHEREAS, the medical profession and health educators have for many years urged the immunization of children against smallpox, diphtheria, whooping cough, tetanus, and other diseases without complete success, and

WHEREAS, the public response to our recent urgings for polio immunization has again pointed out the indifference of many parents to their responsibility in this respect, and

WHEREAS, the neglect of such protection constitutes a threat against all children in our schools, now therefore

BE IT RESOLVED, that the Indiana State Medical Association seek the adoption of appropriate legislation in the 1961 General Assembly to require prior and effective immunization of all children before admission to the first year of school, exempting only the conscientious religious objectors and those persons where a medical reason contraindicates the immunizations, and

BE IT FURTHER RESOLVED, that such immunizations be done at the individual parent's expense, except that appropriate means be adopted to immunize those children whose parents are determined to be indigent.

Technical Exhibits

Booth — **Company and Products**

H-2 **ABBOTT LABORATORIES**
North Chicago, Ill.

R. D. Hickman, J. P. Smith, J. L. Buster, S. D. Redman, W. L. Castner, C. W. Hall.
Exhibit will feature the Abbott Laboratories Antibiotic Triad—three products which together provide control of all coccal infections: Erythrocin[R] Stearate, Compocillin[R]-VK and Spontin[R]. Also shown will be Abbott's unique new "metered release dose form" products, Tral Gradumets[R] and Deoxyn Gradumets[R], plus a selection of other Abbott specialties.

B-12 **AKRON SURGICAL HOUSE, INC.,**
Indianapolis 4

Akron Surgical House, Inc. is pleased to announce its exhibit at the annual convention of the Indiana State Medical Association on October 6, 7, 8 and 9, 1959.
Clarence Lippott, Ed Hallyburton and Bob Pierce will be on hand in our booths to answer any questions about the items of instruments and equipment to be on display.

K-4 **A. S. ALOE COMPANY, St. Louis 3**

Donald DeBasio

Visit booth K-4 where the A. S. Aloe Company will have on display a cross section of their complete line of physicians equipment and supplies. Many new items will be featured and our representative will welcome this opportunity to discuss them with you.

F-5 **AMERICAN FERMENT CO., INC.,**
New York 18, N. Y.

F. W. Dulle

Featuring the digestant, choleretic laxative action of Caroid and Bile Salts Tablets as a logical complement in modern methods of therapy. Stop by for a personal supply of Alcaroid Antacid, powder or tablets.
Also featured: Supligol, a whole bile, bile acid compound tablet.

B-3 **AMES COMPANY, INC., Elkhart**

Robert F. Myers

Featured at the Ames Company exhibit will be the latest developments in new, simplified diagnostic products, which are adaptable to routine examination and patient management. The many advantages of the new diagnostic products are quickly demonstrable, and you are cordially invited to stop at the Ames booth to see them.

D-5 **AYERST LABORATORIES,**
Arlington, Virginia

Ayerst Laboratories welcomes the members to the 1959 Annual Convention of the Indiana State Medical Association. You are cordially invited to visit our booth where our exhibit will feature "Murel," a new spasmolytic which offers a unique 3-way mechanism of action in one molecule.

Booth — **Company and Products**

D-2 & D-4 **BAKER BROTHERS, Indianapolis 2**

Mr. and Mrs. Frank M. Jones

Baker Brothers invites you to visit our booths D-2—D-4 and inspect the latest and finest in invalid equipment.
We would like to take this opportunity to thank you for your patronage and hope you will continue to use our service.
Mr. and Mrs. Frank M. Jones will look forward to seeing you again this year.

I-2 **THE BAKER LABORATORIES, INC.,**
Cleveland 3

J. Marc Connor, Paul Moeder

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.
Baker representatives will be glad to discuss special features of Baker milk products which promote better tolerance, less colic, better gain and improved tissue turgor for bottle-fed infants.

I-6 **THE E. BERGHAUSEN CHEMICAL CO.,**
Cincinnati, Ohio
W. Glen Kern, Robert N. Cook

F-3 **BLACK & SKAGGS ASSOCIATES,**
Battle Creek, Mich.

Allison Skaggs, Harold Neff, Paul Evans, John Hogan
A Complete Business Service for the medical profession
The trademark PM is the brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc., of Battle Creek. It assures PM clients of the knowledge, experience and integrity of the oldest and largest such firm in the country.

E-3 **THE BORDEN COMPANY,**
PHARMACEUTICAL DIVISION,
New York 17

Most important new item at Borden Pharmaceutical Division's booth is Liquid Bremil which adds all the convenience of a liquid to the significant advantages already established by Bremil Powdered. Borden's full line of formula products is on display including Mull-Soy. Other new additions are Dermabase and Junitar, Marcelle Hypoallergenic Cosmetics.

B-6 **BROOKS APPLIANCE COMPANY,**
Chicago 2

W. C. Ayer, R. L. Ayer

Exhibit, describe technique of applying combination pressure bandages, medicated Primer Bandage, Dalzoflex Elastic Adhesive Bandage. As anatomical supports distributors, our representatives will answer questions and explain in detail our Sacral, Sacral-Lumbar and Dorsal-Lumbar Supports. Dr. Hackett "Nationally Approved" "C" Sacral Belt, Flexion Cervical Collar, Nulast Elastic Crepe Bandages, Elastic Stockings, surgical instruments.

Booth	Company and Products
I-20	**BURROUGHS WELLCOME & CO (U.S.A.) INC., Tuckahoe, N. Y.** **NEW PRODUCTS** The extensive research facilities of 'B. W. & Co.', both here and in other countries, are directed to the development of improved therapeutic agents and technics. Through such research 'B. W. & Co.' has made notable advances related to leukemia, malaria, diabetes, and diseases of the autonomic nervous system; and to antibiotic, muscle-relaxant, antihistaminic, and antinauseant drugs.
C-7	**BURTON, PARSONS & COMPANY, Washington 9, D. C.** You are cordially invited to visit the Burton, Parsons & Company booth where information, samples and literature will be available for our original psyllium type bulk preparations, Konsyl and L. A. Formula; and also our new and modern electrode cream, EKG Sol, for electrocardiography and electroencephalography.
I-10	**THE CENTRAL PHARMACAL COMPANY, Seymour, Ind.** Norman Kolbe, Sidney Kemper The Central exhibit will feature Elixir Synophylate for rapid oral control of asthma, and Synate for subacute and chronic asthma, pulmonary emphysema and bronchiectasis.
I-3	**CHICAGO PHARMACAL COMPANY, Chicago 40** E. D. Cole, Forest Willis Urised: Clinically proven tablet for both comfortable sedation and thorough antisepsis in genito-urinary affections. Juniplex: Pleasant tasting liquid tonic containing essential minerals, B complex plus 30 micrograms of vitamin B12 per teaspoonful. Estrosed: Tablet containing reserpine and ethinylestradiol for treatment of the menopausal syndrome. Noscoline: New antitussive, antipyretic, decongestant cold tablet.
H-7	**CIBA PHARMACEUTICAL PRODUCTS INC., Summit, N. J.** Featuring Singoserp, a new synthetic analog of Reserpine possessing favorable cardiovascular effects of Rauwolfia drugs but less sedative. Singoserp has a wide margin of safety, is indicated in most forms of arterial hypertension. Also, Esidrix, improved analog of chlorothiazide, namely, hydrochlorothiazide, most effective oral diuretic-antihypertensive available in very low dosages.
D-14	**THE COCA-COLA COMPANY, Atlanta 1, Ga.** Taylor Land Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company, Indianapolis, and The Coca-Cola Company.
B-2	**CURTIS & FRENCH, INC., Indianapolis 2** Curtis & French, Inc., have an obligation to show all new equipment of interest to the profession. Stop by and visit with Jack Curtis, Mac McCain, Don Graves, John Henry, and Bob Bridges.

Booth	Company and Products
I-19	**DAIRY COUNCIL** **Evansville, Fort Wayne, Indianapolis, Kokomo, Peru, and South Bend** You are cordially invited to visit our booth for a cold, refreshing drink of milk. Dairy Council health education materials to use with your patients will be on display. These materials are free of charge in the localities which have affiliated units.
B-9	**DE PUY MANUFACTURING CO., INC., Warsaw, Ind.** New G. P. Catalog is now available—be sure to sign up for your copy. This book contains an assortment of splints and fracture equipment especially for the doctor in general practice. We also are displaying representative samples of our complete line of products. Stop by and visit with us.
B-8	**THE DIETENE COMPANY, Minneapolis 16, Minn.**
H-14	**DOHO CHEMICAL CORPORATION, New York 13, N. Y.** Mr. Carl Koleman Featuring: Auralgan, otitis media, removal of Cerumen; Otosmosan, fungicidal and bactericidal in suppurative and aural dermatomycotic ears; Rhinalgan, nasal decongestant free from systemic or circulatory effect; Larylgan, throat spray and gargle for sore throat involvements. Rectalgan, for relief of pain, discomfiture in hemorrhoids, pruritus and perineal suturing; Dermoplast, an aerosol spray for surface pain, burns, abrasions.
E-2	**EATON LABORATORIES, Norwich, N. Y.** V. J. Dickman, Arlie E. Bower A new drug AltafurT.M. (brand of furaltadone), in tablet form, is available. It is the first nitrofuran effective orally in systemic infections; found highly successful against pulmonary, upper respiratory tract and soft tissue infections; highly effective against certain gram-negative and gram-positive pathogenic bacteria—sensitivity of staphylococci, including antibiotic-resistant strains, has approached 100% in vitro.
I-17	**C. B. FLEET CO., INC., Lynchburg, Va.** Raymond J. Barrett, A. R. Shelly Fleet will feature Clysmathane, its most recent contribution in the field of medication by rectum—an advanced method of xanthine therapy. Clysmathane is a stable solution of theophylline monoethanolamine; easily retained; rapid and uniform absorption, prompt and predictable blood levels; with no rectal irritation after prolonged use.

Booth	Company and Products
G-19	**GEIGY PHARMACEUTICALS, Ardsley, N. Y.** Charles M. Hoskins and Robert Le Compte Geigy Pharmaceuticals cordially invites members and guests of the association to visit its technical display. Information on products valuable in the therapy of rheumatic, metabolic, dermatologic and cardio-vascular diseases will be presented by personnel in attendance.
B-4	**GERBER PRODUCTS COMPANY, Fremont, Mich.** Bud Farrington, Forrest Edgemon High meat dinners provide more than nine grams of protein per container. With Gerber High Protein Cereal and the Meats-for-Babies, they offer a wide choice of well accepted foods that adequately supply the complete proteins. Ask the Gerber representative for further information on these and other top quality baby foods.
C-9	**GREAT BOOKS OF THE WESTERN WORLD, Chicago** Armin Eastman and Lorraine Eastman The Great Ideas Program, a new advancement in liberal education, is built around the revolutionary Syntopicon. This master-key "Idea-Indexes" all the Great Books, making it possible to find what the great writers and thinkers said about any ideas in minutes. Program will help business, professional people, students, graduates—anyone interested in exploring the fascinating world of great ideas.
A-8	**J. E. HANGER, INC., Indianapolis 4** M. G. Manwaring, Jack Talbert, Charles Trott You will find it interesting to learn why more Hanger prostheses are worn than any other make. Visit the Hanger exhibit. Your amputee will be glad you did.
H-4	**H. J. HEINZ COMPANY, Pittsburgh, Pa.** W. V. Spaulding Heinz Baby Foods announces new varieties: Strained Pineapple Juice with Vitamin C added; Strained and Junior Tutti Frutti Dessert; High Meat Dinners—Chicken a la King and Chicken with Rice. Convenient Screw-On Caps on most Heinz Baby Foods. Literature includes ABC's for Baby Mealtime; lists of Heinz Baby Foods with separate hypo-allergenic varieties.
E-6	**HOLLAND-RANTOS COMPANY, INC., New York, N. Y.** Warren R. Smith, Elton L. Tosch, Ernest W. Kowal Featuring . . . Specific antimycotic, non-messy Hyva Gentian Violet Vaginal Tablets. . . . Trichomonicidal, fungicidal, bactericidal improved Nylmerate Jelly, Nylmerate Antiseptic Solution Concentrate for vaginal trichomoniasis, mixed infections. . . . Hollandex Silicone Ointment with Natural Vitamins A & D—medication for neuro- and contact dermatitis, decubitus ulcers, diaper rash, skin dryness/chafing, etc. . . . Special Koromex (A) for conception control; contouring Koro-Flex Diaphragms, correct standard Koromex Jelly, Cream, Diaphragms and Sets.
Foyer	**HOOSIER CADILLAC COMPANY, INC., Indianapolis** Charles Marlett, Sales Manager; Raymond Moxley, Wholesale Manager; Andrew Hutchison, Stewart Bailey, Robert Feezle, Steve Fenner, Charles Hannon, Leonard McCleaster, Berkley Peck, Ralph Stohler, Homer Stoughton Displaying a typical doctor's car, a four door sedan. Has standard equipment: hydromatic drive, power steering, power brakes, windshield washer, turn signals, back-up lights, oil filters, electric clock and is undercoated. Available optional equipment: White sidewall tires, heater, signal seeking radio with power antenna, two speakers; E-Z Eye tinted glass, autronic eye, power vent windows, air conditioning.
D-12	**INDIANA BRACE SHOP, INC., Indianapolis** This is the year for new developments in the orthopedic field. Showing at our booth—spring twisters for internal and external rotation and the new Indiana Control Cerebral Palsy lateral bar, ball bearing braces, made of aluminum aloy. Also Special Corrective Shoes, Victoria Collars, and Surgical Supports.
A-2	**INDIANA NATIONAL BANK, Indianapolis** Indiana National Bank trust specialists will be available to discuss your investment plans and estate planning. Plan now to visit Booth A-2. No obligation, of course.
D-6	**INDIANA SURGICAL, INC., Indianapolis 2** Jim Traub, Al Dowd, Bob Ettinger and Bob Thomas will be in attendance at our booth and hope to show some new items of interest.
D-10	**INDIANAPOLIS ARTIFICIAL LIMB CORP., Indianapolis 4** S. E. Hedges, Don Hedges The Indianapolis Artificial Limb Corp. has aided in rehabilitating hundreds of amputees during the past several years. You may be sure that when improvements in prosthetics are released from the research laboratories, we will have these to bring to your attention. We welcome you to booth D-10.
B-7	**LEDERLE LABORATORIES, Pearl River, N. Y.** You are cordially invited to visit the Lederle booth where our medical representatives will be in attendance to provide the latest information and literature available on our line. Featured will be Achromycin V, Aristocort and many other of our dependable quality products.
A-12	**ELI LILLY AND COMPANY, Indianapolis 6** Mr. H. O. Johnson (in charge of exhibit), Mr. M. L. Adams, Mr. G. G. Horton, Mr. P. A. Holsapple, Mr. H. P. Brandt, Mr. R. L. McKenna, Mr. N. L. Stephenson, Mr. R. N. Thomas, Mr. Jack W. Hill You are cordially invited to visit the Lilly exhibit located in space No. A-12. The Lilly people in attendance welcome your questions about Lilly products and recent therapeutic developments.

Booth **Company and Products**

E-9 **J. B. LIPPINCOTT COMPANY,**
Philadelphia, New York, Chicago, Montreal

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

C-6 **LOMA LINDA FOOD COMPANY,**
Arlington, Calif.

With years of experience in perfecting a hypoallergenic milk powder, also a newly developed concentrated liquid milk, the protein of which is fully derived from the soy bean and formulated with other essential additives for babies, growing children and adults, we welcome you to Booth C-6. Attendants will discuss values of Soyalac powder and concentrated liquid.

E-1 **P. LORILLARD COMPANY,**
New York 17, N. Y.

J. L. Maze, M. L. Gold, E. J. Rohmer, C. H. White

Presenting the Story of Kent Cigarettes. Learn about Kent's free, easy drawing Micronite Filter . . . exclusive super-porous Micropore Paper which lets cool air in, lets heat escape through microscopic pores . . . 100% natural tobaccos.
Learn how Kent has reduced tars and nicotine to the lowest level among all leading brands.
Receive a table cigarette box with your signature in gold.

G-3 **MAICO HEARING SERVICE, Indianapolis**

A. O. Norris, Mrs. A. O. Norris, G. M. Burrill
Featuring our newest instruments:

(1) a light Stethetron, electronic device designed not particularly for hard of hearing physician, but to make auscultation simpler; built along lines of a stethescope. (2) A light two-tone hearing check, simple to operate, will detect 97% of hearing defects. Much like the otoscope in appearance. (3) A two-channel audiometer for clinical audiometric diagnosis.

C-10 **MALTBIE LABORATORIES DIVISION,**
WALLACE & TIERNAN, INC.,
Belleville, N. J.

William F. Fels, Jr., John Wise, Donald R. Thorp, Karl A. Werneke

Maltbie Laboratories features the new dermatologic ointment, Caldecort, containing calcium undecylenate, hydrocortisone and neomycin for a comprehensive therapy of skin conditions caused by fungi, bacteria or allergy. Also, Desenex, for athlete's foot; Nesacaine, a safe, potent, rapid-acting local anesthetic; Bifran for management of the overweight patient; and Cholans for treatment of hepato-biliary dysfunction.

Booth **Company and Products**

H-6 **MARION LABORATORIES, INC.,**
Kansas City, Mo.

A new iron absorption factor, Sorbit*, with a new well-tolerated iron salt, ferrous fumarate, are compounded in Anasorb and Fumasorb tablets for majority of secondary anemias. Oyster shell calcium, available in Os-Vim, Os-feo-Vim, Os-Cal, Os-feo-Cal, and Os-Quin tablets.
Duotrate, Duotrate C. Phenobarbital, Duotrate-45, and Duotrate-45 C. Phenobarbital are long acting coronary vasodilators utilizing new method of controlled release.

* Registered

E-10 **MARSH AND ASSOCIATES, INC.,**
Indianapolis 4

Richard R. Marsh, Karl H. Andresen, Richard E. Williams

Stereo-High Fidelity Sound will be demonstrated. Ampex tape recorders, McIntosh components, and the complete new Bell line will be shown.

A-6 **MEAD JOHNSON & COMPANY**

John A. Floren, Robert A. Terry, and Oscar L. Miller

The Mead Johnson exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

I-14 **MEDCO PRODUCTS CO., INC.,**
Tulsa 12, Okla.

E. A. Kenneson

Presenting the Medco-Sonlator. Providing a new concept in therapy by combining muscle stimulation and ultra sound simultaneously through a Single Three-Way Sound Applicator.
The Medco-Sonlator is a distinct advance in the effectiveness of physical therapy in your office or hospital. A few minutes spent in our booth should prove of value to your practice.

B-10 **THE MEDICAL PROTECTIVE COMPANY,**
Fort Wayne

K. W. Moeller

Individual Coverage especially designed to meet your needs . . . "in ANY claim or suit for damages based on professional services rendered or which should have been rendered" . . . by the originators of professional liability insurance . . . with 79,000 claims and suits successfully handled . . . while preserving the rights and heritage of the individual physician.

D-1 **MERCK, SHARP & DOHME,**
Philadelphia 1, Pa.

L. R. Woerner, H. S. Faircloth, J. R. Fuzy, M. R. Lewallen

A new adrenocortical steroid is featured, 'Decadron' dexamethasone possesses all the basic actions and effects of other glucocorticoids but in different degree. Its anti-inflammatory activity is more potent on a weight basis than any other known glucocorticoid. Electrolyte imbalance is not ordinarily a therapeutic problem.
'HydroDIURIL,' a new, orally effective, nonmercurial diuretic-antihypertensive agent is also of interest.

Booth **Company and Products**

H-3 **THE WM. S. MERRELL COMPANY, Cincinnati 15**

For the first time, an effective anorexic agent is recommended for cardiac, hypertensive and diabetic patients. New Tenuate is a hunger control agent so free of CNS stimulation it is used for nighttime hunger.
Tenuate and other Merrell drugs will gladly be discussed by Merrellmen.

H-9 **MERRILL LYNCH, PIERCE, FENNER & SMITH, Indianapolis**

J-18 **MILEX ALPHA PRODUCTS, Evanston, Ill.**

Amos B. Phelps, Harry S. Stern

The Milex display will feature the new Seiger Cervitome and Coagsuc for cold conization of the uterine cervix, the new Twin Tenaculum and Amino—Cerv Gel for Post-Surgical use. In addition Milex representatives will demonstrate all the other well-known Milex Gynecic Specialties: Crescent Diaphagms, Milex Folding Plastic Pessaries and Tricho-San.

D-11 **MILLER SURGICAL COMPANY, Chicago 39**

See the Miller Electro-Surgical Units and Accessories such as Snares, Suction-Coagulation attachments, Grasping Forceps, etc. Also a complete line of Diagnostic equipment consisting of Illuminated Otoscope, Ophthalmoscope, Eyespud with Magnet, Transillumination Lamps, Lempert-type Relfecto-Headlite, Vaginal Speculum with smoke ejector, and Gorsch designed Operating scopes and stainless steel Proctoscopes, with magnification.

F-6 **THE C. V. MOSBY COMPANY, St. Louis 3**

New knowledge, new ideas, new research and technic—all are waiting for you in the newest Mosby books for 1958 and 1959. Come in. Look over these books at your leisure and convenience. If you wish his assistance our experienced representative will be happy to discuss any book with you.

I-11 **V. MUELLER & CO., Chicago 12**

Joseph A. Carey, Richard Mathias, Bob Ellis
The V. Mueller & Company (Chicago) exhibit will feature, principally, an interesting selection of fine surgical instruments—both standard and special—of particular importance to the general practitioner. A number of new items and specialities will be included in the display, which is always a worthwhile attraction.

H-10 **MUTUAL MEDICAL INSURANCE, INC. (The Blue Shield Plan), Indianapolis**

R. S. Saylor, L. E. Converse, R. C. Kilbourn

Mutual Medical Insurance, Inc. (Blue Shield Plan) will have its exhibit in Booth H-10. Representatives of the Plan will be on hand at all times to answer questions and be helpful in any way possible. Special materials will be distributed explaining the operation of the Plan, the benefits it affords the physician and the public.

Booth **Company and Products**

I-15 **THE NATIONAL DRUG COMPANY, Philadelphia 44**

Tepanil—for weight control. A completely new compound that curbs appetite without CNS stimulation; safe, well tolerated, suitable for evening use, on patients of all ages.
Orenzyme—the first oral anti-inflammatory enzyme tablet on the market, is swallowed, is indicated for treatment of any acute inflammatory process when swelling slows recovery.

C-11 **NORTH AMERICAN PHARMACAL INC., Dearborn, Mich.**

Jack H. Marx

GERIAMIC: Dual Hormone, vitamin-mineral supplement combined with lipotropics. The 20 to one male to female hormone activity helps restore work capacity and sense of well being in geriatrics.
DEXAMINE SPANCAP: A new time capsule for aid in appetite control. Provides 21 mg. appetite depressing effect with only 15 mg. Central Nervous Stimulating Effect.

Corridor to Theater **O'BRIEN MOTOR SALES, INC., Indianapolis**

Imperial for 1960, the nation's new measurement for graceful performance in motoring. You, too, will discover that this heroically proportioned Imperial is obedient even to the gentlest of women. You owe it to yourself to know why we say elegance weds eagerness. Agility is tempered by a nice maturity of judgment.

B-11 **ORIGINAL CONTOUR CHAIR LOUNGE, Indianapolis**

Mrs. E. K. Bonheim, Myron W. Bonheim, Norma Robertson

Stop, sit down, and stretch out in the Contour Chair-Lounge or Viverator-Lounge, chairs that make you relax. Explore its unlimited usefulness—for office, home and patients. Physicians will be allowed a liberal discount.

F-2 **ORTHO PHARMACEUTICAL CORPORATION, Raritan, N. J.**

Erick G. Tysklind, Thomas A. Hanna, Jr., and Walter R. Phillips

At booth F-2 Ortho is proud to introduce its new blood clot dissolving agent, Actase Fibrinolysin (Human). Indicated specifically in thrombophlebitis and pulmonary embolism, Actase is a naturally derived blood fraction. Ortho representatives on hand will be happy to discuss this important new development as well as the company's other well-known products.

B-1 **PARKE, DAVIS & COMPANY, Detroit 32**

Medical Service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

D-7 **PEPSI-COLA BOTTLING COMPANY, INC., Indianapolis**

You are cordially invited to visit Booth D-7 and spend a few leisure moments while enjoying a refreshing drink of ice-cold Pepsi-Cola, compliments of the Pepsi-Cola Bottling Company of Indianapolis.

Booth **Company and Products**

D-9 **PFIZER LABORATORIES, Brooklyn 6, N. Y.**
The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information.
To make your visit worthwhile, technically trained Medical Service Representatives will be on hand to inform you of the latest developments in Pfizer Research.

-12 **PICKER X-RAY CORPORATION, White Plains, N. Y.**
Picker X-Ray Corporation will exhibit a completely new line of nuclear instrument apparatus and associated accessory items.
Equipment will include the Picker "Cliniscanner" Catalog No. 2960, Picker Basic Scaler, Catalog No. 2950 and Picker Well Counter, Catalog No. 2956.

H-11 **PITMAN-MOORE COMPANY, Indianapolis**
Pitman-Moore welcomes you to Indianapolis. We also extend to you a cordial invitation to visit our booth where we are now showing our newest specialty.
We take pride in whatever service we can perform to help make this excellent assembly both informative and relaxing for you.

H-5 **PROFESSIONAL LIFE & CASUALTY COMPANY, Chicago**
Harold J. Craig, Herbert G. Lahr, Clifford H. Johnson, Warren B. Mickey, and James J. Craig
The exhibit of the Professional Life & Casualty Company will feature a unique new Sickness and Accident Policy, specially designed to provide income protection for physicians and dentists—and offered only to members of the medical and dental profession.

I-1 **THE PURDUE FREDERICK COMPANY, New York 14, N. Y.**
The Purdue Frederick Company will present:
Senokot: Constipation corrective containing the concentrated total senna glycosides.
Actasal: A true pediatric salicylate in palatable solution. Not a salicylate substitute.
Soropon: Antiseborrheic for cradle cap.

J-20 **RESEARCH SUPPLIES, Albany, N. Y.**
Donald S. Gould
Glukor—for impotence, premature-fatigue and executive let-down in men.
Glutest—for frigidity and premature-fatigue in women.
Gould's Stethoscope—permits examination without disrobing. Incorporates complete neurologic instrument.
Wandex—multiple dose vaginal applicator for feminine hygiene and refractory vaginitis.
A-3 Foot Powder—for perspiration, odor and fungus infection.
Contra Creme—First AMA accepted phenylmercuric acetate contraceptive.

F-7 **REX BUSINESS MACHINES CO., Indianapolis**
Curt Benner and Ernest Ball
Featuring a complete line of time-saving office machines on display, including typewriters, adding machines, dictation machines, photocopy machines, etc. Of special interest will be the new models of the "Olympia" typewriters, and DeJur "Stenorette" Dictation Machines, including the new Traveler Model which weighs only 5 lbs. Rex features the rental-purchase plan.

Booth **Company and Products**

F-8 **R. J. REYNOLDS TOBACCO COMPANY, Winston-Salem, N. C.**
C. A. Burgess, J. M. Herbert and R. O. Zeigler
Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of Camel, Winston Filter, Menthol Fresh Salem or Cavalier King Size Cigarettes.

E-7 **A. H. ROBINS COMPANY, INC., Richmond, Va.**
Donald Rasico, James McKinney, Dwaine W. Otoupal
Dimetane Expectorant and Dimetane Expectorant-DC (with dihydrocodeinone) are featured by Robins as the fall "cough season" gets under way. Basic formula includes an antihistaminic (Dimetane), expectorant (glyceryl guaiacolate), two nasal decongestants. Also featured: the Phenaphen "family" of analgesics; the Pabalate group of antirheumatics; Ambar, for appetite control, mood amelioration; Allbee with C, therapeutic B complex with vitamin C.

A-10 **J. B. ROERIG AND COMPANY, New York, N. Y.**
J. B. Roerig and Company will welcome members of the medical profession at the company's exhibit of leading specialties and new products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will describe and give information on the results of clinical reports.

K-3 **ROSS LABORATORIES, Columbus 16, Ohio**
William Bolling and John Truner
As adjunct to the physician's oral reassurance of anxious new parents the Ross Developmental Aids offers visual materials (individual case records, behavioral development folders, emotional development booklets). Current concepts stress the development of the infant as a whole being. Physiologic infant feeding may be discussed with your Similac representative.

D-3 **ST. PAUL FIRE AND MARINE INSURANCE CO., ST. PAUL MERCURY INSURANCE CO., St. Paul 2, Minn.**
Robert E. Aurelius
Information pertaining to Indiana State Medical Association Professional Liability Insurance Program.
Underwitten by: St. Paul Fire and Marine Insurance Company, St. Paul Mercury Insurance Company.
A Local Agent in Every Community. Pay Us A Visit.

C-1 **SANBORN COMPANY, Waltham 54, Mass.**
New Electrocardiographs of advanced design and function, as well as latest models of other instruments for diagnostic use, will be displayed and demonstrated.
Demonstrations and/or data will also be available on Sanborn instruments for biophysical research—single and multi-channel recording systems, monitoring oscilloscopes and physiological transducers.

Booth	Company and Products
B-5	**SANDOZ PHARMACEUTICALS, Hanover, N. J.** Reily Burrel, Jack Laughner, Earl Blanchard, J. A. Beck Mellaril—the first potent tranquilizer with a selective action (i.e., no action on vomiting centers). This unique action gives specific psychic relaxation with safety at all dosage levels. Bellergal—Space Tahs assures around the clock control of functional complaints (example—menopause symptoms) in the periphery where they originate. Fiorinal—a new approach to therapy of tension headache and other head pain due to sinusitis and myalgia.
A-4	**W. B. SAUNDERS COMPANY, Philadelphia** G. D. Miller The large number of new Saunders books, published since last year's meeting, include: De Palma: Fractures; Weyrauch: Surgery of the Prostate; Nelson: Pediatrics; Meschan: X-Ray Anatomy; Jackson & Jackson: Nose, Throat and Ear; Lewis: Dermatology; Dowling & Jones: That the Patient May Know; McLaughlin: Trauma; Shambaugh: Surgery of the Ear; Murphy: Radiation Therapy; and Cecil-Loeb: Medicine.
E-8	**SCHERING CORPORATION, Bloomfield, N. J.** Edwin Leinhos, Glen Kile, Rollan Perry, and William Rosner Schering Corporation cordially invites members of the Indiana State Medical Association to visit the Schering technical exhibit. Featured products include Fulvicin, first oral antifungal antibiotic for ringworm; Deronil, the corticosteroid of choice; Polaramine, the lowest dosage antihistamine; and Trilafon, the tranquilizer and antiemetic of unexcelled efficacy.
C-8	**CLAYTON L. SCROGGINS ASSOCIATES, Cincinnati 19** Clayton L. Scroggins and John R. Lesick This professional business management firm has rendered a complete, comprehensive service to physicians exclusively since 1945. A few moments at this booth may be the most important moments you could devote in behalf of your practice. Tax returns—Bookkeeping—Office Layout—Individually Typed Letters to Delinquent Accounts (no commission)—Personnel Selection and Instruction—Fees—Partnerships—Investments.
C-12	**G. D. SEARLE & CO., Chicago** P. E. Rinderknecht, G. A. Yotter, R. W. Schulz New: Dartal, tranquilizing agent controlling activities associated with anxiety states, other neuroses; Enovid, synthetic steroid for treating various menstrual disorders; Zanchol, biliary abstergent; Nilevar, anabolic agent, and Rolicton, safe, non-mercurial oral diuretic. Also, Vallestril, synthetic estrogen with extremely low incidence of side reactions; Pro-Banthine and Pro-Banthine with Dartal, and Dramamine and Dramamine-D.
C-4	**SEVEN-UP BOTTLING COMPANY, INC., Indianapolis**
H-12	**SMITH KLINE & FRENCH LABORATORIES, Philadelphia 1, Pa.** S.K.F. features (1) 'Hispril' Spansule® capsule (NEW), a potent low-dose antihistamine with remarkably low incidence of drowsiness approximately 4%—for allergic patients who must remain active and alert; (2) Stelazine® Tablets (NEW), for b.i.d. control of anxiety—particularly when expressed as apathy, listlessness and emotional fatigue; and (3) Feosol® Spansule® capsules, iron in its most effective form with a single capsule daily—usually with a total absence of iron's side effects.
I-4	**SMITH, MILLER AND PATCH, INC., Stoneham 80, Mass.**
C-2	**E. R. SQUIBB & SONS, New York 22, N. Y.** E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the medical profession in new products or improvements in products already marketed. At booth C-2 we are pleased to present up-to-date information on these advances for your consideration.
D-8	**THE STUART COMPANY, Pasadena, Calif.** Robert Moon, Edward Nichol, Hugh Wallace The Stuart representatives extend a cordial invitation to physicians attending this meeting to discuss with them the latest pharmaceutical developments of The Stuart Company. Especially featured will be Effergel and Effersyl, the first effervescent bulk laxative.
E-5	**TESTAGAR & CO., INC., Detroit 26** Robert H. Lacy, Sr., G. Dale Trabue Stop by and see O Caps-Amodex; the newest concept in time release capsules. It's clever! It's unique! O Caps-Amodex for high level anorexigenic activity without excitation. O Caps-Amodex insures accurate time release.
H-8	**THERMO-FAX SALES, INCORPORATED, Indianapolis 2** Featuring the Thermo-Fax completely dry all electric copying machine, drys copies of an original in four seconds without chemicals or negatives, three models to select from, choice of several paper colors. The new Thermo-Fax Microfilm Reader-Printer. A fully automatic printer, shows document you want reproduced on a big, easy-to-read screen, copies in eight seconds.
C-3	**S. J. TUTAG & COMPANY, Detroit 34** Stanley Tutag, Max Hull, William Wilber, Richard Teagan S. J. Tutag & Company will feature Geritag . . . Recent publications have attested to the advantage and efficacy of the 20 to 1 ratio of androgen to estrogen in the treatment of the ever-present "aging" problem. The Geritag formula embodies this very relationship plus a vital range of 9 vitamins, 10 minerals, Rutin and three lipotropic agents.

Booth	Company and Products
I-18	**U. S. STANDARD PRODUCTS CO., Mount Prospect, Ill.** W. H. Snider, M. Reisman Featuring Americaine topical anesthesia for effective and prolonged relief of surface pain and itching, in ointment and aerosol form. Silicote Skin Protective Ointment and Spray, containing 30% of the dramatic silicones, will be displayed, and clinical studies are available showing Silicote to provide excellent protection for the skin in contact dermatosed, diaper rash, colostomies, etc.
H-1	**U. S. VITAMIN & PHARMACEUTICAL CORPORATION, New York 17, N. Y.** John Porter, Lawrence Schardon Exhibit features Pantho-F, a strikingly effective combination of inflammatory-supressive hydrocortisone 1% with antipruritic, epithelizing pantothenylol 2% (Panthoderm). For quick relief of pain, inflammation and itch, and rapid healing of eczemas, stings, burns, etc. Also available: Pantho-F 0.2% (hydrocortisone 0.2% with Pantothenylol 2%).
E-4	**THE UPJOHN COMPANY, Kalamazoo, Mich.** Upjohn personnel will be present at booth E-4 throughout the convention. It is our hope that we may make some contribution to the success of your meeting. We will be available for discussion of subjects of mutual interest. We hope you will stop and chat.
F-4	**VAN AUSDALL & FARRAR, Indianapolis**
F-1	**WARNER-CHILCOTT LABORATORIES, Morris Plains, N. J.** James P. Kleinhelter, H. Wayne Cumbee, Vincent F. Vornhagen, Russell E. Lindenmuth Biomydrin Nasal Spray, for effective muco-lytic-penetrating antibacterial activity, prolonged nasal decongestion and antiallergic effect. Nardil—Safe, new, rapidly effective treatment for true (endogenous) depression, restores depressed and despondent patients to reality with no toxic effect on blood, liver or kidneys. Peritrate—Painful seizures often create fear in the patient with angina pectoris.
C-5	**THE WARREN-TEED PRODUCTS COMPANY, Columbus 8, Ohio** The Warren-Teed Products Company is featuring four pharmaceutical specialties at their booth No. C-5. Modane—a nutritional deconstipant. Ilopan—injectable d-pantothenyl alcohol for treatment of intestinal distention. Ilopan-Choline Tablets—oral therapy for gastrointestinal gas retention in ambulatory patients. Kaon—an extremely palatable oral potassium. Warren-Teed representatives cordially welcome all registrants to visit their display.
H-17	**WILSON MILK COMPANY, INC., Indianapolis 4** Don Honaker, Lynn Bultman, R. H. Keyes Descriptive, time-saving literature on infant feeding and child care will be available or we will be pleased to mail a supply to your office address. Wilson's Milk as a baby food is safe, pure, easily digestible, inexpensive and is available locally. Courteous representatives will be in attendance.

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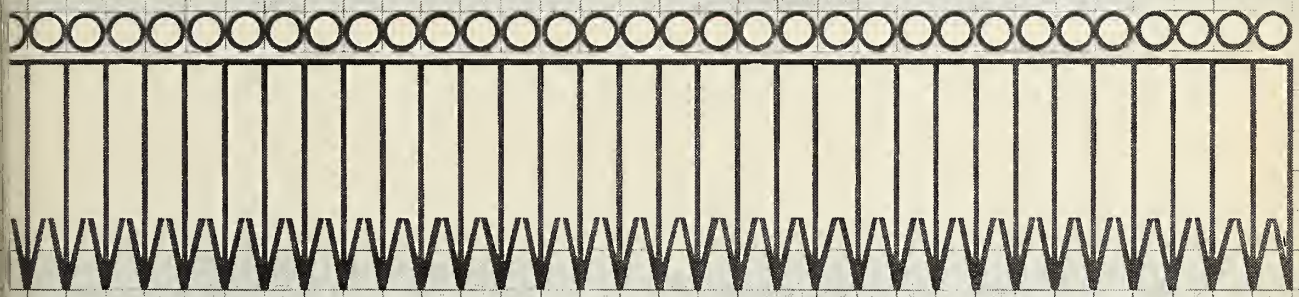
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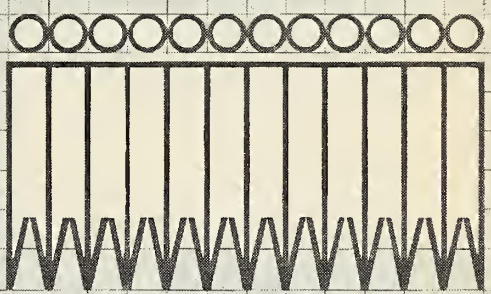
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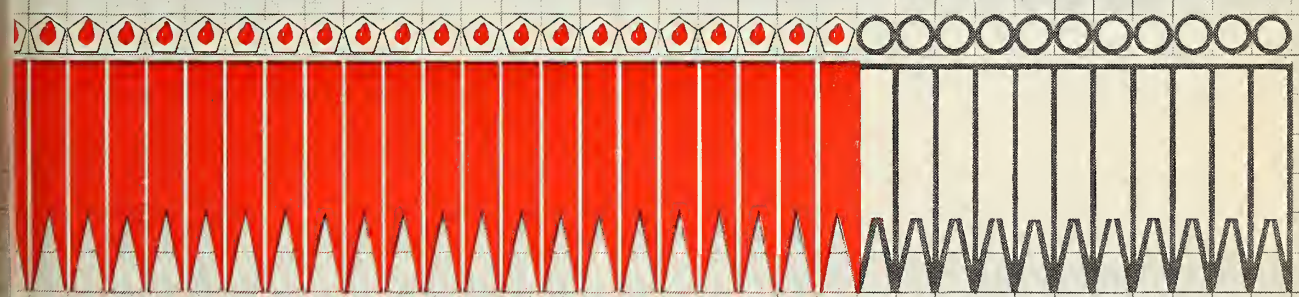
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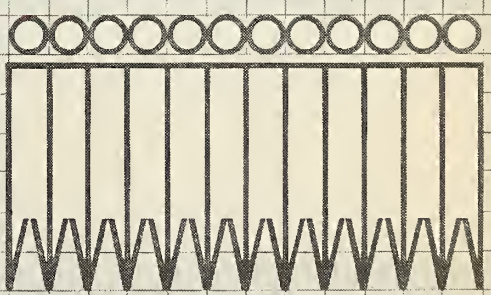
22 were successfully treated with Decadron[1,2]

1. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
2. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

*Cortisone, prednisone and prednisolone.

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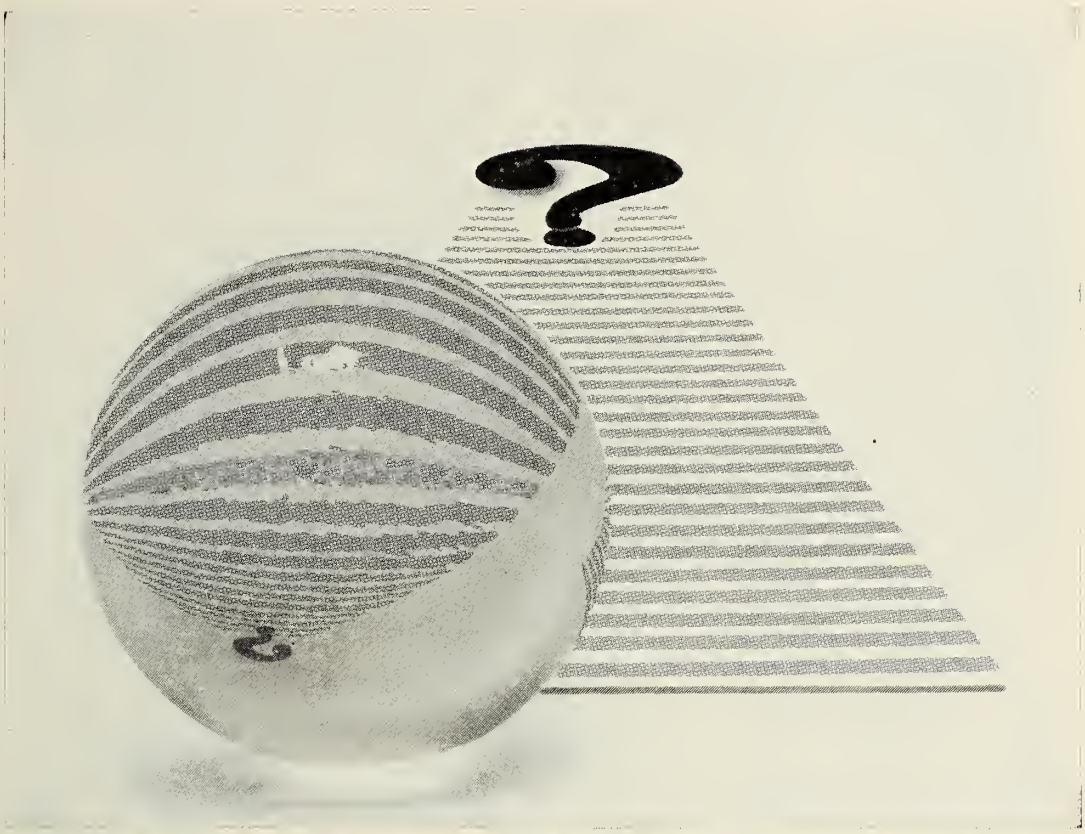
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District	President	Secretary	Place and date of meeting
1.	Noel Neifert, M.D., Tell City	Gilbert Wilhelmus, M.D., Evansville	1960
2.	Herbert O. Chattin, M.D., Vincennes	J. S. Brown, M.D., Carlisle	1960
3.	P. T. Hodgin, M.D., Orleans	(to be appointed)	Fench Lick, 1960
4.	Robert M. Reid, M.D., Columbus	David L. Adler, M.D., Columbus	Columbus, May 11, 1960
5.	Gilbert Rhea, M.D., Greencastle	James B. Johnson, M.D., Greencastle	Greencastle, 1960
6.	Kenneth G. Hill, M.D., Newcastle	John A. Davis, M.D., Flat Rock	Shelbyville, May 11, 1960
7.	Leon Gray, M.D., Martinsville	Herbert L. Egbert, M.D., Indianapolis	Fall, 1959
8.	Richard C. Swan, M.D., Anderson		Anderson, June 8, 1960
9.	Harry E. Klepinger, M.D., Lafayette	Forrest J. Babb, M.D., Stockwell	Lafayette, May 18, 1960
10.	Martin O'Neill, M.D., Valparaiso	John R. Frank, M.D., Valparaiso	1960
11.	George Jewell, M.D., Kokomo	Charles L. Wise, M.D., Camden	Wabash, 1960
12.	Harold F. Zwick, M.D., Decatur	Stephen C. Michaelis, M.D., Fort Wayne	1960
13.	Richard W. Holdeman, M.D., South Bend	James M. Wilson, M.D., South Bend	South Bend, Nov. 18, 1959



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References: 1. Dowling, H. F.: Postgrad. Med. 23:594 (June) 1958. 2. Gimble, A. I.; Shea, J. G., and Katz, S.: Antibiotics Annual 1955-1858, New York, Medical Encyclopedia Inc., 1956, p. 676. 3. Long, P. H., in Kneeland, Y., Jr., and Wortis, S. B.: Bull. New York Acad. Med. 33:552 (Aug.) 1957. 4. Rein, C. R.; Lewis, L. A., and Dick, L. A.: Antibiotic Med. & Clin. Ther. 4:771 (Dec.) 1957. 5. Stone, M. L., and Mersheimer, W. L.: Antibiotics Annual 1955-1956, New York, Medical Encyclopedia Inc., 1956, p. 862. 6. Campbell, E. A.; Prigot, A., and Dorsey, G. M.: Antibiotic Med. & Clin. Ther. 4:817 (Dec.) 1957. 7. Chamberlain, C.; Burros, H. M., and Borromeo, V.: Antibiotic Med. & Clin. Ther. 5:521 (Aug.) 1958. 8. From, P., and Alll, J. H.: Antibiotic Med. & Clin. Ther. 5:639 (Nov.) 1958.

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1. Editorial, New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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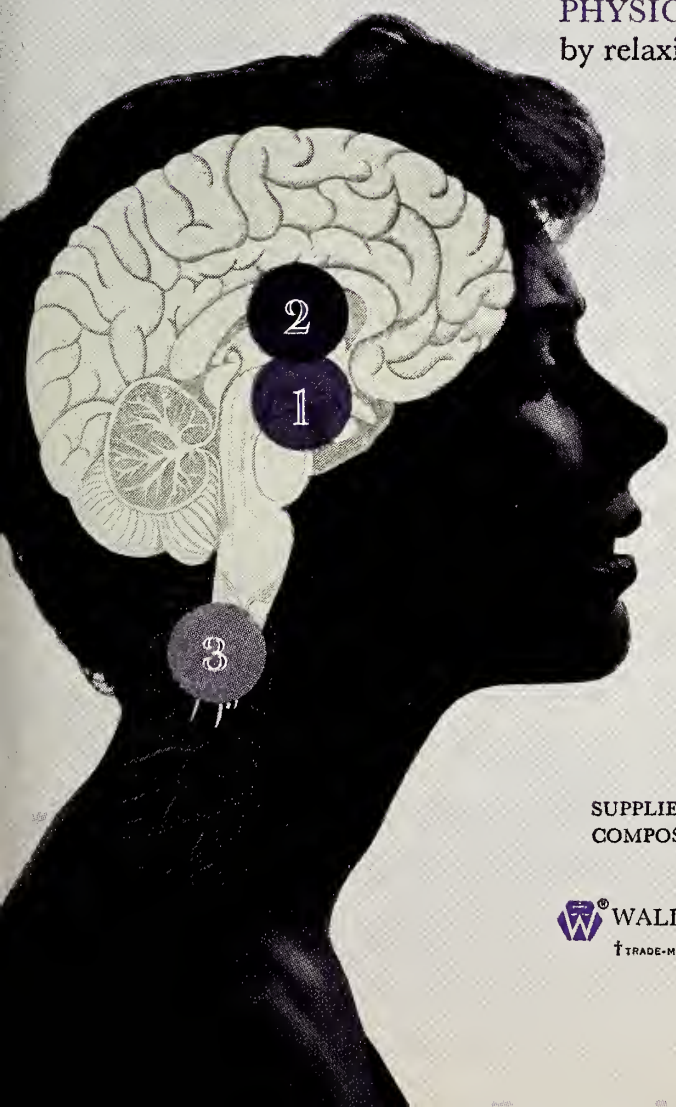
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This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and airmailed to THE JOURNAL on the ninth of each month preceding month of issue.

THE MONTH IN WASHINGTON

Washington D. C.--Congress this year failed to take final action on any legislation of major interest to the medical profession except for the annual appropriation for medical research.

However, work was started on three measures of particular concern to physicians--the Forand, Keogh-Simpson and international health research bills. Showdown votes on them are probable next year. If there are not votes next year, they will die and must be reintroduced in 1961 if they are to be considered further by Congress.

The House Ways and Means Committee held hearings on the Forand bill, but deferred showdown voting on it until next year. The legislation--which is vigorously opposed by the medical profession, other groups on the health team and the Eisenhower Administration--would provide hospital, surgical and nursing home care for federal Social Security beneficiaries. Social Security taxes would be raised to help finance the expensive program.

The Keogh-Simpson bill, after being approved by the House, was left hanging in the Senate Finance Committee. The Senate committee held two sets of hearings. It could vote early next year on the legislation which would grant income tax deferrals to physicians and other self-employed persons as an incentive to invest in private pension plans.

Chairman Oren Harris (D., Ark.) postponed until next session a vote by the House Commerce Committee on the Senate-approved international medical research bill because of a backlog of more urgent measures requiring committee action this year. He said that "a diligent effort" would be made during the recess to clarify a number of points at issue revealed in testimony before his committee.

The bill calls for an annual $50 million authorization to finance a new national institute of health to foster international medical research programs and cooperation. The Administration opposes some of its provisions.

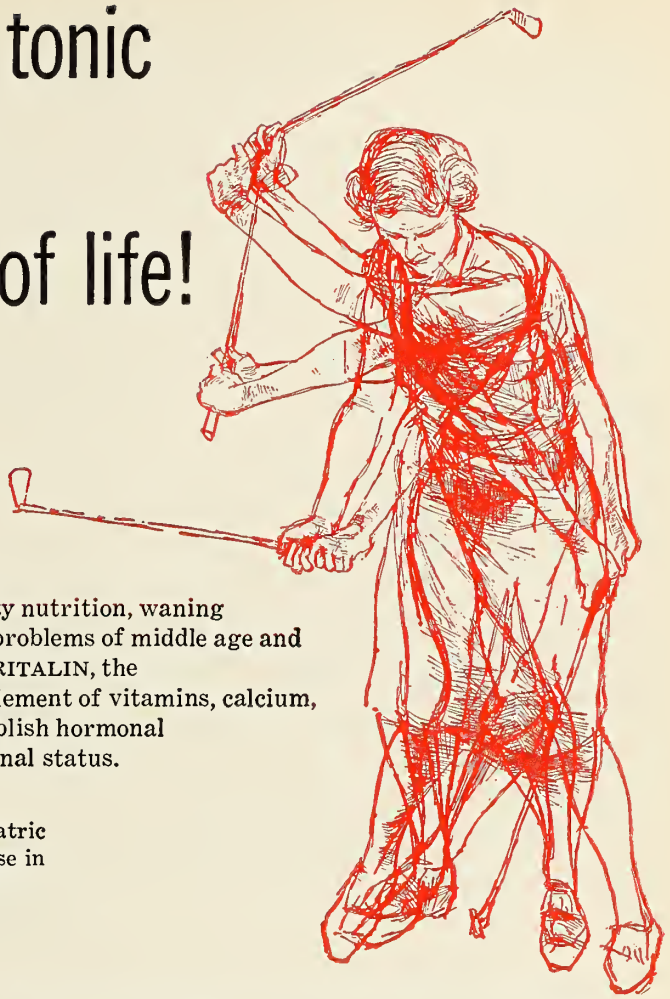
President Eisenhower and Arthur S. Flemming, Secretary of Health, Education and Welfare, made clear that they didn't feel bound to spend the additional $106 million which Congress voted for medical research. Congress raised the $294 million requested by the President to $400 million.

Mr. Eisenhower expressed concern that Congress is going too fast in providing medical research funds which are administered by the National Institutes of Health. He warned of a danger that the quality of research projects might be lowered and that manpower and other resources might be diverted from "equally vital teaching and medical practice."

He directed that every project approved must be "of such great

Continued on page 1702

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2. Bachrach, S.: To be published.
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Month in Washington

Continued from page 1698

promise that its deferment would be likely to delay progress in medical discovery."

Secretary Flemming said that the President's criteria would be followed conscientiously. But the Secretary gave assurance that the restrictions would not be so rigid as to hamper research by denying funds for worthwhile projects.

One of the most important and surprising developments during this session of Congress was the political power shown by Mr. Eisenhower, a lame-duck Republican president, in generally calling the shots on legislation although Democrats controlled the House and Senate with substantial majorities.

In his fight against "big spending" measures sponsored by Democrats, the President effectively used his veto power to get the bills more to his liking. The Democrats were unable to muster the votes to override vetos of two housing bills.

A third compromise housing bill retained three provisions of interest to the medical profession. One would provide Federal Housing Administration loan guarantees for building proprietary nursing homes. A second would provide FHA loan guarantees and direct loans for housing for elderly persons. The third would authorize loans for construction of housing for interns and nurses.

Live polio virus vaccine may be licensed for public use within a year or two. Dr. Leroy E. Burney, Surgeon General of the Public Health Service, said:

"If energetic efforts are continued to find answers to the remaining technical questions concerning safety, effectiveness and manufacturing procedures, one or more of the three vaccines now being proposed may be under production within one to two years."

Primary responsibility for radiation health safety has been transferred from the Atomic Energy Commission to the Department of Health, Education and Welfare.

Such a shift in responsibility was called for in legislation pending in Congress but President Eisenhower ordered the transfer without Congressional action.

The President directed HEW to "intensify its radiological health efforts and have primary responsibility . . . for the collation, analysis and interpretation of data on environmental radiation levels such as natural background, radiography, medical and industrial uses of isotopes and X-rays and fall-out."

HEW Secretary Flemming also was named chairman of a cabinet-level Federal Radiation Council.

Officers in charge of the Medicare program for military dependents were optimistic that certain medical benefits dropped for economy reasons in October, 1958, will restored next January 1. But the professional director of the program, Col. Norman E. Peatfield, said that the Medicare permit system will be retained.



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The Fourth Estate Looks at Medicine

Beware of Socialized Medicine

In a "Letter To The Editor" on this page today, a reader expresses himself strongly in favor of free medical care and hospitalization for social security pensioners, and in doing so levels an excoriating attack upon the medical profession. The medical profession doubtless has some sins it needs to expiate (indeed it commendably has been taking some steps more adequately to police its members). However, resorting to any entity of socialized medicine certainly would savor of leaping from "the frying pan into the fire."

If anyone, like our reader, thinks that better medical attention would be forthcoming under such auspices, they would be shockingly enlightened if they would make a thorough canvass as to what has happened in any country where socialized medicine has supplanted free elective medical attention. Without exception medical care has greatly deteriorated. And if anyone thinks that socialized medicine can be made available without costing the people of the country anything, they would be sadly disillusioned too.

The bill, indorsed by our reader, was introduced by Democratic Congressman Aime J. Forand of Rhode Island. It would in effect provide persons on social security rolls with paid up hospital and medical insurance. The plan, of course, would be financed by higher social security taxes on workers and their employers.

The Forand plan, indorsed by some big labor leaders, is commendably opposed by the Eisenhower Administration. The American Medical Association claims (and its claim has thus far not been conclusively rebutted by anyone) it would enact a form of national compulsory health insurance, and, of course, it would necessarily impose government regulation on both patients and doctors. The AMA convincingly cites how the plan would lead to overcrowded hospitals, and in the end would result in poorer, not better, health care for older people.

The American Medical Association's views were recently presented before the House Ways and Means Committee by Dr. Frederick C. Swartz, of Lansing, Mich., chairman of the AMA Committee On The Aging; and Dr. Leonard Larson, of Bismarck, N. D., AMA Board chairman.

Dr. Larson testified that the Forand Bill would carry a *"staggeringly expensive"* price tag of two billion dollars a year to start, and he noted that supporters of the plan are planning to broaden it to cover the entire population at a cost of 10 times that sum.

Dr. Larson reminded the committee members that, *"slightly more than one year ago, I appeared before this committee and pledged the American Medical Association to a dedicated, continuing effort in the field of health care for the aged. I am proud to be able to tell you that the American Medical Association is making good progress on that pledge."* He cited how ;—

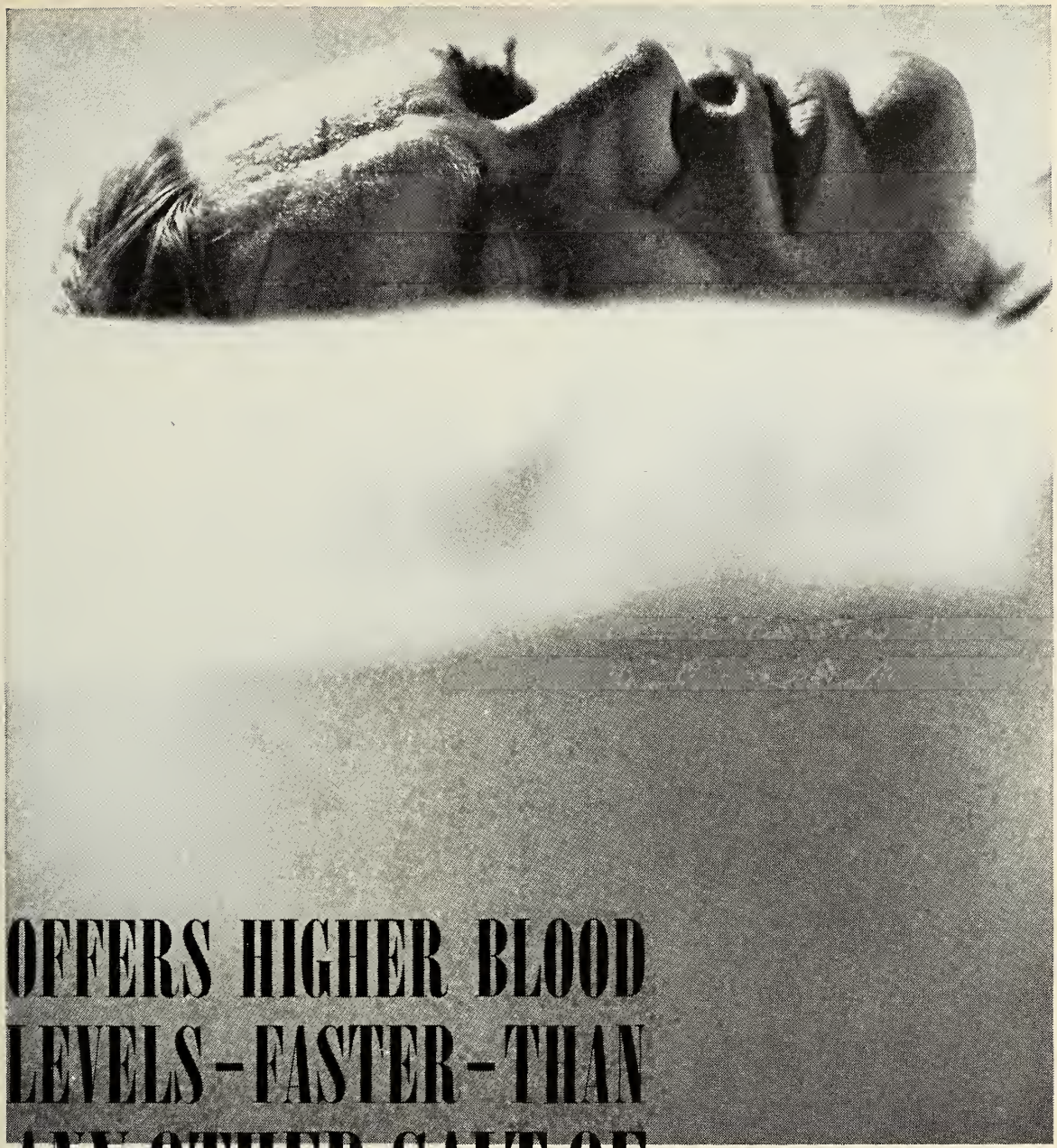
"Retirement villages, new nursing homes, chronic disease care centers, home care centers, recreational facilities and research projects have been established and many, many more are on the way. We believe, therefore, that any proposal that would undermine or destroy the voluntary progress we are now making should not receive favorable consideration. We believe a compulsory system can lead only to inferior medical care for those millions of older citizens who deserve the opportunity of making their extra years rewarding."

But aside from the billions of dollars in cost and of the inevitable poorer medical care, the greatest objection to socialized medicine of all, is the fact that it robs the patient of free choice as to what medical attention he might desire and need, and the free choice as to whom his physician or surgeon shall be.

That is today one of our inalienable freedoms which ranks most importantly with all of our fundamental freedoms.

So assuredly, socialized medicine is not the answer to such shortcomings as the medical profession may have.

Fort Wayne News-Sentinel
July 30, 1959



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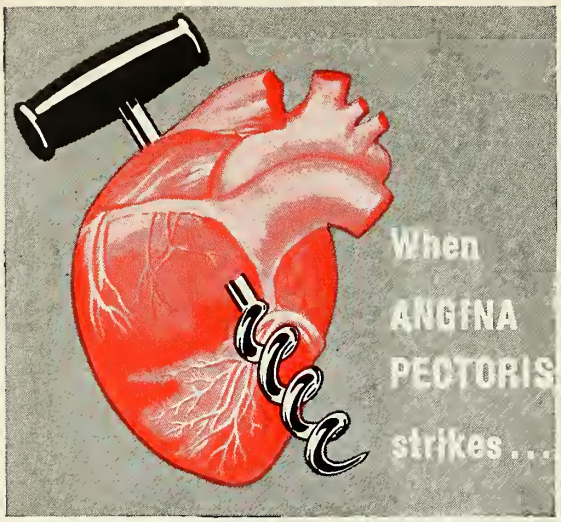
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NIPHYLLINE

the unique specific

This exclusive development is a ***definite chemical,*** neutral in action, and ***specific in prophylaxis and treatment of angina pectoris.*** It is effective orally in about thirty minutes, for periods of 7 to 8 hours . . . and, even when given routinely, does not cause nausea or gastric upset. Niphylline is an efficient vasodilator and diuretic combining the effectiveness of Neothylline (soluble, neutral, stable derivative of theophylline) and pentaerythritol tetranitrate, substantially more effective than mannitol hexanitrate. Thus, the patient receives the benefits of both drugs without any annoying side effects.

Niphylline is safe, and well tolerated . . . exerts strengthening effect on heart muscles, and acts synergistically, remarkably reducing severity and frequency of cardiac attacks.

Indications: Relief and control of angina pectoris, cardiovascular symptoms, asthenia, coronary spasm with myocardial pain, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Dosage: One or two tablets, 3 or 4 times daily, or as directed by physician.

Supplied: Bottles of 100 and 1000 tablets.

PM **PAUL MANEY**
LABORATORIES, INC.
Cedar Rapids, Iowa

to the editor:

TO: Editors of State Journals and County Bulletins.

SUBJECT: Film on Rehabilitation of Asthmatic Children.

"The Hidden Tear," a new 16-mm. motion picture with sound about a successful rehabilitation program for asthmatic children, was premiered August 21 at the annual meeting of the West Virginia State Medical Association in White Sulphur Springs and is now available for showing to medical and lay groups throughout the country.

The film, which runs about 15 minutes, shows the rehabilitation program developed by Merle S. Scherr, M.D., chief of the Allergy Section, Charleston Memorial Hospital, Charleston, W. Va., as it is carried out by Lawrence Frankel, physical education director of the Charleston YMCA. It was filmed in the Charleston Public Schools and the YMCA gymnasium. All of the characters, except one adult, were actually participating in the rehabilitation program.

Although presented in a manner readily understood by laymen, the film is sufficiently detailed to be of interest to a professional audience, particularly general practitioners and allergists concerned with asthma and its relief.

"The Hidden Tear," production of which was made possible by a grant from Warner-Chilcott Laboratories division of Warner-Lambert Pharmaceutical Company, may be obtained for showing under medical auspices to professional or lay groups. Requests for a print of "The Hidden Tear" should be addressed to Mr. George Rohrmann, Film Dept., Warner-Chilcott Laboratories, Morris Plains, N. J.

Sincerely yours,
Charles Lively
Executive Secretary
West Virginia State
Medical Association

To: The Editor

Subject: Bismuth Injections for Warts, (Common, Plantar, or Venereal)

The writer claims no originality at all, but for some curious reason a little gimmick of wart therapy used by Dr. Frank Gastineau and de-

scribed to junior medical students at the Indianapolis City Hospital Skin Clinic by him does not seem to be very well remembered by most doctors with whom I've discussed the matter.

I presume that the very fantastic nature of the treatment and its simplicity stuck in my mind.

I remember Dr. Gastineau asserted that he, too, thought it was akin to "witchcraft" or "hocus-pocus" but that it did work. According to him distilled water injections will sometimes work and so will simple suggestion, *a la* the 'charming away" of warts.

At any rate I've had remarkable success with bismuth injected a few droplets, in, under or around one or two or through warts and then about 1 cc injected deep intramuscularly.

We have used either a water soluble preparation such as bismuth potassium tartrate or the old bismuth subsalicylate in oil. The aqueous solution goes through fine gauge needles better. Incidentally, bismuth preparations of this kind are obsolete nowadays.

Often times multiple warts will disappear following the intramuscular injection as well as the one or more individual warts locally injected. I once cured a 12-year-old girl of plantar and general body surface warts with only one quick gluteal injection as I was hurrying out to an O. B. case.

Following Dr. Gastineau's advice—it is advisable (and perhaps essential!) for the doctor to make as positive a statement, as judicious, about the efficacy of the method and to radiate an air of confidence in it. Don't promise a cure but just say it usually works and ask the patient to return in 2 to 4 weeks for inspection and follow up and repeat treatments if indicated by failure of the warts to shrivel and drop out.

Being a busy G. P. and writing this at 2 a.m. on the spur of the moment I'll not attempt to give any statistics.

However I'd like to hear from others who may have learned this method from Dr. Gastineau and others.

I have one very grateful patient, a civil engineer, known personally by Dr. Maurice Glock, when surgeon of the 342nd Engr. Regt. (G.S.) during WW II.

I'd treated Lt. R. G. with this method in our 342nd dispensary in England and he'd later had plantar recurrences, and had been to civilian and

Continued on page 1710



If she needs nutritional support . . . she deserves

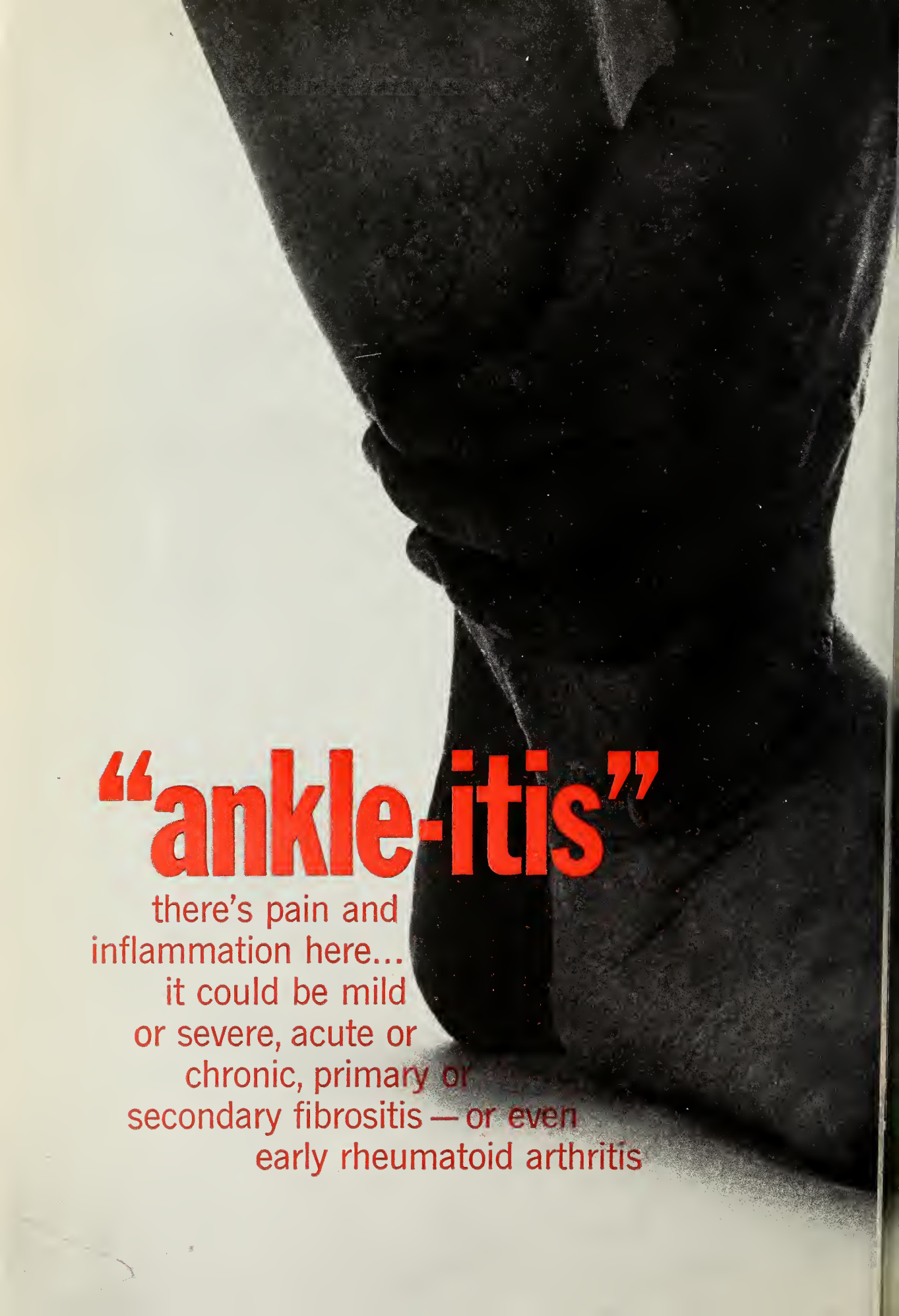
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"ankle-itis"

there's pain and inflammation here... it could be mild or severe, acute or chronic, primary or secondary fibrositis — or even early rheumatoid arthritis

ore potent and comprehensive treatment an salicylate alone

sured anti-inflammatory effect of low-dosage rticosteroid[1] . . . additive antirheumatic action of rticosteroid plus salicylate[2-5] brings rapid pain lief; aids restoration of function . . . wide range application including the entire fibrositis syn-ome as well as early or mild rheumatoid arthritis

ore conservative and manageable than full-sage corticosteroid therapy—

uch less likelihood of treatment-interrupting le effects[1-6] . . . reduces possibility of residual ury . . . simple, flexible dosage schedule

ERAPY SHOULD BE INDIVIDUALIZED

ite conditions: Two or three tablets four times daily. After ired response is obtained, gradually reduce daily dosage d then discontinue.

acute or chronic conditions: Initially as above. When sat-actory control is obtained, gradually reduce the daily sage to minimum effective maintenance level. For best ults administer after meals and at bedtime.

cautions: Because SIGMAGEN contains prednisone, the ne precautions and contraindications observed with this roid apply also to the use of SIGMAGEN.



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corticoid-salicylate compound tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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to the editor

Continued from page 1707

V.A. M.D.'s and clinics for a year or two after return to civilian life, had had surgical excision, cauterization and x-ray treatment with recurrence.

Plantar warts are "rough" on a civil engineer who was very actively engaged in big jobs in the Pacific Northwest.

The former lieutenant of the corps wrote me about 1946-1947.

I described the method in detail in a letter he gave to his doctor.

Since then he has written me several times and still sends annual Christmas cards stating his warts are cured.

Hastily yours,
s/ Hugh S. Ramsey, M.D. ◄

A new man in the office was given some fatherly advice by the boss: "I don't mind you following in my footsteps, but please wait until I get out of them." —*Office Economist.*

Tested . . . and proved . . .

ORAL therapy in diaper rash!



Convenient . . . simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions . . . no rinses . . . no ointments . . . just oral therapy.

Send for samples and literature.

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timed-release tablets

Controls congestion
with Triaminic,[1,2,3] the leading oral nasal decongestant.

Controls aches and fever
with well-tolerated APAP, non-addictive analgetic[4] and excellent antipyretic.[5]

Each TUSSAGESIC Tablet provides:

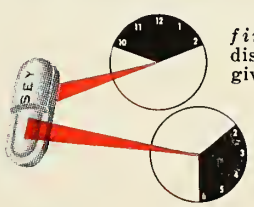
TRIAMINIC® 50 mg.
(phenylpropanolamine HCl 25 mg.
pheniramine maleate 12.5 mg.
pyrilamine maleate 12.5 mg.)
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(brand of dextromethorphan HBr)..... 30 mg.
Terpin hydrate 180 mg.
APAP (N-acetyl-p-aminophenol) 325 mg.

References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

Controls cough centrally
with non-narcotic Dormethan, possessing "amply demonstrated" antitussive activity,[6] as effective as codeine.

Liquefies tenacious mucus
with terpin hydrate, classic expectorant.

Prompt and prolonged relief because of this special "timed release" design:



first – the outer layer dissolves within minutes to give 3 to 4 hours of relief

then – the inner core releases its ingredients to sustain relief for 3 to 4 more hours

Dosage: One tablet in the morning, midafternoon and at bedtime. Pediatric dosage chart for Tussagesic Suspension available on request.

TUSSAGESIC SUSPENSION provides palatability and convenience which make it especially attractive to children and other patients who prefer liquid medication.

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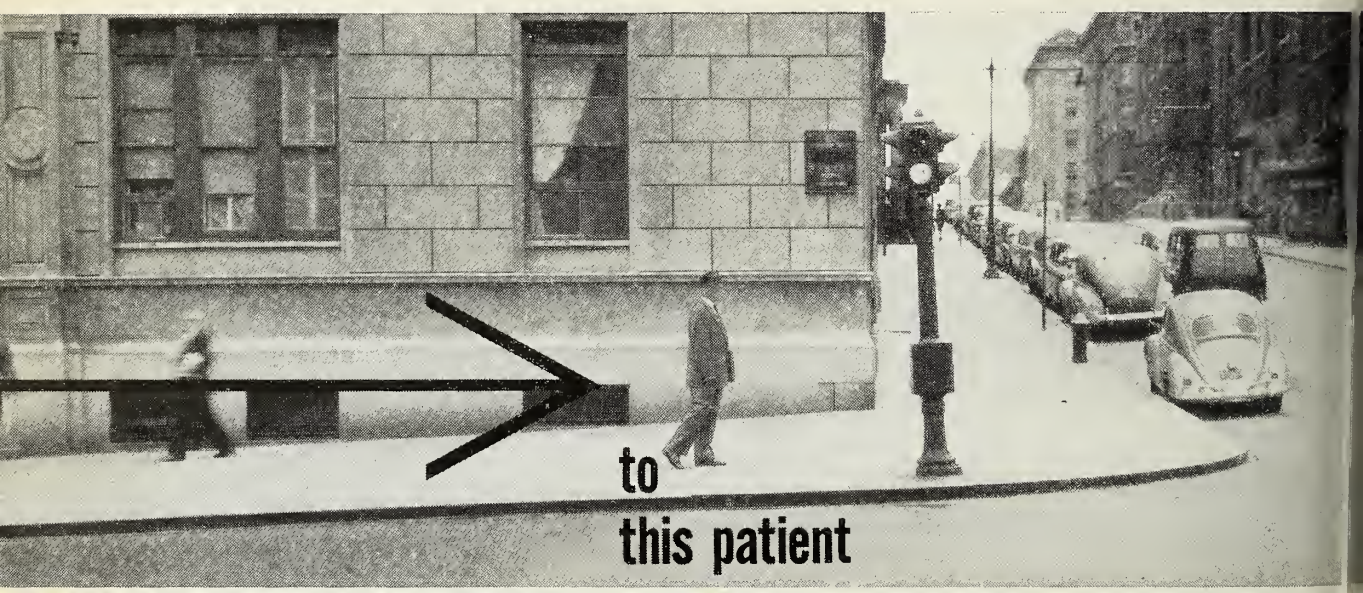
Blue Cross-Blue Shield: Why So Many Programs?

This article is the eighth in a series prepared by Blue Cross-Blue Shield dealing with health care financing trends.

The question of "why does Blue Cross-Blue Shield have so many programs available?" has very likely often crossed your mind. It is quite conceivable that you, the doctor, have been irritated because you run across so many "kinds" and coverages offering an assortment of benefits. Your office girl, too, no doubt has wondered about the various numerical codes (kind numbers) in handling Blue Shield claims. This question deserves an answer.

Blue Cross and Blue Shield were developed to fulfill the public's need of meeting the expense of medical care. Its purpose has not changed, though the concept of "medical care" has grown to include more complete programs of health protection. Blue Cross and Blue Shield do not dictate what benefits a member or account must take. We can only advise prospective accounts as to what program is best suited to their needs for the funds they have available.

For example, managements of large accounts such as General Motors, U. S. Steel or Chrysler meet with their labor leaders to discuss the health care benefits desired by the parties concerned. After reaching an agreement on what they want, they come to us and ask whether or not we can provide this coverage. Naturally, benefits will vary according to labor-management agreements. As a health care organization, it is up to Blue Cross-Blue Shield to arrive at the best program



with intermittent claudication every block was a mile long

now... **arlidin**

makes the blocks so much shorter...
he can walk many more of them in comfort

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possible, based on sound actuarial practices, for the money made available. If we can not do this, such services will be sought elsewhere.

It is for this reason that as a doctor, you come across a variety of benefit schedules. This same procedure is in effect whether the account membership consists of five or 50,000 employees.

Though small firms do not generally have labor spokesmen, the same basic health coverage problems arise between employer and employee. The employer questions what to offer in health protection. Should it be administered through payroll deduction or collection? What share, if any, should he provide towards the cost? What benefits can be provided for this cost? Again, Blue Cross-Blue Shield must work out a schedule of benefits best suited to individual needs. The result, a variety of programs and codes.

Through Blue Cross-Blue Shield's program flexibility, this can be done. Such flexibility is needed to meet competition of commercial insurance companies. Health care programs can be tailor-made to meet changing needs and specific requirements. Yet, even though Blue Cross-Blue Shield have grown to nearly a million-and-a-half members, it maintains an individuality of personal service to its more than 10,000 accounts.

The non-group or direct pay membership must be controlled to maintain a sound health coverage program for all. This group contains a heavier proportion of poor risks. Membership consists of individuals terminated from accounts, pensioners, people of low income, the aged and those physically ill who have enrolled through open enrollment campaigns such as those held in 1954-55. They are accepted as part of Blue Cross-Blue Shield's community responsibility, regardless of their risk. Special programs supported by experience and statistics have been developed to serve the needs of these individuals. Again, this necessitates an assortment of "kinds."

Continued



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safely increases local blood supply and oxygen where needed most... in distressed "walking" muscles for sustained, gratifying relief of pain and spasm in

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cold feet, legs and hands

Arlidin is available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution. See PDR for dosage and packaging.

Protected by U. S. Patent Numbers: 2,661,372 and 2,661,373

For the Medical Record:

How Hoosiers Voted In Washington

Following are records of voting by Indiana Congressmen and Senators on measures in which medicine has an interest as compiled by the AMA Washington office, Law Division.

H.R. 2260, extension of the draft including extension of the special doctor draft, passed the House by vote of 381-20. Of the Indiana delegation, only Mr. Harmon voted against it. In the Senate the vote was 90-1. Both senators favored the legislation. The AMA in its statement left it to the wisdom of Congress as to the extension of this law but urged that other professionals be brought under its terms.

S.J. Res. 41, international medical research, passed the Senate by a vote of 63-17 with Senator Hartke in favor of the resolution and Senator Capehart opposed. The bill has not been voted in the House. President Gunnar Gundersen testified in favor of the legislation before the Senate suggesting some amendments.

S. 2162, federal employees health insurance, passed the House by vote of 382-4. All members of the Indiana delegation favored the bill. In the Senate the vote was 81-4 with Senator Hartke favoring the bill and Senator Capehart not voting. The AMA forwarded statements favoring the legislation in principle.

S. 57, the first housing bill, passed the House by a vote of 261-160. Halleck and Adair voted against the bill and the rest of the delegation in favor of it.

S. 57 passed the Senate by a vote of 60-28 with both Senators favoring it. The AMA favored the enactment of FHA insurance for nursing home construction loans.

S. 2539, the second housing bill, passed the Senate by a vote of 71-24. Both Senators favored the bill. The nursing home features of the bill remained unchanged. Therefore, the AMA's statement on S. 57 would apply to this bill also. The bill passed the House by a vote of 283-105. Representatives Halleck and Bray voted against the bill, Representatives Adair and Denton did not vote, the rest of the delegation favored the bill.

S. 2654, the third housing bill, passed the Senate by vote of 86-7. Senator Capehart voted for the bill and Senator Hartke did not vote. The nursing home provisions remained unchanged in this bill, too.

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Blue Cross-Blue Shield

Continued from page 1713

The same is true for other groups such as minor married children, divorced spouses, or the 19-year-olds. In order for Blue Cross-Blue Shield to serve all of its publics, meet competition and provide health coverage, it is necessary to provide a variety of programs.

Blue Cross-Blue Shield are household words for medical care prepayment. Their job is to provide to the member the prepaid services of the physician and hospital when needed. Their function is to underwrite and make possible that program. Money entrusted by the public is used for this purpose; it is not given away. For this reason, the widely known and highly respected name and symbol of Blue Cross-Blue Shield are extremely valuable properties. They represent medicine's concern for the welfare and security of the public they serve. This is the continuing job of Blue Cross and Blue Shield.

Sanford Schwartz
Public Relations Division ◄

CASE HISTORY OF AN ARTHRITIC

Age: 55 Sex: Male Race: White

Diagnosis: Rheumatoid arthritis.

Previous Therapy:
40 mg. triamcinalone per day.

Complicating States:
Duodenal ulcer, steroid intoxication.

Current Therapy: ARTHROPAN Liquid.

Results: The patient improved on ARTHROPAN and "...is now on Choline Salicylate [ARTHROPAN] alone and has returned to work."[1]



SUPPLIED: 8 and 16 oz. bottles.
Each ml. of ARTHROPAN Liquid contains 174 mg. of Choline Salicylate.
Each teaspoonful (5 ml.) contains 870 mg. of Choline Salicylate.

1. Clark, G.M.: Personal Communication, 1958.

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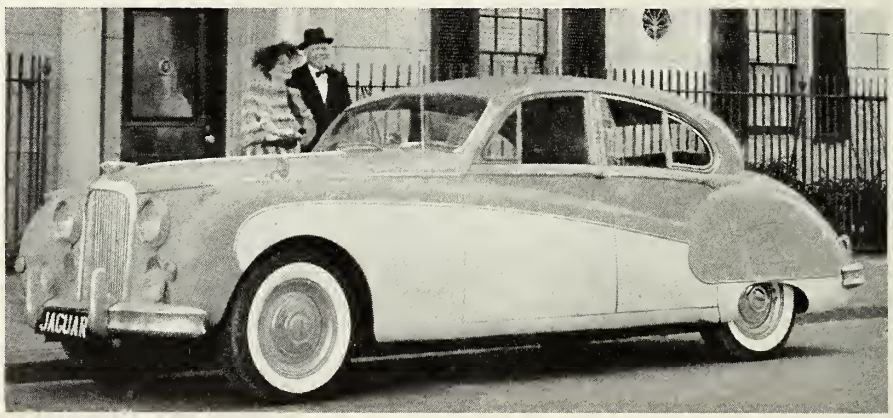
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Indiana State Board of Health

DIVISION OF COMMUNICABLE DISEASE CONTROL

MONTHLY REPORT – August, 1959

Disease	AUGUST 1959	JULY 1959	JUNE 1959	AUG. 1958	AUG. 1957
Animal Bites	618	605	1264	653	394
Chickenpox	7	35	142	22	10
Conjunctivitis	59	43	68	38	7
Diphtheria	0	1	0	1	0
Dysentery, Unspecified	15	3	7	15	38
Impetigo	99	57	69	159	36
Infectious Hepatitis	20	17	19	12	19
Infectious Mononucleosis	4	2	8	14	8
Influenza	150	88	217	248	99
Measles (Rubeola-Rubella)	64	141	582	81	49
Meningitis, Meningococcal	2	2	2	3	4
Meningitis, Other	25	15	6	27	21
Mumps	11	65	248	70	47
Pertussis	56	65	44	109	46
Pneumonia	61	54	106	62	50
Poliomyelitis	40	24	7	33	47
Streptococcal Infections	150	124	285	179	98
Tinea Capitis	3	0	7	11	11

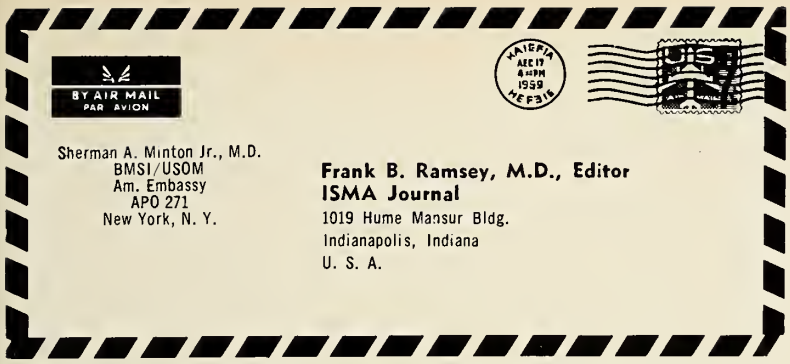


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Report from Pakistan

Karachi, Pakistan
August 31, 1959

Dear Doctor:

I thought many of your readers might be interested in knowing what some of our every day medical problems are. This is in no sense an epidemiological report nor does it embody the opinions of anyone but the writer.

In a land of many people and few physicians, a preclinical professor is likely to find he has suddenly become a general practitioner. I had been in Karachi less than a month when I began to be consulted by my servants and their families. As the Basic Medical Sciences Institute gradually got into operation, I became a sort of unofficial physician to the employees, their families, the students, the staff and (I suspect) occasional fellows who just happened to stop in.

By and large I have had a most gratifying relationship with my Pakistani patients, but there have been some problems. Language is one. Only a few Pakistanis speak English well, and some of those who do have trouble with the language as spoken in the midland United States. Although I have, through the months, learned a few pertinent phrases of Urdu, I much prefer to have an interpreter handy. I once had a young girl recoil in terror when I asked in her language if I might stick her finger for a blood smear. I later found she believed I was going to bite her. Another time I confused the words "hath" and "hathi" with the result that my patient thought he was supposed to give an elephant a warm bath instead of soaking his hand in warm water.

The symptoms that seem to alarm the Pakistani patient most are sharp abdominal pain and bleeding from any site. I have come to learn that not every patient who hugs his belly, rolls his eyes and groans, "Oh Sahib, I die!" is in need of an emergency laparotomy. An enema or a dose of belladonna and phenobarbital often does wonders in such cases if there is no objective evidence of serious trouble. The fear of blood loss is so marked that it often takes considerable persuasion to obtain a sample for serological tests or even a malaria smear. The fear is not wholly illogical; for many, especially among women and children of the lower socioeconomic class, have sub-normal hemoglobin values and low erythrocyte counts.

In contrast with their less than stoic reaction toward some types

Continued on page 1726

new hope for fetal salvage

DEL

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein[1] in a compilation of data supplied by 45 investigators. Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that in Delalutin-treated women, fetal salvage of infants below term weight (1000 to 2000 gm.) was significant improved. 108 (76%) of 142 babies of tl birth weight survived without mothers rece ing progestational therapy, while 16 (100 of 16 babies of this birth weight survived w mothers receiving Delalutin therapy. A co parison study was made of a group repeated aborters treated with Delalut and a group with a similar history treat with bed rest and sedation.[4] Pregnan salvage with Delalutin was twice that of t control group. Delalutin was found to "highly active", well-tolerated and lo acting.

According to Tyler and Olson,[5] "Th qualities of prolonged action and relat freedom from local reactions ma [Delalutin] a generally more desira therapeutic agent for intramuscular t than progesterone...."

DELALUTIN BABIES WHOSE MOTHERS WERE HABITUAL ABOR



Mary Ann Cribben
Garden City, N. Y.



Amy Sue Greenman
Lincolnwood, Ill.



William Peller
Skokie, Ill.



Randy Sinis
Denver, Colo.



Richard Miller
Denver, Colo.



Scott Knuds
Norwich, Vt

References: 1. Reifenstein, E. C. Jr.: *Annals N. Y. Acad. Sc.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. & Gynec.* 76:279, 1958. 5. Tyler, E. T., and Olson, H. J.: *J.A.M.A.* 169:1843, 1959.

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improved progestational therapy

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LALUTIN offers these advantages over other progestational agents:

- long-acting sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requiring injection of less vehicle
- unusually well-tolerated, even in large doses
- fewer injections required
- low viscosity makes administration easier

ALUTIN is also potent and safe therapy for: threatened abortion; postpartum afters; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated genital malignancy; infertility with inadequate corpus luteum function; production of tory endometrium and desquamation during estrogen therapy; premenstrual tension; enorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

inistration and dosage:

use of its low viscosity, Delalutin may be admined with a small gauge needle (deep intragluteal tion). Complete information on administration dosage is supplied in the package insert.

Supply:

Delalutin is available in vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

f these healthy, normal babies was born by a mother with a documented previous history habitual abortion, who was treated during her most recent pregnancy with DELALUTIN.



utkowski
lle, Ill.



Rosanne Guberman
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'DELALUTIN'® IS A SQUIBB TRADEMARK.

Report from Pakistan

Continued from page 1723

of illness, many of the poorer people show a frightening indifference toward relatively painless tumors and ulcers. Also, in a land where human bone and sinew still bear most of the burdens, there is surprisingly little complaining of chronic muscle and joint pain. Perhaps the people learn from childhood more physiological methods of lifting and weight bearing than are used in the United States, or perhaps they feel that a working man's back is supposed to ache at the end of a day.

Whatever their complaint, patients expect to receive medication and explicit directions for its use. If you say that a tablet is to be taken with water, you will almost always be asked if it can also be swallowed with tea or milk.

Hypochondria is not uncommon. It often takes the form of undue concern with diet or bowel habits. Western type vitamin tablets are extensively used by those who can afford them, while the poorer folk rely upon locally produced "tonics." Many Pakistanis are inveterate users of cathartics, and it is difficult to convince them that daily evacuation of the large bowel is not essential to health.

Sanitation in Karachi is totally inadequate by western standards, and it is scarcely surprising that filth-borne diseases are prevalent. Diarrheal disease varies from the relatively mild "Karachi trots" to dangerous shigella infections. There is a tendency on the part of Americans and Europeans to call all cases of diarrhea "amoebic dysentery." In my limited experience, endamoeba histolytica is rather seldom found in stools of Americans in Karachi. Among the Pakistani nationals, however, it is quite a common parasite.

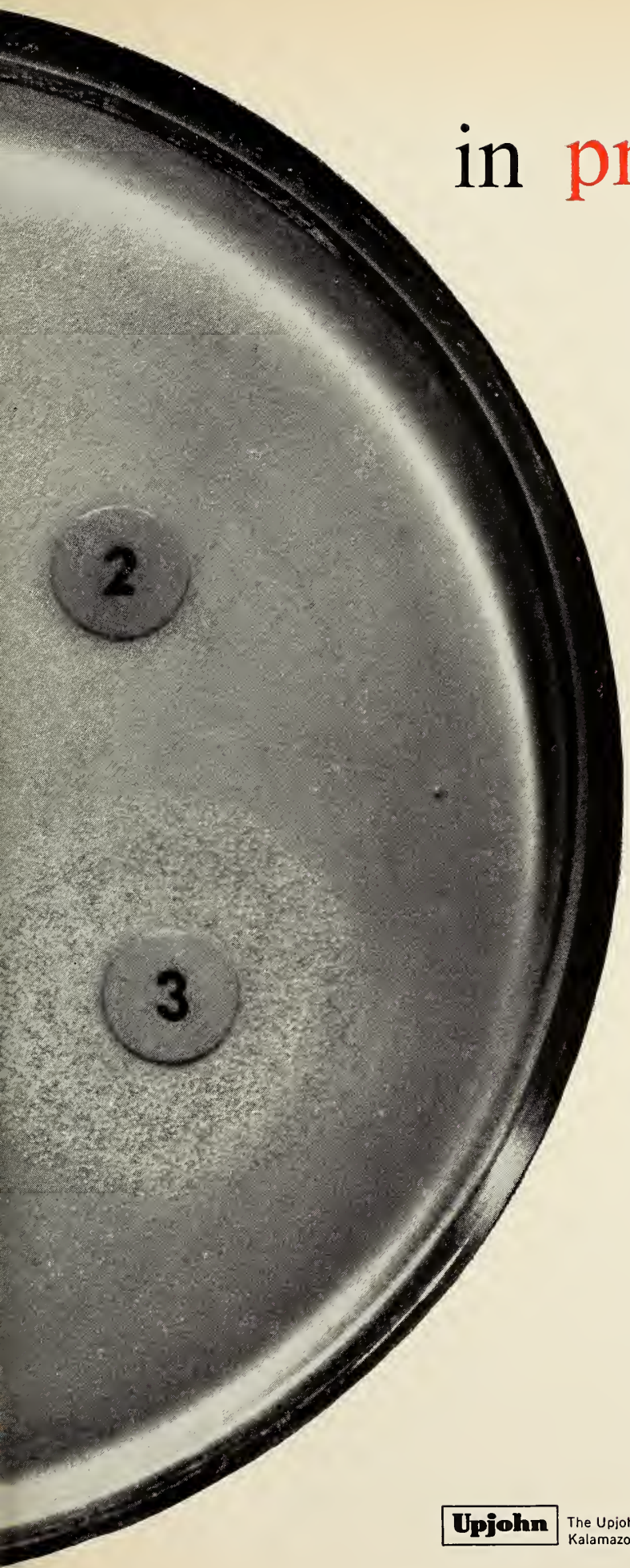
Other intestinal protozoa, particularly giardia and trichomonas, are common, although their relationship to disease is not always clear. The entire matter of etiology of diarrheal disease in the tropics is by no means simple. In my experience known pathogens can rarely be isolated. Instead it is often found that a paracolon bacillus or an atypical proteus is the dominant organism in the stool. One of our students at the Basic Medical Sciences Institute is now at work on the bacterial flora isolated from cases of acute diarrhea.

During late 1958 and early 1959, Karachi experienced an outbreak of severe gastrointestional disease. Some of the cases were almost certainly cholera, although local health authorities were most reluctant to admit this. Until one has seen the stools from such a case, he cannot fully appreciate the phrase, "profuse watery diarrhea." Most of the cases were from a particularly squalid refugee encampment. The surprising thing to me was not that the outbreak occurred but that it failed to develop into a devastating epidemic.

Diseases clinically resembling typhoid fever are seen with some frequency. Laboratory findings do not always support the clinical impression, and here also is an area where more careful bacteriological and serological studies are needed.

One Sunday afternoon an employee of the Institute brought his young son to my home. The child had been vomiting persistently, had a low fever and appeared dull and toxic. When palating the abdomen, I felt coils of intestine with a peculiar rope-like texture. A fleck of fecal material obtained

Continued to page 1730



in pneumonia

. . . into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

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Report from Pakistan

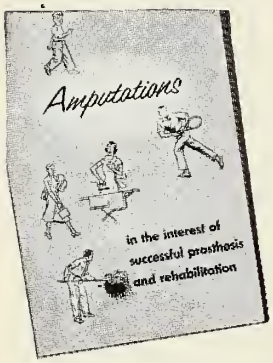
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by rectal examination contained dozens of ascaris ova. Administration of a small dose of a piperazine preparation was followed by the vomiting of five good sized ascaris. More piperazine was given. During the next two days, the child passed approximately a pound of worms and was much improved. Pinworm (enterobius) infections are also common among children as are infections with the dwarf tapeworm, hymenolepis nana. The hot, arid climate of Karachi evidently plays a large part in keeping hookworm a minor problem in the city.

Karachi's climate does not, however, seem to inhibit respiratory infections. Colds and acute sore throat are common, although chronic sinusitis does not seem to be the problem it is in the northern United States. Otitis media is common in children especially, and stubborn infections of the ear canal are seen in all age groups. A good number of the latter seem to be caused by bacteria of the genus pseudomonas. During the pleasant days of the last Christmas season, we had an epidemic of influenza-like disease affecting both foreigners and nationals. Cases were characterized by a very sudden onset, fever often to 104, and, in most cases, equally rapid improvement within a day or two.

Malaria has not been common in the city since I have been here. Although the diagnosis is often made on clinical grounds, it is rarely confirmed by blood smear. This season we have had an unusual amount of rain and a good crop of anopheles mosquitoes, so it is possible there will be an increase in malaria during the coming months.

Very sincerely yours,
s/Sherman A. Minton Jr., M.D.◄

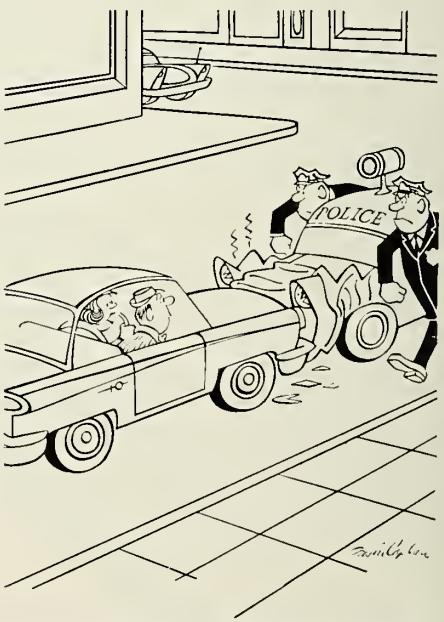


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"REMEMBER NOW, IT'S JUST THEIR WORD AGAINST OURS."

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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Disharmonies in Education

With Laws of the Mind and of Life

JOHN R. FRANK, M.D.

Valparaiso

IF MAN is a creature of evolution, it is only by following nature, leading the life that nature and God intended us to lead, that we can pursue that personal happiness mentioned by Thomas Jefferson. We propose to show (1) that we teach arithmetic before the child has any need for it or any interest in the subject; (2) that we teach mathematics, subjects that require reason and abstract thought, in high school before the human mind can reason well; and (3) that we fail to teach languages when the child is young, when memory is the best and the mind in the imitative state. Also, some important *laws* of the mind, some of the mind's pitfalls in thinking, the three main stages in modern times of the mind's development and growth, and a brief description or anatomy of its organ, the brain, will be given. Although we never cease to learn, for men the period of education is considered to be from birth to maturity (about 22). Next to being the parent of a child, the greatest, noblest work in life is that of the teacher of children.

Since the brain is the organ of the mind, we should think of the *mind* as being and including all the activities and functions of the brain. We distinguish in the brain two principal divisions, an old brain and a phylogenetically new brain. Most of the cells of the new brain are on the surface of the cerebral convolutions and migrate there in embryonic life from the region of the hollow ventricles. The nerve cells and centers of the old brain are between and below the new brain, and for millions of years were the only brain our aquatic ancestors had. In the old brain we distinguished (1) several basal "ganglia" or groups of nerve cells that are motor (efferent) in function, and (2) a large centrally located sensory center, the thalamus (Greek for a room). The latter is the brain's principal way-station for all incoming (afferent) sensations and is the chief seat or center of our affects or emotions. (Fig. 2.)

The nuclei (groups of cells) at the base of the brain (the hypothalamus), and the centers in the brain stem and medulla, contain the higher

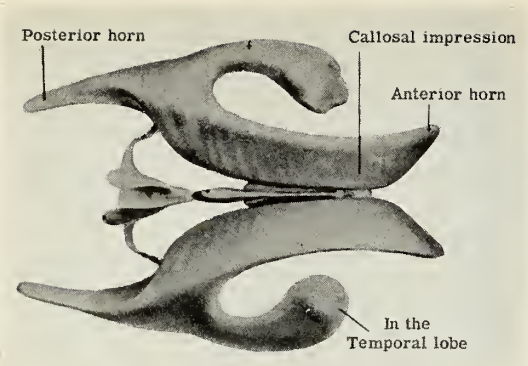


Fig. 1. Dorsal view of a cast of the brain ventricles of man. (Retzius.) (From "Anatomy of the Nervous System," ninth edition, Ranson-Clark, pub. by W. B. Saunders Company, p. 254, fig. 201.)

centers for the two *autonomic* nerve systems, the sympathetic and the para-sympathetic or vagus, etc. which opposing each other control the heart and blood pressure, the temperature, the respiration and which, with the aid of the hormones, integrate and control all the body's activities concerned with self preservation and race preservation or reproduction.

We do not know just when nerve cells cease to multiply and divide, but judging from the fact that brain cells injured at birth or subsequently do not usually regenerate or heal, they stop multiplying at or soon after birth. It has been estimated that the average human brain contains about ten billion nerve cells. The human infant at birth is weak and helpless because, unlike lower animals, the brain cells are very poorly connected with each other and with the body. From birth to the age of eight the brain grows very rapidly to about four (4) times its size at birth, so that a boy of eight often seems to have an abnormally large head when compared to his body. This growth is accomplished by an increase in size of nerve cells; by increase in the supporting cells and fibers (neuroglia, etc.) and by billions of new connecting fibers, axones and dendrites between nerve cells in all parts of the brain. Then at puberty, when the sex and other hormones stimulate growth of body and brain, there is another rather rapid increase in the size of the brain and more extensive intercellular synaptic connections.

The new brain (neopallium) is divided into five lobes and numerous deep ridges called convolutions. In the frontal lobes are most of the cells with which man reasons and thinks; in the posterior part, the occipital lobes, are the higher cortical cells for vision. On each side of the old brain and occupying the middle fossae of the skull are the temporal lobes which contain the higher centers for the senses of hearing and smell. Above the temporal lobes and separated from them by the large lateral fissure are the parietal lobes which contain the higher sensory and motor cells for sensations from and to all parts of the body.

The extensive connections of the "smell brain" with the new brain, although the olfactory connections are now in many places rudimentary, indicates that man's ancient ancester had a very keen sense of smell, and it was apparently largely due to this fact that he developed a big new brain or neopallium. (Fig. 3.)

Laws of the Brain and Mind

1. The law of dynamic polarity states that nerve cells have a polarity so that impulses over nerve fibers travel in only one direction. Nerve fibers are either motor or sensory.

2. The all or none law. The impulse from a stimulus apparently never goes only part way along a nerve pathway.

3. **Laws of Memory:**

 a. The younger one is, the stronger and more lasting the sensory impressions on the brain cells; and there is a progressive

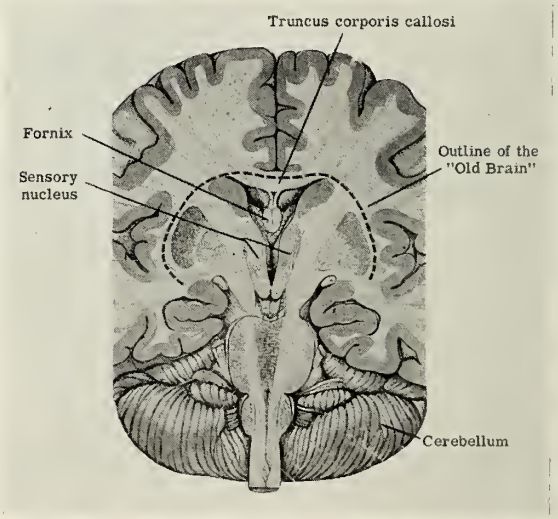


Fig. 2. Section through the brain on the axis of the brain stem, showing the entire extent of the corticospinal tract. (Toldt.) (From "Anatomy of the Nervous System," ninth edition, Ranson-Clark, pub. by W. B. Saunders Company, p. 325, fig. 258.)

loss of the ability to remember as one grows older.

b. *Law of Repetition.* Repetition of words, actions, etc. deepens the impressions in the brain cells, makes the memory more lasting.

c. *Laws of Association.* New words and names are best retained by association with words or objects similar to the new and with which the mind is already acquainted.

d. *Law or rule about loss of memory, forgetting, etc.* The mind likes to forget *painful, unpleasant* facts in life; therefore, all such ideas, even names, etc., associated with an unpleasantness are often difficult to recall.[1] Facts unpleasant to us we tend to doubt or completely reject. Logic or reason is usually helpless against wishful thinking. And we are like a schizophrenic (have split minds) if as adults we believe in the wishful myths of religion and still claim to be scientific.[7]

e. *Law of Retention of Mental Images.* Nothing once experienced and learned is ever completely lost or forgotten. Applied to education, a foreign language learned in early life and through disuse mostly forgotten, is soon relearned in contact with others who speak it. Lost skill in playing a piano, typing, etc. after a little practice is soon regained.

4. **The Law of Nutrition:** A poorly nourished brain or a brain exhausted from loss of sleep or lack of food or toxic from metabolic or other poisons, does not function well or retain sensory impressions well and has difficulty remembering. Impulses along nerves travel at an average rate of about 100 feet a second. The impulse is, therefore, not an electric current whose rate of speed is that of light, 186,500 miles a second. It has been demonstrated that the nervous impulse is apparently a very rapid explosive combustion of sugar derivatives, as acetylcholine. Therefore, *sugar* is absolutely necessary for the brain and nerves to function well. However, too much sugar or sweets in our diet should be avoided.[4]

5. **The Law of Recapitulation.** This, known as the fundamental biological law, states that the

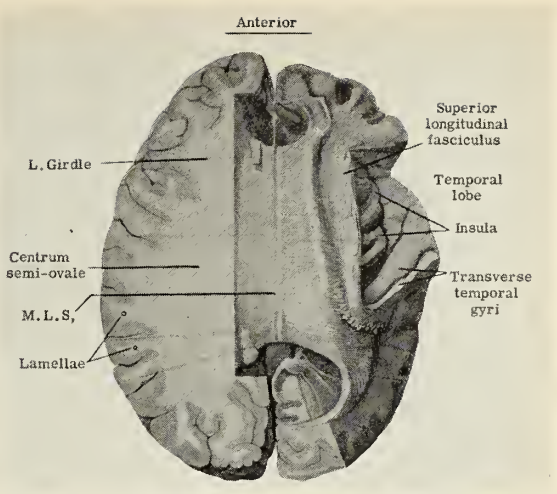


Fig. 3. Dissection of the human telencephalon to show the radiation of the corpus callosum. Dorsal view. (From "Anatomy of the Nervous System," ninth edition, Ranson-Clark, pub. by W. B. Saunders Company, p. 253, fig. 200.)

individual, plant or animal, in its development, passes briefly through the different stages its ancestral race passed through in evolution. Applied to the brain, we conclude that the structures and their functions, the last to appear in evolution, are the last to function in the developing brain of man. Now, these are the functions of the neo-pallium, especially those of the frontal lobe where it is well known are the cells with which man reasons. Full *synaptic* connections of these frontal cells do not occur until after puberty, or until the sex hormones stimulate their growth and development. As Herbert Spencer said in 1861, intellectual precocity and moral precocity both have detrimental results. "Our higher moral faculties, like our higher intellectual ones, are complex and both are comparatively late in their evolution."[5] This fact would seem to account for much of the "juvenile delinquency" of teenagers. As "hothouse virtue" often leads to delinquency (as is often the case of a preacher's son), so the pushing of a child's intellectual development, as the teaching of mathematics before he can reason well, often leads to a hatred of mathematics and of the teacher.

6. **Law of Separation of parent and offspring.** All throughout nature, in both the plant and animal world, we find an effort made to separate offspring and parent when the former matures. Seeds have wings and burrs, or fleshy parts tempting animals to eat them. Animals do not feed and care for their young after the young

mature. Man is the only animal that violates this law. When dependency on the parents is unduly prolonged and emotional separation does not occur, we often find a warped and abnormal personality, such as a neurosis, psychosis or an abnormal interest in religion. Therefore, our greatest duty to our children is to so rear and train them so that at maturity they will be emotionally and economically independent of us.

7. **The two great laws under which the mind works or thinks are:**

a. The association of ideas by their similarity and

b. The association of ideas by their contiguity in space or time.

An example of the former is that savage magic of bringing rain by sprinkling some water. An example of the latter of the *post hoc* idea, an incident following another incident is caused by the first incident. The misapplication of these two laws of thought constitute pitfalls in the thinking of both primitive and modern man.[2]

8. **The Law of Emotional Development.** The evolution of man's mental-emotional life both as a race or phylogenetically and in the individual person, in general, is in *three stages:*

a. A world of belief in magic, belief in the power of thought, day dreams, make believe, etc. such as we see in children and in primitive man.

b. At puberty, religion and mythology take over the emotional life of the mind. They are important because they *function* to *sublimate* and to repress the sex instinct and the three (or more) family romances that have developed in the average family: Thus in a family with two children of both sexes, there are four family romances:

Father - Mother
Father - Daughter
Mother - Son
Son - Daughter

These family complexes, developed universally in a normal family, are the most important and most enduring in our lives. They should be known and taught in high schools. But the average person today has never heard, for instance, of the Oedipus complex, the one best known in psychology.

c. From religion a few in our modern civilization have matured into a state of mind we may call the *scientific,* in which we have a better knowledge of self, especially of our emotional life. To "know thyself" said Socrates, is the highest attainment in life.[2,3]

Disharmonies exist in our educational system as a result of our violation of the law of early memory and the law of recapitulation as it applies to the brain. Foreign languages (especially Spanish in the U.S.) are best taught early in life in the primary grades. The earlier a language can be taught, the better; in fact, the average child can learn from others by imitation and repetition three or four languages almost as early as it can learn one. Some pertinent illustrations are of interest:

(1) In 1953 the Wilmette, Ill. delegate to the Paris Rotary International convention, Mr. William Alexander, took along his family, the wife and seven children ages 3 to 17: (story in the *Rotarian,* April, 1955). They bought a 3-seated Volkswagen in Paris and tourned the countries of western Europe. Little 3-year-old Jimmy Alexander, of the seven children, learned the most words of languages in the countries visited.

(2) Six-year-old Francie Abbott in India translated from English on a record player, Dickens' *Christmas Carol* to children of India. (*Saturday Evening Post,* 3-24-56, p. 79.)

(3) In a family with five children living in Santiago, Cuba, which the author once knew, the father was German, the mother French and they knew English. All children could speak fluently four languages. Spanish was learned at school and at play.

(4) In *Julius Caesar,* Cassius, speaking of the strange abnormal happenings, says, "Why, old men fool and children calculate!"

In his autobiography Ben Franklin advocates the teaching of the Romance languages before Latin, if ever, is taught, and compares the process to ascending a stairway, Latin being at the top or last, and easier to learn. Also it's better and easier to learn a *live* language than a dead one (Latin) if they both contain about the same vocabularly. College professors, however, usually say no to this proposition. Physical activities also, such as dancing, piano playing, typing, etc. are best learned in early life—8 to 16 years. The teaching of foreign languages at least in the col-

lege years, is something like locking the barn door after the horse is stolen.

The teaching of arithmetic, which almost universally is begun in the first grade, should be omitted until the third grade or until the child is eight years of age and the brain is more mature. An average child of 4-8 years of age shows little interest in arithmetic. Also, subjects like algebra and geometry which require reasoning, should not be taught until *after* puberty—16 to 17 for boys—or until the body and the brain are fairly mature and the *mind can reason*. However, there are a few, perhaps 5% of the boys, who are bright enough to be an exception to this rule, but experience shows that it is often detrimental to push them ahead of others.[5] Since girls mature about three years sooner than boys, they may be taught mathematics sooner. But practically they should wait until age 15-16 to take those subjects along with the boys. Because of this difference in development, we often see girls in the seventh to tenth grades making much better grades than boys of the same age and an 11-12 year old girl will be much taller than her 14-15 year old brother.

Dr. Ray Lyman Wilbur, a physician, an educator and secretary of the Interior under President Hoover, once said that changing a curriculum was like moving a cemetery. Mrs. Robert H. Morgan, Melvin, Ill., in Voice of the People, *Chicago Tribune* (3-28-56) says, "In 18 hours of *education* I took in one of the leading universities, I submit that they were the most deadly, dull and unrewarding of all the courses. Every teacher I have ever talked to agrees with me." Other teachers complain of too much appreciation of art and "methods" in their courses.

Finally, a great emotional disharmony exists for civilized man in that the sex or reproductive instinct becomes intense and active before full growth is attained. Marriage is not advisable until maturity and economical security are reached. However, earlier, rather than late marriage, as noted recently in our young people, is the best solution of this conflict between nature and our civilization.

Summary

The concept of *mind* should include all the activities and functions of the human brain, the most marvelous product of God's evolution. A knowledge of the development, evolution and anatomy of man's brain and the functions of its different parts, if applied in education and educational guidance, will yield big dividends. The frontal lobes of the new brain under the stimulating influence of the sex hormones are the last to mature; therefore, subjects which require reasoning and abstract thought must be taught *after* puberty, and memory subjects, literature, language, history, etc., should be emphasized *before* puberty.

Important laws of the brain and mind are at present generally ignored for ancient, traditional methods of instruction. The educational wheel is in a rut because of this clinging to the past. We see boys in the first two grades of high school dropping out for the same reason that, over 300 years ago, Ben Franklin, who had one of the greatest minds this country has ever produced, "failed in arithmetik" and dropped out of school.[6] Apparently, at age 11 his mind could not reason out or solve the problems often given in early texts. The failure to teach foreign languages early in life and in the primary grades when the memory is best and the drive or instinct to imitate the greatest, results in unnecessary difficulty in learning them in high school and college. If we follow more closely the aptitudes of the developing mind, we will achieve much greater efficiency in training and educating our children.

The course of man's mental-emotional-evolution as a race (phylogentically) and in each individual as he matures, has been and is "from magic through religion to science."[2]—P. 711. Earlier marriage and more education of youth in the interesting *knowledge of self,* both leading to greater stability of the home, are commendable procedures.

23 Lincolnway
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Charles Darwin

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Department of Zoology
Indiana University

ON THE 100th anniversary of the publication of Darwin's book, "Origin of Species," in 1859, it is appropriate in retrospect, that we take a look at the man, pre-Darwinian thought about evolution, Darwin's theory of Natural Selection, the general acceptance of evolution as a natural law and the impact of this acceptance upon other fields of knowledge. This article is intended to be only a brief restatement of some of the facts and theories, well known to biologists, about evolution, Charles Darwin and the part he played in presenting factual evidence for the idea of common descent and also for presenting a plausible explanation of the way in which continuous becoming is possible.

Before proceeding, however, we should understand the difference between fact and theory, between evolution and the method of evolution. Given the origin of living substance some time in the remote past, evidence demonstrates that present living organisms have arisen through a series of modifications from pre-existing living organisms. This is organic evolution. It means continuity, relationships, change. In this sense evolution may be said to be an established fact as all the accumulated scientific evidence points in the same direction. What are the causal factors which operate to bring about evolution? Here the evidence is not conclusive and may be interpreted differently by different people. The different interpretations are theories and Darwin's theory of Natural Selection is only one.

The life story of Charles Darwin is interesting from several points of view. He was born at Shrewsbury, England in 1809. At that time the history of the earth and its inhabitants as related in the book of Genesis was generally accepted by scientists as well as laymen. There were exceptions, but few were bold enough to raise questions. The church tended to dominate all thought. Under the influence of this environment Charles Darwin grew from boyhood to manhood, accepting the orthodox teachings of the church. At the age of 8 his mother died. The year following he was sent to a day school in Shrewsbury and then to Dr. Butler's school where he remained for 7 years. The school was strictly classical and as expressed in his autobiography, Charles gained little of educational value. This was probably not a fair judgment on his part, however. During the period extra-curricular interests, such as insect collecting and chemical experimentation with his brother Erasmus developed and added to his zest for life.

The father, thinking Charles was wasting his time, sent him to Edinburgh University to study medicine. His efforts here were little better than at Dr Butler's School, in part because he found the lectures dull and in part because he was convinced his father would leave him sufficient property for comfortable subsistence. Perceiving Charles' lack of interest in medicine, his father suggested that he become a clergyman. The idea appealed to Charles although he was not sure he believed in all the dogmas of the Church of England. In spite of these doubts he entered Cambridge where he remained 3 years. As at Dr. Butler's school he thought his time wasted. He did, however, make several influential acquaintances, the most important of which was Professor Henslow, who later recommended Charles' appointment as naturalist on the Beagle. Henslow was a botanist but he was also acquainted with other sciences, entomology,

chemistry and geology. While he gave formal lectures, his best teaching, in so far as Charles was concerned, was through field trips and special sessions in his home.

Another professor whose teachings provided an introduction to geology was Sedgwick, who invited Charles to accompany him on a field trip to North Wales, an experience which proved valuable to Charles during his explorations in South America. Up to the time of the completion of his stay at Cambridge, it seems that Charles had developed no impelling interest which would lead him toward a successful career. He did, however, continue to collect, to hunt and to have an interest in biological phenomena.

These brief details of the education of Charles Darwin have been given as they form the background of a young man of 22 who was to be invited to serve as naturalist on a scientific expedition to last for 5 years and who was destined to present convincing evidence of organic evolution and to develop an acceptable theory of the causal factors involved in evolutionary changes.

Today we would no doubt seek a man with a better academic record if we were asked to recommend a naturalist for a scientific expedition. Henslow, however, through personal contacts with Darwin, must have observed indications of interest and ability in things other than academic courses. In some respects a lack of a formal education may have been in Darwin's favor. He was left freer to think for himself and to develop his own individuality, uninfluenced by many of the prejudices and false theories prevalent at the time.

The voyage of the Beagle, under the command of Captain Fitz-Roy, began Dec. 27, 1831, and ended Oct. 2, 1836. The expedition touched land at many places, including the east and west coasts of South America, the Falkland, Galapagos, Marquesas and Society Islands, Tahiti, New Zealand and Australia. During the voyage Charles devoted his time and energies to the study of natural history. He described what he saw, collected, read the geological record and even did some dissecting. In contrast to his indifference toward his earlier educational experiences, Charles found a vital interest which called for his best efforts. As he said in his autobiography, he worked during the voyage for the mere pleasure of investigation and to satisfy a personal ambition to take a fair place among scientific men. To his interest, orderly scheduling of his time and diligent application to whatever undertaken, he felt he owed the first real training of his mind.

When Darwin began the voyage of the Beagle he believed in the special creation and fixity of species. Before departure, Henslow advised him to purchase the first volume of Charles Lyell's Principles of Geology, but "on no account" to accept the principle of continuity as an explanation of the geological record. Observations along the way, however, as well as the reading of Lyell's Principles raised questions. If the age of the earth is millions of years instead of the Biblical 4004 B.C., and if natural laws operating over the longer period can explain geological changes as advocated by Hutton and Lyell, why could not the same laws apply to changes in living organisms? As he traveled south over the continent of South America, why did closely related plants and animals replace one another? Why did fossil armadillos look like but vary from the living? Why did plants and animals of the separate but nearby Galapagos Islands differ and why were they related to those of the continent?

After return from his prolonged scientific trip around the world Darwin spent a few months in Cambridge, then moved to London where he remained until Sept. 14, 1842. He was married to his cousin, Emma Wedgwood, Jan. 29, 1839. As the noise and distractions of the city were not to their liking they moved to Downe village, a community of about 40 houses 16 miles from London. Here Darwin lived and worked the rest of his life, free from the necessity of earning a livelihood as subsidies and inheritances from the Darwin and Wedgwood families were more than adequate for all needs.

At Cambridge, Charles arranged his collections and placed them in good hands for future study. At London and later at Downe he worked on various projects, including his diary of the voyage of the Beagle, geological observations in South America, volcanic islands, origin of coral reefs and others. He opened his first notebook on the origin of species in July 1837. Fifteen months later he read a paper by Malthus on Population. It was this paper which called his attention to the question of the struggle for

existence which follows overpopulation and which led him to the idea that if favorable variations appeared they would tend to be preserved while unfavorable ones would be destroyed, thus leading to the formation of new species. Here was a possible method of evolution, later to be known as Natural Selection. By 1839 the theory began to take definite shape and in 1842, Darwin wrote a 35-page abstract which was enlarged to 230 pages in 1844. He delayed publication in order to collect additional data and to write more fully. This work continued through the years until 1858 when Alfred Russell Wallace sent him a paper which outlined independently the theory of Natural Selection much as Darwin had developed it. What should he do? His first inclination was to recommend publication of Wallace's paper without mention of his own work, but to lose priority after accumulating data for 20 years in support of the theory would, indeed, be a blow. Upon the advice of a few friends who knew of his long labors, Darwin wrote a short paper which was published simultaneously with the Wallace paper. These papers, which attracted little attention, were followed by Darwin's publication in 1859 of his epoch making book, "The Origin of Species by means of Natural Selection." The book did not include the great mass of supporting data as originally intended but which were later published separately. This omission proved to be all to the good, however, as the major ideas stood out more boldly and were not lost in a mass of details.

The first edition of the book, 1250 copies, was sold out immediately, an indication of the interest of laymen as well as scientists in evolution. Even though the subject had been discussed by the Greeks and others in between, notably Buffon, Erasmus Darwin, Lamarck, Goethe, Naudin, Wells, Spencer, Maupertuis and Chambers, the operation of natural laws as applied to the origin of living organisms was acceptable to a few only. Stormy discussions followed. Many scientists remained unconvinced. Even Lyell who had accepted the principle of continuity as applied to geological formations, held reservations, especially when applied to man. Asa Gray, too, while generally favorable was reluctant to give complete approval. Others were outright critical—Sir John Herschel, Whewell, Agassiz, Sedgwick, Owen. On the other hand Hooker and Huxley were ardent in their support.

Fortunately, perhaps, Darwin did not discuss the evolution of man in the Origin. If he had done so, prejudice and antagonism might have been aroused to the point of rejection, at that time, of the idea of continuity. While Darwin believed that man was subject to the same natural laws as plants and animals generally, he was content to say that studies of evolution would probably throw light on the origin of man. He delayed his discussion of the descent of man for 10 years in order to gather the necessary facts in support of his position.

As we look back over the past century, it may seem almost incredible that the principle of the origin of the living from the living, the continuity of all living forms, the principle of continuous becoming, should have been rejected for so many centuries. It is a good example of how long superstitution and preconceived ideas may persist, of the influence of the church in dominating scientific thinking and of how man may overlook obvious facts which lie round about him and of his failure to read meaning into such facts.

During the past century science has advanced at a rapid rate. In the light of these advances what is the status of evolution and Darwin's theory of Natural Selection? Of evolution, or common descent, the origin of present living forms from pre-existing living forms, there is no longer any question. All additional facts point in the same direction. As to evolution by means of Natural Selection, even Darwin in his later years realized there were questions which the theory did not satisfactorily answer. Instead of letting the theory stand or fall on its own merits, however, he resorted, unfortunately, to speculation and suggested subsidiary hypotheses such as sexual selection, effects of the environment and of use and disuse. Darwin's most serious handicap was his lack of knowledge of variations. Variations he could see and he could also see that man made use of inherited variations in his attempts to improve domestic plants and animals. He assumed variations occurred in nature and that in the struggle for existence useful variations would be preserved while injurious ones would be destroyed.

Today we understand the mechanism of heredity and that it is the same from unicellular forms to man. The theory of the gene is well established and inherited variations may be the result

of gene changes, gene rearrangements or gene duplications. Variations, however, can do no more than provide the characteristics which form the bases upon which evolution operates. Here is where the theory of Natural Selection enters and most biologists today accept the theory as an essential factor in any explanation of a method of evolution.

While science may seem to advance by leaps from mountain top to mountain top, the facts are that significant advances are dependent upon many lesser developments in the valleys in between. This was certainly true of Darwin's contributions to evolutionary thought even though he did not give full credit to his predecessors.

Apparently Darwin thought the idea of evolution by means of natural selection was new and original with him, but the concept had been in existence a long time. If we are inclined to be critical of him for neglecting the past, as some critics are, we should remember that communication in his day was difficult and that workers were more or less isolated. Also, theories were often little more than suggestions couched in vague terminology, difficult of interpretation and without supporting evidence.

Darwin thought of himself, "as slow of apprehension, a poor critic, limited in his power to follow abstract thinking, memory extensive but hazy." On the other hand he thought he possessed, "ability to reason, to invent and to observe carefully." What he thought was more important was his, "industry and ardent love of natural science."

Characteristics such as Darwin has enumerated for himself in no way place him in the class of so-called brilliant men and some of his biographers do not place him in that class. Certainly he was not quick of wit nor was he clever, characteristics so often enumerated as associated with brilliance. But what is brilliance? I shall not attempt to define it, but accomplishments such as those of Charles Darwin are not signs of mediocrity. To revolutionize the thinking of man, not only with respect to biology, but in every department of knowledge—the physical sciences, psychology, sociology, religion—is the accomplishment of a truly great mind. ◄

Grass-Roots of Organized Medicine

County societies compose the grass-roots of organized medicine. As the societies go, so shall the future of medicine go.

The *Journal* staff would like to feature more information on activities of county societies as well as district meetings.

Secretaries of county societies are not only welcome to send in contributions to the *Journal* containing county information, but are urged to do so. Just remember that absolute deadline is the 10th of the month preceding month of issue. This means such copy must be in the *Journal* office, say, by November 10 to be carried in the December issue. This is necessary due to the time involved in preparing and printing (see *Add 1*, page 1855).

Address such information about your society to: Editor, Journal of the Indiana State Medical Association, 1019 Hume Mansur Bldg., Indianapolis 4.

A Clinical Evaluation of Theracor

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THERACOR®** is an enteric coated tablet designed for use in the treatment of hypertensive-cardiovascular disease states. It contains a simple physical mixture of theophylline and choline (as the bitartrate salt) in the companionship of reserpine. The rationale for such a combination is sound. It offers the complementary action of a tranquilizing hypotensor, reserpine, and a mild vasodilator-bronchodilator-diuretic, theophylline. The third component, choline, has been incorporated in the formula for two reasons. First, several investigators have suggested that this physiologically important lipotrope may be helpful in the treatment of subjects who have suffered cardiovascular episodes. Second, because of the strongly basic character of this quaternary compound, it serves to help solubilize theophylline. Thus, the presence of the choline salt in Theracor should enhance the absorption of theophylline and appreciably reduce the irritant effect of the latter on the gastrointestinal tract.

Extensive animal studies have been carried out on Theracor by Pircio, Purvis and Grattan.[1] They found that rats receiving the preparation for a period of 65 days, at levels as much as 45 times the dosage suggested for an adult human, showed no ill effects. Blood counts and hemoglobin values remained normal throughout the course of the experiment. At the time of sacrifice no gross changes were seen in the heart, lungs, liver, spleen, kidneys and adrenals. Histopathological examination of organ sections revealed no abnormal changes ascribable to Theracor treatment. Blood pressure values of dogs receiving Theracor were lowered to a degree comparable to that observed when reserpine alone was administered in an amount equivalent to that present in Theracor. Blood theophylline levels of rabbits given a single dose of the Theracor formula were twice as high ½ hour after dosing as those recorded for theophylline alone in equivalent dosage. Further, peak blood concentrations were appreciably higher after Theracor ingestion than after theophylline. This pattern of superiority maintained over a period of seven hours.

Di Palma, *et al.*,[2] carefully studied Theracor in 10 selected subjects who had been followed for several years as members of a clinic population. Included in the program were patients with angina, emphysema, bronchial asthma and hypertension. Theophylline concentration in the blood reached a maximum three hours after intake of a single tablet of Theracor. Significant levels persisted for at least seven hours. On a dosage regimen of 1 tablet Theracor 4 times daily (taken at 4-hour intervals) for a period of four weeks, a maximum fall in blood pressure of 30 mm. systolic and 19 mm. diastolic was noted. Blood theophylline levels were measured twice daily during the first and fourth weeks of the study. It was found that on the reference dosage schedule theophylline values remained relatively constant throughout the day. No changes of consequence were detected in chest x-ray, electrocardiogram, electroencephalogram Rorschach test, white cell count, hemoglobin, uranalysis and vital capacity throughout the

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** Supplied by the Carroll Dunham Smith Pharmacal Company, New Brunswick, N. J. Tablets used in this study had the following composition: theophylline, 100 mgm, choline bitartrate 209 mgm (equivalent to 100 mgm choline) and reserpine, 0.05 mgm.

study. The preparation was well tolerated and no serious side effects were encountered.

Blinder[3] evaluated Theracor over a period of six months in a series of 25 patients chosen at random from private practice. The exact status of those selected for the study was known, since they had all been under observation for periods ranging from six months to 20 years. The cases treated fell into the following diagnostic categories: arteriosclerotic heart disease with coronary artery disease or cerebral arteriosclerosis, chronic asthmatic bronchitis, essential hypertension, hypertensive heart disease and arteriosclerosis complicating chronic bronchitis. Initial dosage was one tablet daily. Dosage was gradually increased until tolerance and response established the preferred dosage for each individual. Blood pressures, electrocardiograms and x-rays of the chest were taken routinely. In addition, urinalysis, blood counts and blood chemistries were carried out on each person taking part in the program. Blinder observed that Theracor was generally well tolerated, except for occasional bouts of nausea in highly sensitive individuals. He concluded that the preparation proved beneficial in those classes of patients treated and suggested that it should be considered as basic medication for severe hypertensives who would be logical candidates for therapy with more potent hypotensive drugs.

The present report recounts our own experiences with the use of Theracor in a small series of 14 cases studied over the course of three months.

Materials and Method

The subjects selected for this study were principally clinic patients from a large private hospital. There were 11 females and three males, white or colored, ranging in age from 25 to 79 years.

The group included two asthmatics, three patients with angina pectoris, seven hypertensives and two subjects with both angina and hypertension. The asthma and angina were of long standing. The hypertension was of moderate degree. Most of the patients had previously received other treatments for their underlying symptoms.

Base line laboratory studies, including electrocardiogram, chest film, non-protein nitrogen and kidney function tests, were obtained on all those participating in the study. Each patient was examined periodically and blood pressure determinations made. During examination the individual was queried concerning his personal estimate of the progress he was making on the preparation he was receiving, and his considered tolerance or intolerance of the medication.

All patients initially received 4 tablets of Theracor daily, in divided doses. In two instances this dosage pattern was altered during the period of study.

Results

The pertinent data on the patients treated with Theracor have been incorporated in Table I. Also, it was found the preparation did not unfavorably influence ECG, chest x-ray, NPN or liver function test findings.

Of the 14 subjects placed in the program, one failed to cooperate in keeping examination appointments. It would be impossible to do more than conjecture as to the usefulness of Theracor to this individual. One patient was carried for two months on one tablet Theracor 4 times daily, then maintained for three months on an intake of 5 tablets daily. A slight headache and some dizziness was experienced at first, but thereafter the higher dosage was well tolerated. In another case, 4 tablets daily for a period of one week provoked headache and vertigo. Tolerance to a lower dosage was not determined and the patient was withdrawn from further consideration. The 4 tablets daily over a course of two weeks time caused nausea and a degree of insomnia in one instance. Reduction of dosage to 1 tablet twice a day eliminated these disturbances. Dosage was then maintained at 1 tablet 3 times daily for six weeks without untoward effect. In the remainder of the series a dosage of 4 tablets a day was generally well tolerated.

Both subjects with bronchial asthma responded rather dramatically to Theracor. Symptoms were reduced to a minimum during the fall and early winter months, whereas in past years, on other therapies, the condition had been exceptionally difficult to control. The case history of one patient demon-

TABLE 1

BRIEF CASE DATA ON PATIENTS TREATED WITH THERACOR

Case No.	Age	Sex	Race	Diagnosis	Status At Onset Of Therapy	Theracor Dosage	Period Of Therapy	Response To Theracor
I	25	F.	N.	Asthma	Frequent visits to emergency room for treatment.	1 tab. q.i.d.	3 mo.	Only one emergency (pneumonia) noted during period of therapy.
II	58	F.	W.	Asthma	Severe asthmatic. Required 2 courses ACTH in fall of previous 2 years.	1 tab. q.i.d.	3 mo.	Only mild wheezing fall months while on Theracor.
III	49	M.	W.	Angina	Severe angina. As many as 100 tabs. weekly nitroglycerin.	1 tab. q.i.d.	3 mo.	Marked relief of angina. Patient able to resume work.
IV	58	M.	W.	Angina	Severe angina. Nitroglycerin tabs. routinely.	1 tab. q.i.d.	3 mo.	Excellent relief. No further need for nitroglycerin while receiving Theracor.
V	67	F.	W.	Angina	Moderate angina.	1 tab. q.i.d.	3 mo.	Good relief initially; slight angina occasionally thereafter.
VI	67	F.	W.	Angina and Hypertension	Frequent episodes of anginal type chest pain. Resistant hypertension. B.P.: 220/110.	1 tab. q.i.d.	3 mo.	Anginal attacks less frequent. No significant change in blood pressure.
VII	61	M.	W.	Angina and Hypertension	Moderate angina. B.P.: 230/110.	1 tab. q.i.d.	3 mo.	Feels excellent. No anginal attacks while on Theracor. B.P.: 160-180/80-90.
VIII	75	F.	W.	Hypertension	B.P.: 230/110 (Av.). Duodenal ulcer.	1 tab. 5 x daily	3 mo.	Felt better. Systolic pressure erratic, with little change. Diastolic value 90-100 mm.
IX	65	F.	W.	Hypertension	B.P.: 200/100. Diabetic.	1 tab. q.i.d.	2 mo.	No change in systolic reading. Diastolic drop of 10-20 mm.
X	46	F.	W.	Hypertension	B.P.: 200/125. Very obese.	1 tab. q.i.d.	3 mo.	No change in systolic reading. Sustained drop of 15-30 mm. in diastolic value.
XI	34	F.	N.	Hypertension	B.P.: 180/120 (Av.).	1 tab. q.i.d.	3 mo.	No significant change in blood pressure.
XII	56	F.	W.	Hypertension	B.P.: 180/100 (Av.).	1 tab. q.i.d.	1 wk.	Developed headache and vertigo and refused further therapy.
XIII	46	F.	W.	Hypertension	B.P.: 160/95.	1 tab. q.i.d. 1 tab. b.i.d. 1 tab. t.i.d.	2 wk. 2 wk. 6 wk.	Nausea and insomnia. No change in B.P. No side effects. B.P.: 140/80. No side effects. B.P. slightly lower than initially.
XIV	69	F.	W.	Hypertension	B.P.: 200/100.	1 tab. q.i.d.	?	Failed to return for follow-up.

strates the beneficial response ascribable to the administration of Theracor:

White, female, 58 years of age. Recurrent episodes of bronchial asthma during preceding six years, attributable to multiple causes. Upper respiratory infection and ragweed apparently prominent offenders. Developed allergic nasal polyps resulting in the need for two nasal polypectomies. Received two courses of nasal radiation. Hospitalized on four occasions, principally due to exacerbation of asthmatic symptoms. Two hospital admissions were at the height of the ragweed season in successive years. Innumerable visits to the emergency room during acute asthmatic attacks in recent years. At such times treatment included epinephrine subcutaneously and aminophylline intravenously. Treated in the outpatient department with three courses of ACTH in three instances. Classified as severe asthmatic problem.

Patient placed on Theracor, one tablet 4 times daily, in late August, prior to the time usually experiencing difficulty associated with ragweed sensitivity. Kept on therapy for three months. During this period no emergency was encountered requiring control with adrenalin or parenteral aminophylline. ACTH treatment was avoided. For the first time in three years hospitalization at this season of the year was found to be unnecessary. Only minimal findings of asthma were recorded while on Theracor therapy.

Three of the five subjects with anginal symptoms were appreciably improved while receiving Theracor. Very marked relief was noted by the other two. In one of them the dyspnea was considerably less apparent than previously, and he had become practically free of chest pain. In fact, he was able to completely dispense with the use of nitroglycerin. In the other patient the response to Theracor was most gratifying. The case history outline for this individual follows:

White, 47-year-old male. Rheumatic fever at age 15 and St. Vitus' dance one year later. When 35 he first experienced paroxysmal nocturnal dyspnea, orthopnea and chest pain. After several weeks the symptoms subsided. Remained symptoms-free until four years later when he had a similar episode. The next occurrence of the same condition was not until seven years had elapsed. On routine heart failure management since age 46. The year previous had positive serology with penicillin therapy.

Patient admitted to hospital early in his 47th year. Complained of severe chest pain. Examination revealed: Blood pressure 160/80; NPN 145; albumin, pus and blood in urine; suppression of renal function (established by x-ray); markedly enlarged heart with congestive failure (confirmed by x-ray). Diagnosis: rheumatic heart disease, mitral stenosis, mitral insufficiency, aortic insufficiency, aortic stenosis, pyelonephritis, with congestive heart failure secondary to rheumatic heart disease and azotemia secondary to chronic pyelonephritis. Patient was placed on a program of digitoxin, Diamox, parenteral mercurial when needed, nitroglycerin orally as necessary.

Over the course of the next several weeks the patient was seen rather consistently because the chest pain became more frequent and pronounced. Aminophylline and Peritrate were prescribed. As many as 100 tablets of nitroglycerin were consumed weekly in an effort to gain relief from chest discomfort. After three months time he was readmitted to the hospital because of refractory heart failure. Examination findings: Blood pressure 140/70; NPN 91; ECG demonstrated left ventricular hypertrophy and "strain," atrial hypertrophy, old posterior myocardial infarction and ventricular premature contractures. While hospitalized he responded to the usual failure treatment regimen and was shortly released.

Two months later the patient again presented himself with the typical complaints. He was placed on Theracor, 1 tablet 4 times daily. By the end of two weeks chest pain had completely disappeared. He stated that he now felt better than he had for the past several years. During the period of study his physical comfort was genuinely satisfactory, and he was able to return to work once more. Three months after completion of the Theracor evaluation program the patient was re-examined. No substantial change in blood pressure had taken place. The urine still contained albumin, blood and pus, and the NPN remained elevated (approximately 80). He has continued virtually free of chest pain, except for an occasional, mild attack.

In none of the subjects with hypertension was an increase in blood pressure noted during the period of Theracor administration. There was no significant lowering of blood pressure in two of the hypertensives. A decrease of 10-30 mm.

in diastolic pressure was observed in five patients.

Interestingly enough, in only one case was there a substantial drop in systolic pressure. In this individual the systolic average was lowered as much as 60 mm. and the diastolic as much as 30 mm. mercury. The patient presented angina in conjunction with hypertensive vascular disease (moderate). There were no signs of anginal involvement while receiving Theracor, and his general well-being was excellent. The results seen in this patient represent a well-controlled diastolic pressure level and a fluctuating blood pressure. This type of patient must be distinguished from those with sustained high pressure values.

Discussion and Conclusions

In the past several years many notable advances have been made in the medical management of angina pectoris, asthma and hypertension. A number of exceptionally potent drugs have become available which are expressly suitable for certain patients presenting one or more of these reference conditions. However, these newer therapeutic agents must be administered rather selectively, since not infrequently side effects of some consequence attend their use. Generally, it is better to reserve such preparations for especially severe cases, for emergency situations, for those individuals demonstrably resistant to milder medicines, and for those other occasions when the possibility of eliciting side effects is distinctly secondary to the patient's need for the primary effects of the drug. It follows that for many subjects requiring treatment, the older therapeutic principles will most often produce quite a satisfactory response. In this regard it is well to consider Visscher's[4] reminder that the xanthines should not be overlooked or neglected by the physician.

Theophylline is a time-honored medicinal compound which exerts an effect on diverse physiological processes.[5] It increases cardiac output, improves respiratory function, enhances bronchodilation, and acts as a mild diuretic through its capacity to increase glomerular blood flow. It may also have a direct dilating action on the coronary arteries, although the latter property is the subject of much debate and controversy. Through the years, the oral use of theophylline itself has been limited principally by the fact that the characteristic insolubility of the compound makes it difficult to establish effective blood concentrations of the drug, and by the fact that gastric upset often attends the administration of therapeutic dosage. These disadvantages have been largely overcome through the presentation of theophylline along with a solubilizing substance; for example, choline.

The therapeutic usefulness of reserpine is well-documented.[6,7,8] In the past decade several hundred papers have appeared in the scientific literature defining the pharmacological action and describing the clinical effects of Rauwolfia serpentina and its most potent single alkaloidal fraction, reserpine. The drug has been particularly helpful to the psychiatrist because of its recognized tranquilizing influence in disturbed and agitated patients. The sedating quality of reserpine is of adjunctive significance when the compound is prescribed for hypertensive subjects.[9] Reserpine may be classified as a mild to moderate hypotensor, effecting a relatively small drop in blood pressure when administered in preferred daily dosage. It is perhaps most useful in hypertensives of the neurogenic type. It is also a very acceptable baseline preparation for use in conjunction with the more potent agents now employed in the control of severe hypertension.[10,11,12,13] Reserpine also demonstrates bradycardic activity[14]—a quality which may be of significance in the treatment of certain cardiovascular disorders. More recently evidence has been presented indicating that reserpine or the alseroxylon fraction of Rauwolfia serpentina has a beneficial action in cases of angina pectoris.[10,15,16,17,18] Also, Segal and Attinger[19] have presented data revealing the adjunctive value of reserpine in the management of chronic bronchial asthma and chronic pulmonary emphysema.

Since theophylline and reserpine are of established efficacy when administered singly, it might be expected that their simultaneous administration would offer certain advantages. Further, it would not be anticipated that the identified activities of either drug would interfere with those of the companion agent if the two compounds were used concurrently. In some respects these therapeutic principles should also be complementary in action. These expectations seem to have been confirmed by Cohen[20] who has demonstrated that Rauwolfia-xanthine-barbiturate

mixtures are of distinct usefulness in the treatment of moderately severe essential hypertension. From the observations made in our own small series of patients it appears that reserpine and theophylline, administered orally along with a salt of choline, are indeed a suitable and effective combination therapy for selected cases of asthma, angina pectoris and hypertension. Thus, Theracor represents the harmonious pharmacologic union of two salutary agents, reserpine and theophylline. The physiologically important lipotrope, choline, significantly contributes to the therapeutic value of this useful drug duo by promoting absorption of theophylline and by enhancing patient tolerance to the latter. These are major considerations in therapy, since systemic efficiency of theophylline is directly related to blood titers of the compound, and since preparations of this type are frequently prescribed for prolonged periods of time.

The response to Theracor was quite satisfactory in most of the clinic subjects included in our study. Supervisory observation of an additional 17 cases seen in the general practice of two other physicians confirmed the findings of the clinic program. Side effects noted with Theracor were mainly those commonly associated with reserpine administration—nasal stuffiness and headache—and were not particularly discomforting to the majority of patients. Gastric distress was not a problem on the dosage schedule employed in our investigation. Thus, our results indicate that four tablets daily, in divided dosage, can be administered to most patients for as long as three months without producing gastric intolerance. Further, this dosage pattern appears to be an appropriate one to assure establishment and maintenance of therapeutically adequate blood concentrations of theophylline.

In our two difficult cases of classical asthma the relief obtained with Theracor was most gratifying. Presumably the reserpine component of the formula acts to allay the apprehension and modify the tension of the asthmatic, thereby reducing the severity of the situation. In this supporting role reserpine indirectly potentiates the bronchodilating effect of the theophylline component of the combination. Our observations suggest that the dual action of reserpine and theophylline is superior to that of theophylline alone, and that Theracor should be a useful preparation in the treatment of chronic bronchial asthma and chronic pulmonary emphysema.

We found that Theracor significantly reduced the frequency and severity of attacks in subjects with typical symptoms of angina pectoris. Here again, one may accept that reserpine's tranquilizing action was perhaps of primary benefit to the patient. However, there is also the possibility that the myocardial requirements of the affected individual were more satisfactorily met under the pharmacologic influence of the drug. Regardless of the mode of action principally involved, the fact remains that the capacity of theophylline to effect an increase in cardiac output is apparently more pronounced in the presence of reserpine. It is also interesting to consider that the bradycardic property of reserpine may offset any cardiac stimulant action of theophylline. Our results permit the conclusion that Theracor should be distinctly helpful to the person with angina, moderating the symptoms, extending his latitudes of physical exertion and elevating his effort tolerances. Similarly, the product should afford relief to those unfortunate enough to experience angina in association with mild to moderate hypertension.

Our results with Theracor in the treatment of hypertensives demonstrated that its effect on blood pressure values is substantially due to the reserpine component of the formula. However, it is likely that the vasodilating activity of theophylline accentuates the action of reserpine as a hypotensor. It is proposed that, as a solitary agent, Theracor should be reserved for those subjects whose hypertensive status is recognized as being mild or moderate in degree, and for those unable to tolerate more potent hypotensive drugs. However, in our estimation the preparation should be ideally suited for use as a baseline agent in severe hypertension. Further, it is intriguing to speculate that Theracor might be expressly suitable for administration in conjunction with the recently introduced hypotensor-diuretic drugs.

Initial experience with Theracor leads us to believe it is a logical and useful addition to the physician's selection of preparations expressly designed for the treatment of many of the cardiovascular problems he sees so frequently. It is relatively well tolerated and is therapeutically effective when administered with due regard

to the spheres of action recognized for theophylline and reserpine.

Summary

Theracor is an enteric coated tablet incorporating reserpine, theophylline and the bitartrate salt of the physiologically important lipotrope, choline. Its therapeutic effectiveness and patient tolerance were determined in 14 selected clinic cases of asthma, angina pectoris, hypertension and angina associated with hypertension. In addition, supervisory observations were made in 17 cases from the general practice of two other physicians.

Patients received 4 tablets Theracor daily, in divided dosage, for periods as long as three months. In general the product was well tolerated. Gastric distress was not encountered on the dosage employed, and nasal stuffiness and headache were not a major problem in most patients. Apparently, effective blood titers of theophylline are achieved with Theracor administration since:

1. Two cases of long-standing asthma were excellently controlled with Theracor.

2. All patients with anginal symptoms—alone, or associated with hypertension—were appreciably relieved by Theracor administration. In two instances the relief was marked.

3. A slight reduction in blood pressure values of the hypertensive subjects was observed during the period of treatment with Theracor.

On the basis of the results noted in this preliminary study, it has been concluded that Theracor is a logical combination of drugs whose spheres of pharmacologic influence are closely identified; that it should be given proper consideration in the choice of therapeutic regimens for angina pectoris, asthma-emphysema, and mild to moderate hypertension; that it should be ideally suited for use as a baseline agent when the newer, more potent drugs are employed in severe hypertension; that its relative freedom from side effects permits the routine oral administration of theophylline in most of those patients with cardiovascular problems who are leading candidates for xanthine therapy.

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Prevention and Treatment of

Head and Brain Injuries

JOHN A. HETHERINGTON, M.D.

Indianapolis

I WAS ASKED to give a talk on the prevention and treatment of head and brain injuries during this Coaches and Physicians Conference on athletic injuries. I think that most of us primarily associate this type of injury with the sport of football. I know that in my own practice of neurosurgery, the majority of head injuries that I see in athletes come as a result of this sport; however, I have seen a few as a result of baseball, and one case where a boy was struck in the head by a shot causing a depressed skull fracture.

As I thought over this topic of prevention and treatment of head and brain injuries, I found that there isn't a great deal that one can say regarding prevention of head injuries. I believe there are two factors to consider: FIRST, the wearing of protective head gear and SECOND, limiting a player's participation after he has sustained a head injury, in order to prevent additional injury. The plastic football helmet with its foam padding and face-guard has done a lot to help keep head injuries at a minimum, as far as the total number of all injuries is concerned. I remember one young athlete I saw with a head injury, who had butted heads with another player during practice and sustained a concussion and skull fracture. Upon questioning him, I found that he hadn't been wearing his helmet during practice and in my opinion there is no excuse for this.

Need Better Helmets

In baseball, the batter is protected by wearing a helmet while at the plate. However, it appears to me that the helmet is not made just right, since it leaves the thin-boned temple region exposed. It would be much better if the helmet would curve down and cover the temples, instead of going stright back over the ears. The plastic helmet could occasionally come in handy for the baseball catcher, especially in the younger ages. I remember one high school boy who was catching during a game, and after the batter struck out he swung the bat around once, and then again just at the catcher stood up, and the bat struck him in the side of the head, causing a severe head injury with depressed skull fracture —requiring surgery. A helmet would have helped him in this case.

There is no doubt that in any sport, the helmet has prevented many head injuries, or at least prevented severe ones. We see many examples of this in auto racing. Recently the city police have furnished all of the officers on motorcycles plastic helmets, and there have been several accidents since then without head injury—where in the past we have seen more than one fatal head injury in a motorcycle policeman that may well have been prevented, had he worn a helmet. I, for one, was very glad to see that the motorcycle men are wearing the helmets.

The other part of prevention of head injuries in athletics is the recognition and treatment of head injuries, plus the limiting of activity of a player to prevent possible re-injury. I believe that this can be discussed along with the second part of the title, and that is the Treatment of Head Injuries.

Brain Injury Most Important

Head injuries can affect either the skull, brain or both, and of course the most important of these is the brain. The most frequent skull

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fracture is a crack in the skull, which we designate as a linear skull fracture. Another type of skull fracture is the depressed fracture, where the bone is driven against or into the brain, and of course, in most cases, is a surgical lesion.

The brain lays on the base of the skull, or the floor, and this floor is the weakest part of the skull, and where many fractures occur. These are called *basilar skull fractures.* Personally, I feel that the clinical determination of this type of fracture is the best, since only 50% of these fractures will show on x-ray. Some of the clinical findings that we watch for—to tell about basilar skull fracture—are such things as black eyes (coming on 2-3 days after injury), or black-and-blue spot behind the ear over the mastoid region, also coming on several days after injury. Local bruising usually comes on very soon after injury. In any case that has spinal fluid draining from either the nose or an ear has a basilar fracture with tearing of the covering of the brain, causing the leakage of spinal fluid. Bleeding from the ear, in most cases, is due to basilar fracture. Bleeding from the nose also may be due to a basilar fracture, but there are many cases of nosebleed due to local nose injury rather than a basilar fracture. Patients who have spinal fluid drainage from the nose or ears require prophylactic antibiotics in an effort to prevent meningitis, because these fractures are compound ones.

Antibiotics should be continued for a few days after the drainage stops. Those individuals with spinal fluid drainage from the nose, as well as all head injuries—if their condition will permit—should have some elevation of the head of the bed. They should also be instructed not to blow their nose while the fluid is draining, and to be very cautious for several weeks or a month after the drainage has stopped. Sneezing should be avoided, if possible, during that period. Those people with drainage from the ear should have the external ear and outer part of the canal cleaned out with something like merthiolate and then sterile dressings kept over the ear, but do not plug the ear canal with cotton—because I feel that this drainage should not be blocked off, but allowed to flow freely. Those cases with drainage from nose or ears will usually stop draining within a week, and it is the rare case that requires surgery for closure of the opening. For obvious reasons, those people with spinal fluid drainage from the nose should not be aspirated through that passageway.

Three Brain Injury Types

The brain injuries are classified, I believe, primarily into three headings: Concussion, Contusion and Compression. *CONCUSSION,* of course, is the simplest and the most common type of brain injury, and one that is certainly familiar to all of you men in sports. The commonest example of a concussion is the knockout in prize-fighting, which lasts a matter of seconds and then the individual comes to, and gets to his feet, or tries to anyway. Concussion is a condition where there is no organic change in the brain, but a temporary physiological paralysis of function. It can be momentary or could last several hours.

CONTUSION is a more serious head injury and signifies actual organic changes in the brain, such as swelling, bruising and even actual bleeding, any of which may cause increased intracranial pressure. The initial signs of contusion may be like concussion, with unconsciousness; however, instead of reviving promptly or within a few hours, the patient may remain comatose for many hours, days or weeks. There may also be restlessness, vomiting and, as the stupor lightens, headache will be complained of; and in many cases of contusion, there are very definite neurological findings. One might find pupillary changes, weakness of one or more eye muscles—causing double vision—paralysis of part of the face, or even actual weakness or paralysis of arms or legs. With cerebral contusion, one may also have convulsions following the injury.

The third part of brain injury *COMPRESSION,* and in this we have a situation where something is taking up space within the skull and compressing the brain. The conditions that we think of in this category are epidural and subdural hematomas. The epidural hematoma is found between the skull and the dura (which is the thick outer covering of the brain). This is truly a surgical emergency. The earlier that it can be diagnosed, the quicker it can be treated before it is too late.

How Does An Epidural Hematoma Develop? It takes a skull fracture that will tear the middle meningeal artery or one of its branches. This artery runs in the dura, or thick covering over the brain, and usually—in part of its course—

runs in the bone, so that when a fracture occurs across this vessel, in many cases it tears it—causing arterial hemorrhage. The classical case is a history of immediate unconsciousness with the individual soon regaining consciousness and seeming perfectly normal, only to later begin to develop evidence of increased intracranial pressure, such as headache, weakness of an arm or leg, convulsion and increasing stupor. As the clot gets larger and larger, the more pressure is exerted on the brain. Since the hemorrhage is arterial, the clot forms quickly—so that usually within 6-12 hours after injury, this individual is in critical condition and if surgery is not done immediately he will die. If the diagnosis is made too late, the patient will die, even with surgery.

Subdural Hematoma

The second type of hematoma is the subdural hematoma—which, as the name implies, lies under the dura, or thick outer covering of the brain. These are either acute or chronic. The individual has a head injury, and in the acute type it is usually a severe brain injury and the hematoma is produced by either tearing of the veins that are draining blood from the brain and crossing into venous channels in the dura on its way back to the heart, or from laceration of the brain. The bleeding, of course, is venous, and is slower; thus the hematoma is slower in forming. The acute hematomas, as I mentioned, are in severely-injured individuals and as the signs develop—giving clues to the formation of the hematoma—it may be several days or more before it is evident that a hematoma has developed. Treatment is surgical, but here the mortality rate—in spite of surgery—can be high because of the associated brain damage that has occurred at the time of injury. The individual, even though the hematoma has been evacuated, may die because of the irreversable brain damage.

The chronic form of subdural hematoma has a much better prognosis. As the name implies, it takes time in developing and the person may have had what seems to be a trivial blow to the head; but some weeks or months later, develops symptoms indicative of increased intracranial pressure. The individual may begin to have headaches, he may show a personality change, he may develop seizures, or some other neurological complaint or finding that would indicate an intracranial lesion. I believe that most chronic subdurals will show up within a week or a few months; however, I have had one case that was injured in March—and at that time had a mild, seemingly-harmless head injury—only to come into the hospital again six months later with signs of a brain tumor, and at surgery a huge chronic subdural hematoma was found. The man made a complete and uneventful recovery, as will most chronic subdural hematoma patients, after surgery. In this type of lesion, the bleeding has stopped and the clot then liquifies and by osmosis draws in tissue fluids, causing a gradual increase in size in the lesion. As it increases, the individual finally begins to have complaints.

One cannot, in 20 minutes, give a complete detailed discussion on the treatment of head injuries, and, of course, I know you men did not come here to try to become doctors in one easy lesson. How an individual gets a head injury doesn't alter the treatment. I do believe the treatment has changed some over the years. For example, it used to be the practice, and some men still do, to treat head injuries with long periods of bed rest, but I believe that with concussions and skull fractures without any evidence of brain injury, that is no longer necessary. A concussion or uncomplicated skull fracture can be gotten up after a few days when he is asymptomatic. Basilar fractures with cerebrospinal fluid leakage are, of course, kept down until the drainage has ceased and then some, but even those cases, as a rule, are ambulatory within 10-14 days.

Head Injury Over-treatment

I actually believe that head injuries can be over-treated and in doing so, help produce some of the functional and emotional problems seen following some head injuries. I grant that some people don't need any excuse, but I do believe there will be more of a tendency for their development with long periods of bed rest and transferring the impression that these people are severely injured.

It is interesting to note the misconceptions that laymen have regarding head injuries. I see it frequently in cases where the individual has a severe brain injury but no skull fracture, and the relatives seem greatly relieved when they learn there is no skull fracture; yet the patient may be dying of a severe brain injury. The reverse is also true, when a patient has a skull fracture but nothing else, and when the relatives hear that he

has a skull fracture, they are sure his days are numbered. Laymen have a great fear of skull fractures and to them a severe head injury is a skull fracture. They don't seem to realize that the primary vital organ is the brain—and that, to doctors, of main concern is that region; and we are greatly relieved when we find no evidence of brain injury no matter what has happened to the skull.

That raises the question of closed head injuries. Some of the worst head injuries are those without any skull frature but with severe brain damage. In many of those cases, it would have been better had the skull fractured, because a lot of the force would then have been absorbed in fracturing the bone rather than all that force acting on the brain.

The one question that always comes up when you discharge a patient, and of course is of great interest to coaches, is the one *"How long before this boy can play?"* This question must always be answered before you discharge a ball player who has been injured, and I believe the most difficult person to face is the boy that has been injured. I am sure there are many mild concussions we don't know about and never leave the game, but any boy who has had a concussion that removes him from the game should certainly not go back that day, and it would be wise to have him take it easy for several days. One has to individualize these cases, because your decision regarding when the boy can return depends upon the period of unconsciousness, and the post-concussive complaints that the individual might have.

As far as more serious injury, I do not believe it is difficult to make a decision. The boy who has a head injury requiring surgery, whether it be a depressed skull fracture or a hematoma, should be kept away from the sport for a year. There are other cases: for example, a boy with a linear fracture and nothing else, who would not have to be off that length of time. I feel that anyone who has had definite signs of cerebral contusion should forget the sport. A punch-drunk prizefighter, as a rule, doesn't become that way with a single injury, but it is the repeated pounding that produces frequent multiple small hemorrhages in the brain that leads to that condition.

In closing, I should like to say that I don't wish any participant in any sport bad luck—but in the future, I hope that the primary injury continues to be in bones and joints, rather than heads; because if it were reversed, we certainly would lose a wonderful part of living—participating, in the younger days, and quarterbacking from the bleachers at the game, and—in many cases—from our living room chair in front of the television set, in our older days. ◄

1633 N. Capitol Ave.
Indianapolis 2

The Prevention and Treatment of

Common Muscular-Skeletal Injuries

FRANK W. TEAGUE, M.D.

Indianapolis

THE SHOULDER is probably the third most frequently involved joint in the game of football. We are limiting this discussion to football because it probably produces most of the injuries.

Certainly, at the age group of the boy in high school, the most serious shoulder injury we get is a dislocation. A dislocated shoulder is reduced with less difficulty the first time, if it is not complicated by fracture. If the boy is brought into the hospital and given an anesthetic, the shoulder is completely relaxed when reduced. Rarely, if ever, will he get a sequel to his injury.

I would like to describe the capsule of the shoulder to you. I presume you have all studied anatomy, but let's review it for a minute. The front capsule of the shoulder is like an accordion. With your shoulder in the position with your arm in front of you, the accordion is all folded up and the pleats are all closed up. With your arm rolled out, the accordion is opened out and the pleats are all stretched out. The thing that produces the dislocated shoulder is that, when the arm is carried outward, backward and upward the capsule becomes split and tears, and lets the head of the humerus drive out through the capsule. The most frequent dislocation of the shoulder is the one which is anterior, and the head of the humerus is found down on the front of the chest under the coracoid process. You find the cavity underneath the acromion; it's not hard to diagnose as far as the doctors are concerned, and I am sure all of you have seen enough dislocated shoulders that there is not much doubt when you see one. It is not altogether a matter of diagnosis but the treatment is very important; so this boy should be taken where he can have an anesthetic for the reduction of the dislocation.

I remember when I was an intern, someone described to us in the emergency room at the General Hospital the method of reducing a shoulder by the chair method. The patient was placed on the side of the chair and the individual who was to reduce the shoulder put his knee just below the elbow, and kept the arm horizontal with the floor, with gentle but firm downward pressure applied to the forearm. I have heard the crunchings that occur with this method of reduction, and it is not good.

If a shoulder has been out a dozen times, you and I, and anybody can put it back without an anesthetic in some instances, but we must remember that a certain damage is done to a shoulder unless that shoulder is completely relaxed with an anesthetic. I am referring to the first time that a boy gets a dislocated shoulder, not the fourth or fifth time. By the fifth time his shoulder is dislocated, the capsule is torn and relaxed and all we can do with him then is to go in surgically and reef his capsule, and double it over the front, to produce a capsule. These boys are usually kept up about four weeks with a fresh dislocation of the shoulder if we expect them not to recur and be subject to another dislocation.

I would like to describe to you one more situation which I just saw a few days ago. A boy had tackled another boy, who went down with him. There were only two men involved in the

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incident. The boy who did the tackling was then dived upon by three more with his left shoulder down on the ground and his right shoulder up, and he was in such a position that he could not roll, he couldn't protect himself. He had enough weight pushed down on him from the top that he dislocated his collar bone on the inner side. It was driven completely across toward his trachea, and the boy was pretty hoarse by the time I saw him. That is a rather serious injury. Many of these have to have surgery to correct and maintain the new position. I merely mention this injury because during the afternoon I hope the "pile on" will be mentioned.

I will not spend much time on fractures of the clavicle as I am sure you have all seen a lot of them. Certainly a simple fracture of the clavicle will heal in four to six weeks. Playing after a fractured clavicle; if the boy fractured his clavicle in the middle of August, the chances are he might get a little time in, although I think there is a lot of room for discussion as to whether a boy can get back into condition in such a short time.

Now regarding the prevention of these things. I mentioned "pile on." I believe this is only one thing. Certainly, condition as we have already discussed it this afternoon, is probably our best approach to prevention of injuries. If men are in condition, we have made an important step to prevent injuries. ◄

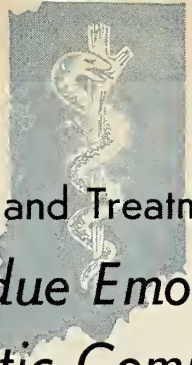
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Indianapolis 4

NARCOTIC REGULATIONS

Mr. George M. Belk, district supervisor of the Federal Bureau of Narcotics, whose jurisdiction covers the states of Indiana, Illinois and Wisconsin, has informed this office that many physicians in the State of Indiana are obtaining their office narcotics by means of prescriptions written "for office use" or written in the names of their patients. This practice is in violation of Federal Narcotic Regulations.

Except as otherwise provided, a physician must obtain his narcotic drugs from a qualified dealer (such as a manufacturer, compounder or wholesaler . . . a Class 1 or Class 2 registrant) on official government order forms.

A person qualified as a retail dealer (Class 3) may also supply registered practitioners or exempt officials on order forms, in quantities not exceeding one ounce at any one time, with aqueaous or oleaginous solutions, compounded by such retail dealer, in which the narcotic content does not exceed a greater proportion than 20% of the complete solution, to be used in legitimate office practice.



Prevention and Treatment of

The Undue Emotional Aspects of Athletic Competition

JAMES E. SIMMONS, M.D.

Indianapolis

THE committee's invitation to speak here stated we would find the above topic a most challenging assignment. I agree! The difficulties I believe are that the "emotional aspects" of athletic competition can be very subtle and the future implications or complications can be quite serious although unpredictable. Emotional injuries in or associated with competitive sports are not as obvious as the physical injuries. Many people can be severely upset emotionally and yet display very few outward signs of the upset. Even if you do see clearly that a boy is disturbed emotionally, it is often not possible to relate this disturbance to some specific event of the game or training. For example, if a player comes from the field with a broken arm, you know he didn't have that condition when he went into the game and can be reasonably certain the break is connected with recent events on the field. By the same reasoning you can be fairly certain that all players who come from the field at the end of a game without broken bones will not develop them tomorrow, next week or next year. At least, subsequent broken bones will probably not be due to a specific event of the game last night, last week or last year.

For the coach or the psychiatrist, personality or emotional injuries are difficult to detect. Such injuries may be due in part, but are seldom caused solely by, athletic competition or a single event of one game. Finally, injuries to the personality often do not become disabling until the trauma or injury has been repeated many times or until several years after the original causes have been forgotten.

Most of you have administered much more psychiatric first-aid than I have. There is the kid with the jitters just before the game or the boy without enough jitters before the game. Another instance is the player with a severe case of the "swelled head" or the one with such an "inferiority complex" or so shy he doesn't really put out all he's capable of showing. In other cases you've helped boys get over the persistent gloom and pessimism that set in just after they lost the first game. Although you probably never called such matters psychiatric first-aid, handling these emotional situations is part of your job. Most of you who have been coaching any length of time have some pretty definite ideas on how these matters should be handled. However, at the risk of being a grandstand coach, I will wager most of you have observed that what works for Jones' "swelled head" doesn't work on Smith's "conceit" and that from time to time there's a Jones or a Smith on whom nothing works and you have to let him go or kick him off the team. I will go further and make a guess that a fairly large percentage of boys are rejected or ejected from teams because of personality or emotional defects.

Some Dilemmas for Coaches

Now I will come down from the grandstand and admit that my profession is much more in

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contact with and much more familiar with your rejects than with the Smith or Jones that is able to get over his obnoxious ways. I would like to confine my remarks to the situations more familiar to me. In the hope I can 'spark' your interest I have subtitled the rest of my talk "Some Dilemmas for Coaches." I will postulate some questions and we will leave it to the following panel to either prove me to be a complete fool or find us some answers. In the frame of reference of mental health a coach would, I think, have dilemmas in relation to the individual team members, to the school and to society at large.

It is my belief or perhaps naive wish that most coaches affiliated with an educational institution are as interested in building men and future citizens as they are in the technicalities of the athletics they teach. Even so, my first question for the panel is: Should the coach concern himself at all with the problems of mental or emotional health? The answer to this question must be found by the individual coach. Society would be very critical of any coach who neglected the physical well-being of one of his boys, but in general many of these same people have little patience with the individual who is emotionally or psychiatrically disabled. People can see and understand the physical disability but they condemn or avoid the emotional disability which they cannot understand. Except in the small school where there is manpower shortage, the coach who rejects large numbers of boys may not be criticized.

This leads me to my second "dilemma" or question: What is the coach's primary role in our educational system? Is he a fund raiser? An alumni morale booster? A teacher? Or a molder of men? Our educational institutions were designed primarily to provide special experiences in learning. Emphasis was solely upon the acquisition of knowledge. It has been shown that good physical health is important in learning. More recently it has become apparent that healthy emotional development is necessary for good intellectual performance. The responsibility for the physical and emotional well-being of the child originally belonged to the family. Schools have to assist parents in these functions if our educational system is to succeed in its primary aim of imparting knowledge to the masses.

Today, the unemployment offices are overwhelmed with emotional cripples. There are so many of them that the psychiatrist must concern himself with prevention as much as treatment. A basic tenet in preventive psychiatry is that an increase in the mental and emotional maturation of the population will be reflected in decreased psychiatric breakdowns. I would hope you, too, are concerned not only with the prevention of emotional stress in athletic competition but also with the ways athletics can promote or hamper emotional development or maturation. Let me be specific. One of the best definitions I know of mental health was written by Dr. Karl Menninger. "Mental health is the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness. Not just efficiency, or just contentment—or the grace of obeying the rules of the game cheerfully. It is all of these together. It is the ability to maintain an even temper, an alert intelligence, socially considerate behavior and a happy disposition."

In the frame of reference of your work is it correct to say that the natural by-products of an athletic program or any teaching endeavor are sportsmanship, personal efficiency and satisfaction, self-control, alertness and happiness? In short these are the same things we value as signs of mental health. Are these natural by-products lost or sacrificed under the public pressure to win games? Is it possible to place emphasis on these by-products and still win games or win even more games? With its preventive potentials in mind, what does the average athletic program contribute to the emotional development of the population? The panel may challenge this but I believe the average school athletic program does not touch the average student in any effective manner. You may answer that the average student is not interested or properly motivated. I can only say that if Ford Motor Company waited for the average citizen to become properly motivated of his own volition to buy a Ford car they would go bankrupt. Do our programs enhance the emotional development of even a few boys or are too many of these unrealistically built up by publicity and left totally unprepared to handle the bitterness they experience later when forced to return to their normal social position in college or life outside the limelight?

Public Won't Pressure You

If you find no merit in the idea of athletic programs as prophylactics against mental breakdown, then forget it. As far as I can see the public will not pressure you into giving serious consideration to these matters. Such ideas will have to be promoted by the coaches themselves and I suspect most of you are too honest to try to sell something in which you don't believe.

The above are "dilemmas" for coaches in relation to society and the school. What about the coaches relationship to individual boys? Adolescence is a period of rapid emotional growth from childhood to adulthood. The vast changes and the rapidity of change promote turmoil and conflict. The average adolescent is vitally concerned with his struggle between remaining dependent (childish) and becoming independent (manhood). This struggle permeates all of his relations with adults. He is also preoccupied with developing a sense of self and personal worth. This is connected with his basic human needs for security, a sense of adequacy and for prestige. He is concerned with sex. He is trying to achieve a comfortable balance between his feelings of love and his feelings of hate and he is struggling to obtain a set of standards, value systems or moral code. The coach must live and work with these problems whether he admits it or not and the manner in which he handles them is infinitely important.

I see the coach as a counselor both formally and informally. This role may occur in the hygiene classes many of you teach, at the request of a boy to talk or in the conversation of the locker room. With the adolescent's growth problems it is even more important what a coach or teacher does or is than what he says. The coach is a model for the youngster to emulate or with whom to personally identify. Time will not permit us to exhaust each of these areas. I would like to cite a few problems. A boy has a father who in fact or fancy was a former All-American. How do you handle the hurt to the boy's sense of personal worth when he cannot measure up to the father's expectations? How do you handle the pressure that some betting uptown coaches may put on your boys? Here, it is most important to find out the boy's feelings. He may have several conflicting feelings. You cannot jump to conclusions or be "more righteous than thou" if you really expect the boy to come to firm grips with his feelings.

In the adolescents' struggle between dependence and independence his behavior often borders on being irrational. . . . Can you teach a boy to take orders and still not give up his independent thinking? Some coaches (none here) are so unsure of themselves that they can only function with a team of robots. In life there is little room for robots and there are no coaches to keep them running. I like my bird dog to be obedient. However, he will never have to earn his own living.

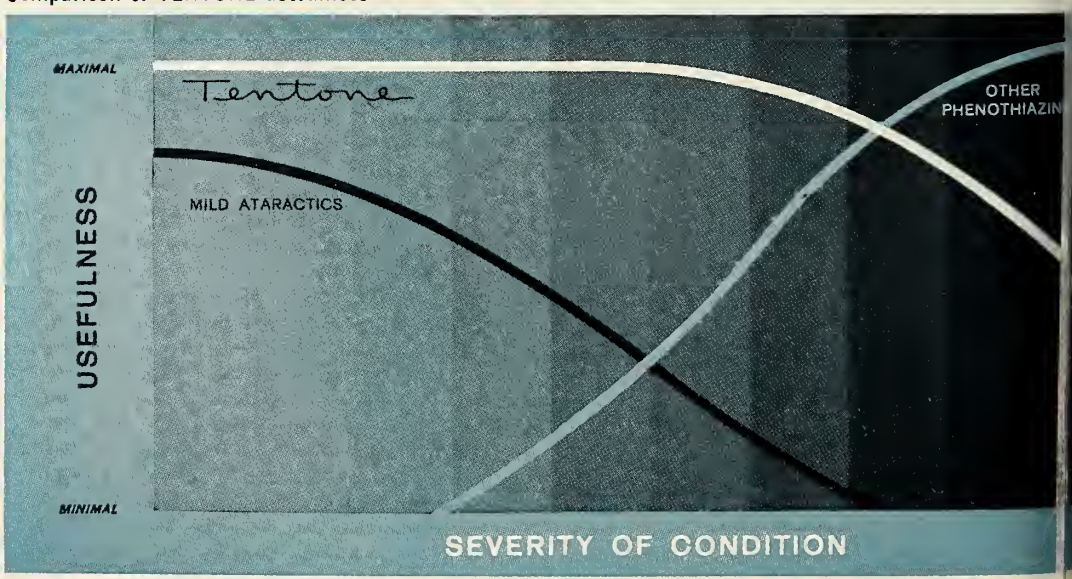
Time is running out and I still haven't mentioned sex which everyone knows any psychiatrist will do. Can you teach the facts of life formally and informally? What is the meaning of homosexuality? How is it handled? The adolescent has strong feelings of all kinds and often they cannot clearly distinguish one feeling from another. In the close association of school, the team, unity, common purpose and many lofty pursuits two youngsters may get too thick with each other. Immoral behavior may or may not occur or may not even enter the boy's conscious mind. You, however, may be aware this is not a completely healthy situation. Do you strike out in horror and anger or can you recognize this is their problem, not yours? It is reasonable to expect them to be more emotionally upset than you and much more in need of help. The transgressions of youth can be overcome and normal adjustments do occur. However, this is made more difficult when they are condemned, rejected and spit upon by significant adults. Here again in the areas of homosexual conflict, concern over the double standard, premarital relations, masturbation and so forth, direct advice, condemnation or bedroom anecdotes are seldom helpful to the boy. First, one must listen and learn with what conflicts and feelings he is struggling before you can help him to a realistic, mature handling of the problem.

In one sense I am sorry I have not been able to give specific instruction in "How to put lids on kids' ids," how to splint a broken spirit, rub salve on a wounded ego or reform a cheater? In general such measures involve the use of one's self in a very personal and feeling manner. Perhaps, the panel to follow can be more concrete. ◄

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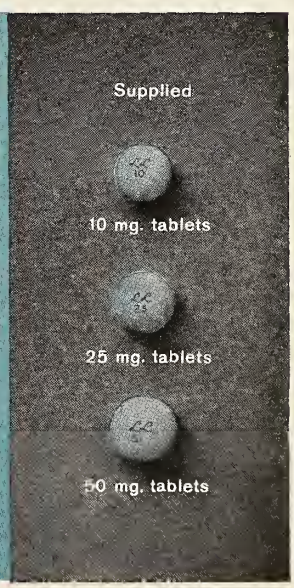
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Injuries to the Knee

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Lafayette

TODAY I am going to talk about injuries to the knee. The knee is the largest joint in the body and is very frequently injured in football, basketball or almost any sport in which there is body contact or rapid action. Anatomically, the knee is a hinge joint and it moves normally only in one plane. There are four main ligaments of the knee which prevent other motions. There is a ligament on each side of the knee; the one on the outside of the knee is called the lateral collateral ligament and the one on the innerside of the knee, the medial collateral ligament. These prevent lateral motion of the knee. There are, likewise, two ligaments inside the knee itself which are called cruciate ligaments. These prevent forward and backward motion of the knee. In addition to this, there are several other smaller ligaments which contribute to the stability of the knee but the ones mentioned previously are the main ones.

I feel that injuries to the ligaments comprise the majority of injuries to the knee. Formerly I thought that cartilage injuries were more common but now I believe that ligamentous injuries are more frequent. Each knee has two cartilages in it and, likewise, these add to the stability of the knee. There is a medial cartilage on the inner side and a lateral cartilage on the outer side. A knee is not a strong structure from a bony standpoint; one bone merely rests on top of the other. For instance, the hip joint is a ball and socket joint and it has a great deal of bony stability. However, the knee derives its stability from ligaments and muscle power. If these ligaments are not intact, the knee is not stable. The patient may have a minor tear of a ligament and have an unstable knee and very easily that can be transformed from a minor injury to a severe injury. It does not take much of a blow on a knee which is a little unstable or a little bit out of line to tear a ligament completely.

It is easier to diagnose a tear of a ligament immediately after it has happened than it is to diagnose it six hours, or the next day or two, or three days later. One can get a pretty good idea if the patient is examined shortly after injury as to the degree of injury to the ligament. The thing to do is to extend the knee; that is, straighten it out. If one cannot straighten it, then there is something inside the joint which is abnormal and investigation is required. The collateral ligaments are not inside the joint itself, but on the outside, supporting it. Therefore, if they are torn, and only these are torn, there will not be any limited motion of the knee immediately. With the knee in extension, or straightened out, if there is excessive lateral motion, and there should be practically none, it means that there has been an injury to a collateral ligament or a fracture. If the knee is straight, the knee should move practically none in the lateral plane. If there is motion, it is a sign that the patient has collateral ligament injury and treatment is required.

The type of treatment will depend on the degree of the tear. A minimal tear will require, perhaps, just rest for a few days; a little more of a tear will require immobilization and a cast; a tear which allows more than just a moderate amount of motion, that is a complete tear, requires surgical repair. It takes a ligament six weeks to heal so that if a patient has more than a minimal tear, he will probably be lost for the remainder of the season. One cannot put a patient in a cast for six weeks then expect him to return to football or basketball the day after he gets out of a cast. If a patient has a ligamentous injury which requires casting or surgery, then he

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is probably through for the year. However, minimal tears can be treated by heat and rest and he can be ready to play as soon as the soreness subsides.

If there is limited motion in the knee at the time of the preliminary examination or if the patient cannot extend his knee completely or cannot flex it completely immediately after the injury, it is usually an indication that he has a torn cartilage. A fracture inside the knee can produce the same symptoms but fractures in the knee in the age group which we are discussing are very rare. So, almost anything which will limit the motion of the knee immediately will be a torn cartilage. The medial cartilage, that is the one on the inside of the knee, is torn much more frequently than the outside cartilage. This is due to the direction in which the strain is usually applied as well as to the fact that the medial cartilage is thinner than the lateral cartilage.

I feel that a torn cartilage is an indication for an operative procedure and this should be undertaken as soon as possible. If the torn cartilage is removed shortly after the accident occurs, the knee does not have time to become distended, the capsule does not become stretched with blood and fluid, the muscles around the knee do not have a chance to become atrophied and weakened and the patient does not have a chance to develop a mental attitude that his knee is going to be unstable or give away with him. Once he develops the attitude that he cannot trust his knee, it is difficult to overcome this. If the boy has a torn cartilage, and the diagnosis is made promptly and the cartilage is removed promptly, the boy can begin to exercise his knee in just a few days and can be back playing football in four to six weeks after the cartilage is removed. That also will give him time for conditioning before returning to the game. If cartilages are not removed, promptly, the benefit of early surgery is lost. If surgery is not undertaken promptly, the muscles have a chance to atrophy and the joint can sustain permanent damage. There are a lot of boys who play with a so called "trick knee" or an unstable knee but they would do a much better job and have a much better knee permanently if their cartilages were removed promptly.

The cruciate ligaments, likewise, can be torn. The test for that is to see if the knee will move in an antero-posterior plane. The knee is flexed to 90 degrees and then one actually tries to force the tibia forward and backward on the femur. If the tibia will come forward, the patient has a tear of the anterior cruciate ligament. If it will go backward, he has a tear of the posterior cruciate ligament and likewise, these require operative repairs. If one would do these tests very quickly after the patient is injured, they are accurate. In a few hours the tests are not accurate because the knee will swell. As soon as the knee becomes swollen, the body compensates for the injury and the parts again resume their normal resistance because of the swelling. In other words, a patient can have a severe tear of the medial collateral ligament and if he is examined a day or so later, the muscles and tissues around will tighten up so much that you cannot detect the tear.

A few days ago Dr. Combs and I saw a boy who weighed close to 250 pounds who had injured his knee two days previously and we could not make up our minds about the severity of the tear. We felt that he had a medial ligament injury from his history and the way the knee felt but we could not get much abnormal motion. We gave him an anesthetic and then a very marked increase in lateral motion was detected. We operated him the next day and found that he had a complete tear of the medial collateral ligament. The ligaments had been torn loose completely from the bone. If this knee had not been operated, when the swelling receded in two weeks or three weeks, he would have had a marked increase in lateral motion and the knee would have been extremely unstable. By that time, however, we would have lost the golden repair opportunity which one has in the first few days. If one waits 10 days, two weeks or until the end of the season, the results of surgery are not nearly so good. We feel that by repairing these injuries promptly, we can restore the knee practically to a normal condition and there just is not a very good reason for having a so called "trick knee" or an unstable knee. If these are repaired promptly, such conditions should not result.

Any fluid inside of the knee joint, more than just a little, should be taken out. When one starts to operate on a knee, the parents always ask (at least 90% ask) if one lets the fluid out of the knee, won't the knee become stiff. Of course this is not so because the knee continu-

ously produces fluid and sometimes it makes too much. When the knee is swollen and there is fluid in it, the fluid should be withdrawn and the knee should be compressed. If the fluid is grossly bloody, that means that there has been a lot of tearing of tissue inside the joint and that boy will not be ready to play football for some time. If the tissue is straw colored, and that usually comes up several days after the injury, that means that there has been some bruising but not necessarily a tearing of tissues. Again, the straw colored fluid should be withdrawn and the knee compressed.

Sometimes there will be fluid around the knee but not actually in it. That occurs when a patient falls on his knee and does not get a twist or a blow but strikes the front part of the knee. He bruises this portion of the knee and gets a collection of fluid between the skin and the knee joint itself. This collection of fluid is within a bursa. He gets bursitis and a treatment for that is to withdraw the fluid and compress the knee. These boys do well and with a few days of rest, they should be ready to play football again.

As far as prevention of injuries to the knee, I think that the main thing is to have the muscles in as good shape as possible. There is not a lot one can do in a short time to strengthen the ligaments; there is not much one can do to strengthen the bones and, as I said before, the bones do not suffer too much anyway. A great deal of stability of the knee is due to the muscles that surround the knee. Anteriorly the quadriceps group of muscles supports it by the patella and the patellar tendon and posteriorly the hamstring muscles support the knee. If these muscles are in as good shape as possible, the knee injuries will be kept to a minimum. If a patient does have a knee injury and one hopes to play the boy again, he should have a complete set of exercises before he is allowed to play again or else the joint will be subject to re-injury.

It is extremely difficult to have a boy play good football, basketball or track if he cannot run well and cannot trust his knee. He cannot do this if he has atrophy of the muscles about the knee. I feel that quadriceps exercises are very important in prevention of injuries to the knee and also in prevention of re-injury to a knee which has once been injured. A lot of the injuries that we see in the college boys are merely aggravations or recurrences of injury which they have had in high school. If they have had proper care previously, I feel that a great number of these can be eliminated and the boy should have a more stable and a more satisfactory knee. ◄

2211 South St.
Lafayette

Malignant Disease Seminar Planned

A two-day postgraduate seminar on "Recent Advances in Diagnosis and Therapy of Malignant Disease" will be conducted on Wednesday and Thursday, November 18 and 19, in Cleveland.

Problems of diagnosis will be discussed at 11 Cleveland hospitals each morning. Pathogenesis and therapy will be discussed each afternoon at the Academy of Medicine. Thirteen hours credit in Category I has been approved by the American Academy of General Practice.

Registration fees are nominal. Inquiries may be addressed to the Academy of Medicine of Cleveland, 2009 Adelbert Road.

Treatment of Superficial Fungous Infections With Fulvicin (Griseofulvin)

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Calumet City, Ill.

*JEAN PILOT, M.D.***
Hammond, Ind.

In 1939 Oxford and colleagues[1] isolated a fermentation product of three types of penicillium and described its use as a fungistatic agent in plants. The therapeutic implications of this discovery were not realized until the work of Gentles[2] in 1958, confirmed by Martin[3] in 1959, showed that the agent, griseofulvin, was effective when administered orally in experimental ringworm of guinea pigs. In 1958 Paget and Walpole[4] investigated and described the cytological characteristics. Riehl[5] reported its first use in man. Oral administration of griseofulvin, without local therapy, produced full recovery from resistant dermatomycoses in 15 patients. Several types of Trichophyton and Microsporum which had been resistant to other treatments responded rapidly to the new agent.

Williams and colleagues[6] used griseofulvin in nine patients with T. rubrum infection of the skin or nails and reported that relief of pruritus, reappearance of normal perspiration on the palm, and regrowth of normal nail occurred within three weeks. The fungus became increasingly difficult to find in scrapings.

Goldfarb and Rosenthal[7] reported on 17 patients treated for two to 12 weeks with griseofulvin, 250 mg. daily in children and 750 to 1000 mg. daily in adults. In glabrous lesions, pruritus and erythema were relieved within seven days and normal perspiration was observed within two to three weeks. The positive cultures and smears usually became negative in three weeks although hyperkeratotic palms and soles did not respond as rapidly. In T. rubrum onychomycosis, significant improvement occurred in 12 weeks. Laboratory studies in these patients revealed no toxic reactions to griseofulvin and the only side effects observed clinically were transient headaches reported by seven patients, bleeding pruritus in two, and fatigue and diarrhea in two. A child who had received 250 mg. daily developed a generalized maculopapular eruption which disappeared when medication was discontinued but returned on readministration.

Blank and Roth[8] administered 5000 mg. griseofulvin daily to a patient with severe cutaneous T. rubrum granulomas. The excellent result on this rather high dosage encouraged further study among 31 patients with dermatomycoses. On doses of 1000 to 2000 mg. daily, results after several weeks were uniformly good. Some patients reported transient headaches or gastric distress during the first weeks of treatment but the only significant side effect was an urticaria-like reaction which occurred in one patient.

Reiss[9] reported extremely favorable results among 36 patients with dermatomycoses who had been treated with griseofulvin, 250 mg. four times daily in adults and halved dosage in children. A rapid response occurred in tinea capitis and corporis although somewhat more time was required for full relief of onychomycosis. The infecting organisms were M. audouini (23 patients) and T. tonsurans, rubrum or mentagro-

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** Pathologist, St. Margaret Hospital, Hammond, Indiana and St. Catherine's Hospital, East Chicago, Ind.

TABLE 1

TEN CASES OF COMPLETED THERAPY AND CURE

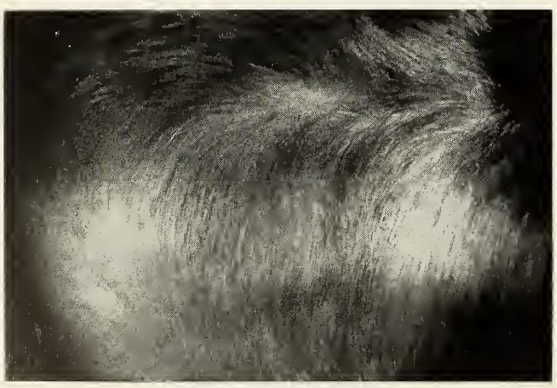
DIAGNOSIS	AGE	DURATION OF INFECTION	INFECTING ORGANISM	DURATION OF THERAPY
tinea capitis	6	1 year	Microsporum audouini	4 weeks
tinea capitis	7	1½ years	M. audouini	6 weeks
tinea capitis	7	1 year	M. audouini	6 weeks
tinea capitis	7	1 year	M. audouini	6 weeks
tinea capitis	8	1 year	M. audouini	5 weeks
tinea capitis	9	8 months	M. audouini	3 weeks
tinea cruris	15	2 years	Trichophyton rubrum	3 weeks
dermatophytosis	19	6 years	T. rubrum	6 weeks
dermatophytosis	56	5 years	T. mentagrophytes	3½ weeks
dermatophytosis, onychomycosis	28	10 years	T. rubrum	7 weeks

phytes. There were no untoward effects except in one patient who reported gastric distress at the beginning of therapy.

Goldman and colleagues[10] studied 46 patients who had received griseofulvin for relatively long periods of time, with particular reference to the occurrence of resistance or relapse. The clinical results were excellent. They concluded that although response was slow in some patients, true resistance was never encountered. There were two instances of presumed relapse in patients with T. rubrum infections of the smooth skin.



A



B

Fig. 1: A male, seven years old, with tinea capitis due to M. audouini before (a) and after (b) six weeks of oral therapy with griseofulvin. New growth of hair was normal.

Method

We have been using oral griseofulvin* for three months among children and adults with superficial fungous infections resistant to conventional therapy but reported to be amenable to this agent. Thus far 21 private patients have received the drug, of whom ten (Table 1) have completed treatment and 11 (seven with Trichophyton rubrum, two with T. mentagrophytes, and two with Microsporum audouini infections of the scalp (skin or nails) are still under therapy. The usual dosage was 250 mg. four times daily although occasionally higher doses were used initially.

All patients received red and white blood cell and differential counts and urinalysis before and after the period of therapy and occasionally more often. Skin scrapings, nail clippings and hairs were examined after clearing with potassium hydroxide for the presence of hyphae and spores, and cultures were made before and after treatment.**

* Griseofulvin is available as Fulvicin from the Schering Corporation, Bloomfield, N. J. An experimental supply was provided by Dr. G. Kenneth Hawkins of the Division of Clinical Research.



A



B

Fig. 2. A male, 15 years old, with tinea cruris due to T. rubrum before (a) and after (b) nine days of therapy. Lesions disappeared completely after three weeks.

Results

Of the 21 patients who have received griseofulvin, 10 are apparently cured (Table 1) and the others, who have not been treated for a sufficient length of time, are well on their way to recovery. There have been no failures.

The six fully treated patients with tinea capitis due to M. audouini showed complete clinical relief in three to six weeks, during which time cultures became negative and microscopic examination of the hair revealed that the characteristic pathological involvement had disappeared. Fluorescence under wood light was absent in five weeks. These patients were examined two weeks after therapy had been discontinued, at which time there was no recurrence and a full growth of normal hair was observed.

The patients with tinea cruris reported that pruritus subsided after a few days of therapy. After three weeks the lesions had disappeared, and both scrapings and cultures were negative for T. rubrum.

Dermatophytosis of the hands or feet or with combined involvement responded within seven weeks in the three fully treated patients. At that time nail involvement, if any, was present to a minimal degree only and was obviously disappearing.

The only side effect was severe headache, which was reported by three patients. This occurred during the early days of therapy but disappeared later although dosage was continued



A



B

Fig. 3. A male, 28 years old, with onychomycosis due to T. rubrum before (a) and after (b) seven weeks of therapy. Proximal growth of nail is normal.

** Laboratory assistance was given by Dr. Milton Golden, bacteriologist at the Mount Sinai Hospital, and by Dr. Jean Pilot, pathologist at St. Margaret's Hospital in Hammond, Ind.

at the same level. There were no gastrointestinal complications and the results of all laboratory studies were negative.

Comment

Two of the children who had been treated successfully for tinea capitis due to M. audouini are siblings and two other siblings are also affected. Treatment of the latter children has just been started. It is hoped that the treated children will not be reinfected through family contact, and they will be re-examined at intervals because of this possibility.

Conclusion

If griseofulvin continues to show the remarkable effectiveness and freedom from complications indicated by this and other preliminary clinical studies, it may well represent the most significant dermatologic advance in many years. The effect of the drug is especially noteworthy in M. audouini and T. rubrum infections, for which no previous therapy was adequate. Further clinical trials with griseofulvin will indicate if administration is associated with late side reactons, recurrence of the lesions or tolerance.

Summary

Griseofulvin (Fulvicin) was used in 21 patients with superficial fungous infections due to Trichophyton rubrum, T. mentagrophytes or Microsporum audouini. After administration of divided doses of 1000 mg. daily for three to seven weeks, all clinical and laboratory evidence of the infections disappeared in 10 patients and excellent progress occurred in 11 patients who are still under treatment. No toxic reactions were observed.

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Calumet City, Ill.

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Tropical Medicine Meeting Here

The Indiana University School of Medicine will be host to the American Society of Tropical Medicine and Hygiene 8th annual meeting at the Claypool Hotel, Indianapolis, Oct. 28 to 31.

The scientific sessions of the meeting will include a total of 74 papers. Additional information may be obtained from Dr. Max C. McCowen, Eli Lilly & Co., 740 S. Alabama St., Indianapolis.

Treatment of Chronic Functional Constipation With Dioctyl Sodium Sulfosuccinate and Danthron

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THE THERAPEUTIC value of dioctyl sodium sulfosuccinate in the correction of constipation has been reported.[1, 3-6] This drug has been found to be an effective fecal softener and daily administration of 180-240 mg of dioctyl sodium sulfosuccinate for two or three days is said to produce a soft stool which can be easily evacuated without straining. The drug is non-irritant and safe for use in children[7, 13] and adults.[1, 3, 6]

In cases where constipation is due to hardening of the stool, administration of an adequate dosage of dioctyl sodium sulfosuccinate appears to result in the formation of an undehydrated soft stool with subsequent normal elimination. Its effectiveness depends solely on its property of facilitating homogeneity of the fecal mass.

In those cases where chronic functional constipation is dependent primarily on atonicity of bowel musculature, however, fecal softening action may require supplementation by a mild peristaltic stimulant.[2, 9, 11] Danthron[1, 8] (dihydroxyanthraquinone) has been reported to be a suitable drug for this purpose. Its effectiveness and safety have been fully demonstrated.[11, 12] A combination of dioctyl sodium sulfosuccinate and Danthron should, therefore, provide both the desired fecal softening action and the needed peristalsis. If the bowel atonicity can be improved, the stimulant drug could then be discontinued.

It appears that rational therapy in atonic constipation would require temporary use of the combined drugs to effect both fecal softening action and mild peristaltic stimulation. When this has resulted in regular evacuation for several days, the fecal softening action of dioctyl sodium sulfosuccinate alone could be expected to be fully effective in many patients. It should then be possible to gradually withdraw the peristaltic stimulant. Since the use of dioctyl sodium sulfosuccinate obviates "rebound constipation,"[9] its corrective action could be a lasting one. Since constipation is a very common patient complaint, it was decided to evaluate the possible merit of Doxinate with Danthron in treatment.

Methods and Material

Two hundred ambulatory patients, 120 females and 80 males, were selected for a clinical evaluation of the combined therapy.** Their ages varied from 30 to over 75 years. Each patient was questioned concerning the past history of chronic functional constipation and the duration of the condition. Table I shows our patient classification.

Patients were divided into three groups. The first group included 150 patients with a long standing history of chronic functional constipation. A second group of 30 patients presented severe constipation without previous history of chronic constipation. In the third group of 20 patients, 12 were considered to have spastic constipation while functional constipation in the remaining eight was probably due to other non-gastrointestinal disease.

Group I—*Patients with History of Chronic Functional Constipation.* In this group, 42 patients had experienced chronic functional constipation for one to five years; 45 had a past history of chronic constipation of five to ten years; 20 of 10 to 15 years; 36 of 15 to 20

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**Material used in this study was supplied as Doxinate and as Doxan (Doxinate with Danthron) through the courtesy of Lloyd Brothers, Inc., Cincinnati 3, Ohio.

years; and seven patients gave a history of constipation of more than 20 years duration.

This group was started on a daily dose of 240 mg of dioctyl sodium sulfosuccinate and 50 to 100 mg of Danthron (2 to 3 Doxinate 60 mg capsules and 1 to 2 capsules of Doxinate with Danthron). In most cases medication resulted in a spontaneous bowel movement on the second day. In a few patients the first bowel movement occurred at late as the fourth day after starting treatment. Before treatment, the frequency of bowel movement in these latter patients averaged once a week or less and regular administration of cathartics or enemas was the rule.

After three weeks of combined therapy, administration of Danthron was stopped and patients received a daily dose of 240 mg dioctyl sodium sulfosuccinate. However, administration of Danthron was suggested for the second evening if bowel movement failed on two consecutive days. The duration of therapy in this group was eight weeks.

Group II—*Patients with Severe Constipation without History of Chronic Constipation.* Patients included in the second group received Doxinate and Doxinate with Danthron in doses similar to those of the first group. The use of Danthron in these patients, however, was withdrawn after the first week of treatment. The total period of therapy varied from one to four weeks, depending on the severity of the constipation in each case.

Group III—*Patients with Spastic Constipation.* Patients belonging to this group received 180 to 240 mg of dioctyl sodium sulfosuccinate daily after an initial dose of 50 mg of Danthron on the first day. A very small number of patients required administration of additional Danthron. Patients in this group received medication for eight weeks or more.

For the purpose of evaluating the effectiveness of therapy and to ascertain that the regimen was taken as instructed, each patient was questioned periodically. Conclusions were based on a consideration of improvement in bowel function, general well being and patient satisfaction. The need for cathartics and enemas in patients with long standing chronic functional constipation, as compared to previous needs, constituted an important factor in evaluating the usefulness of the new therapy.

Table I

Classification of Patients According to Age and History of Constipation.

Particulars	Number of Patients
A. Age	
Under 35 years	18
36 to 45 years	28
46 to 55 years	39
56 to 65 years	68
66 to 75 years	36
Over 75 years	11
B. Duration of Constipation	
Under 5 years	92
6 to 10 years	45
11 to 15 years	20
16 to 20 years	36
Over 20 years	7
C. Type of Constipation	
Chronic	150
Temporary, Severe	30
Acute	8
Spastic	12
D. Consistency of Stool Prior to Treatment	
Hard	194
Soft	4
Watery	2

Results

The results of this investigation are presented in Table II. Follow-up was done except in 23 patients who were not available for further study. Our data show that 18 patients who had temporary periods of severe constipation did not require therapy beyond a period of two weeks. Most of these patients received Doxinate with Danthron only on the first two or three days. Later they were continued on 240 mg of Doxinate alone. In 39 patients frequent administration of Doxinate was needed during the first two weeks and only rarely after that period. These patients received medication for a period of six to eight weeks.

In all of these patients, however, a history of chronic functional constipation of 10-20 years or more was present. They required Danthron on most days during the earlier two or three weeks of therapy to enable them to move the bowels. In the following weeks, patients received 240 mg of Doxinate alone and in a great majority of the patients, Danthron was admin-

Table II

Results of Doxinate and Doxinate with Danthron Therapy in Patients with Chronic Functional Constipation.

Particulars	Number of Patients
A. Duration of Therapy	
1 to 2 weeks	18
2 to 4 weeks	28
4 to 6 weeks	39
6 to 8 weeks	115*
B. Consistency of Stool	
Hard	0
Soft	200
Watery	0
C. Side Effects	
Cramps	5
Gas	10
Fullness	9
Nausea	1
D. Patient Satisfaction	
Good	170
Fair	21
Poor	9

*73 patients needed treatment beyond 8 weeks' period.

istered only occasionally. After the eight-week period, only 73 patients found it necessary to continue the use of Doxinate. Thirty-six of these also required Danthron once a week or less. All of the 73 patients who required medication beyond eight weeks gave a history of severe chronic constipation of 10 to 20 years or longer duration and had been dependent on the use of laxatives and enemas. We were, therefore, impressed with the beneficial results of combined therapy. Most of the patients were successfully changed from the regimen of Doxinate with Danthron to that of Doxinate alone soon after three weeks treatment. The need for additional laxatives and enemas was practically eliminated.

Patients belonging to Group II also showed an excellent response to our therapeutic regimen. In all of these patients constipation was rather severe although they were not addicted to the use of laxatives. The administration of Doxinate with Danthron as "withdrawal therapy" was effective. Only one patient persisted in using "Caroid and Bile Salt" tablets in addition to the prescribed regimen and one other continued the use of saline enemas. All of the remaining patients in this group were relieved of impactions and regular bowel movement was established in one to four weeks. The use of Danthron was withdrawn within the first week of therapy in each case.

Group III consisted of patients with spastic bowel or those who ordinarily could not tolerate laxatives. These patients received 240 mg of dioctyl sodium sulfosuccinate and 50 mg of Danthron on the first day. Subsequently each patient received a daily 240 mg dose of dioctyl sodium sulfosuccinate. In the rare instances where constipation reappeared. Danthron was added for a day or so as needed.

Particular attention was paid to the appearance of significant side effects in these patients. None was present. Nineteen patients complained of gas or fullness, five of cramps and one of slight nausea. A pinkish-yellow coloration of the urine caused concern in several patients but explanation that this was due to Danthron eliminated the problem.

Discussion

Prior to therapy the average consistency of the stool was abnormally hard in 194 patients. One patient had a tendency toward diarrhea on administration of even the mildest laxative. After therapy, all of the 200 patients reported the average stool to be significantly softened. No patient reported hard or watery stools. The need for enemas and additional cathartics was practically eliminated. Patients uniformly reported evacuation of bowels without straining. No impactions were present.

"Patient satisfaction" as a result of this therapy was reported to be excellent or good by 170 patients (85%), fair by 21 (10.5%) and poor by nine patients (4.5%). These latter were disappointed at the lack of purgative effect to which they had become accustomed.

Summary and Conclusion

We have investigated the clinical usefulness of dioctyl sodium sulfosuccinate and its combination with Danthron in a series of 200 patients with either a long standing history of chronic functional constipation, severe temporary constipation or spastic constipation. This therapy provides fecal softening and peristaltic stimulation.

The combined therapy was used strictly on a

"withdrawal basis." This objective was achieved in 82% of our patients within eight weeks. Patients with long standing chronic functional constipation occasionally required continuation of combined therapy beyond this period.

The passage of abnormally hard stools was corrected in all patients. Evacuation generally occurred within 12 to 24 hours. In patients who had required the administration of enemas, the first spontaneous bowel movement occurred within three days. No significant side effects were present.

Patient satisfaction was excellent in 85% of treated patients. The therapeutic effectiveness of the medication was consistent and complete.

On the basis of the results obtained in our group of patients, the most satisfactory regimen for the treatment of persisting chronic functional constipation consists of an initial regimen of 240 mg of Doxinate and 50-100 mg of Danthron for one to three weeks; then continued administration of 240 mg of Doxinate alone for a period of eight weeks or as required.

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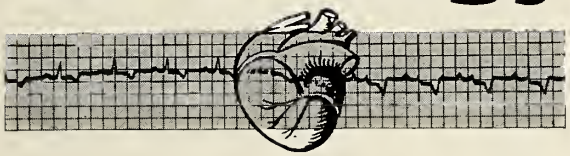
a profusion of color . . .

Where is there such a profusion of color as in the Central States during autumn? Although our cover was photographed in a Northern Michigan swamp, Indiana offers the same array of reds, oranges, yellows, greens and all the in-between hues as her trees and foliage prepare for winter snows. The good earth becomes protected from cold by a soft bed of leaves . . . autumn leaves that crackle as one walks through them and throw off a tantalizing odor that man could never emulate—the smell of autumn!

Whiffs of burning leaves can be just as tantalizing . . . bringing to the Hoosier mind thoughts of winter stews and soups soon to be bubbling on the stove, and of Thanksgiving dinner not so far away. (But is it not sad to think of burning nature's winter blanket, denuding the ground of its protection and of the revigorating ingredients that are designed by nature herself to feed new life into the earth as leaves decay in preparation for spring's rejuvenation.)

Color plates for our cover this month were supplied through the courtesy of and are the property of The Champion Paper and Fibre Company, manufacturers of our cover stock, Kromekote® paper. From time to time, as these color plates are available and suitable for Journal use, we hope to use them for cover variation . . . for your pleasure, doctor. As they are supplied without charge, we are given the opportunity to present four color photos and stay within our budget. (C.W.)

Condensed Cardiology



Presented as a regular feature of The JOURNAL, Condensed Cardiology is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Drug Therapy of Hypertension

B. L. MARTZ, M.D.

Indianapolis

IN RECENT YEARS, an increasing number of physicians have accepted the premise that every patient with sustained elevation of diastolic blood pressure, taking age into consideration, is a candidate for some type of drug therapy. The concept on which this therapeutic approach is based is that abnormal elevation of blood pressure results in, or at least is accompanied by, 1) increased left ventricular work with eventual dilatation and hypertrophy of this chamber, 2) accelerated atherosclerosis manifesting itself as an increased morbidity and mortality from cerebral and coronary vascular disease, and 3) arteriolar sclerosis, especially severe in the kidneys. Since these vascular changes appear so consistently in the course of sustained diastolic hypertension, it is possible that their appearance might be postponed or their processes even reversed by blood pressure control.

It is emphasized in the classic study of Perera that the typical patient with primary essential hypertension begins showing elevation of blood pressure in the late 30's or early 40's and will, on an average, survive without treatment for at least 20 years. Typically, at least 15 of these years are spent in a relatively asymptomatic state, there being few or no symptoms *directly* attributable to the blood pressure elevation. At the time symptoms typically appear, the processes of left ventricular hypertrophy, atherosclerosis and arteriolar nephrosclerosis are usually well under way. With this reasoning, one can build a good case for drug management of the asymptomatic hypertensive patient. It also follows that many *symptomatic* hypertensive patients will have such marked narrowing in certain regions of their vascular system that blood pressure lowered to normal levels will not sustain adequate blood flow. Some of the hypertension may then be truly "essential." Another important limitation to therapy is that nearly all currently available drug regimens are associated with side effects, inconvenience to the patient, and may also be quite troublesome to the physician. The premise that asymptomatic hypertensive patients should have their blood pressure lowered needs further support from critical evaluation of groups of patients treated with currently available drugs with comparison of survival rates, etc., of previously untreated groups of patients of the same order of severity. That heart failure can be postponed or improved and that retinopathy can be reversed by hypotensive drugs is much more firmly established than is an improved prognostic picture in regard to cerebral or coronary thromboses or renal failure.

There appear to be a few generally agreed upon relative contraindications to hypotensive drug therapy. A blood urea nitrogen above 60 mg.% is usually indicative of rather severe primary or secondary renal damage; blood pressure lowering under such circumstances by further decreasing renal blood flow and glomerular filtration very frequently hastens the progres-

Lilly Laboratory for Clinical Research, Marion County General Hospital, Indianapolis

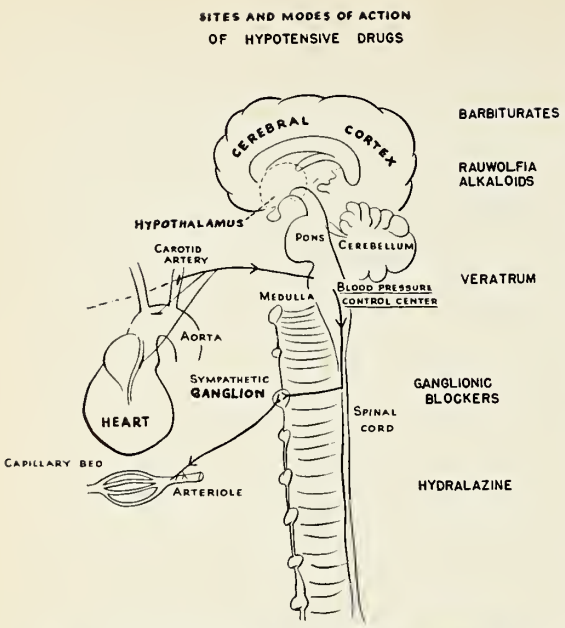


Fig. 1. This diagram depicts the probable site of action of the commonly used hypotensive drugs. These agents have the common effect of decreasing vasoconstrictor impulses reaching the arterioles. Not illustrated is the possible central action of hydralazine suggested by some data. A "catechol amine releasing" effect of rauwolfia alkaloids on the myocardium and blood vessels has recently been demonstrated.

sion of the azotemia. Patients with primary renal disease must be treated with considerable caution in that lowering the blood pressure may in this situation also contribute to renal inadequacy. Clinical evidence of current or recent (within six months) cerebral or coronary insufficiency or a recent thrombotic episode in either region of the circulation, in the opinion of most, constitutes a contraindication for intensive blood pressure therapy. An elevated systolic blood pressure not accompanied by diastolic elevation in the sixth, seventh or eighth decade is usually indicative of a marked loss of elasticity of the aorta and other major arteries. With any emotionally-induced increase in cardiac output, a marked rise in systolic pressure occurs. This individual typically does not have a significant increase in peripheral resistance and ordinarily should not be treated with potent hypotensive agents.

With the advent of many new drugs in recent years, the problem of selection of a drug or drugs for a given hypertensive patient has become increasingly difficult. In figure 1, the various groups of drugs available are shown and an attempt made to indicate diagrammatically their site and mode of action. With the exception of chlorothiazide and ganglionic blocking agents, the available data suggest that the common denominator of their mechanism of blood pressure lowering is a reduction in peripheral resistance, produced by a direct action on vascular muscle as in the case of hydralazine, or by some indirect mechanism as in the case of the barbiturates, rauwolfia alkaloids and veratrum.

With the advent of ganglionic blockers, it became possible to medically produce what surgical sympathectomy accomplished, a pooling of blood below heart level in the upright position, which "takes the load off" the pumping mechanism. Severe sodium restriction, administration of chlorothiazide, and other means of decreasing body sodium enhance the effectiveness of ganglionic blockers and other hypotensive drugs by mechanisms not entirely understood. It appears that "desalting"* in itself alters vasomotor tone

* This term is used to denote the various incompletely understood phenomena associated with a diminished body sodium resulting from an extremely low dietary intake of sodium or sustained natriuresis.

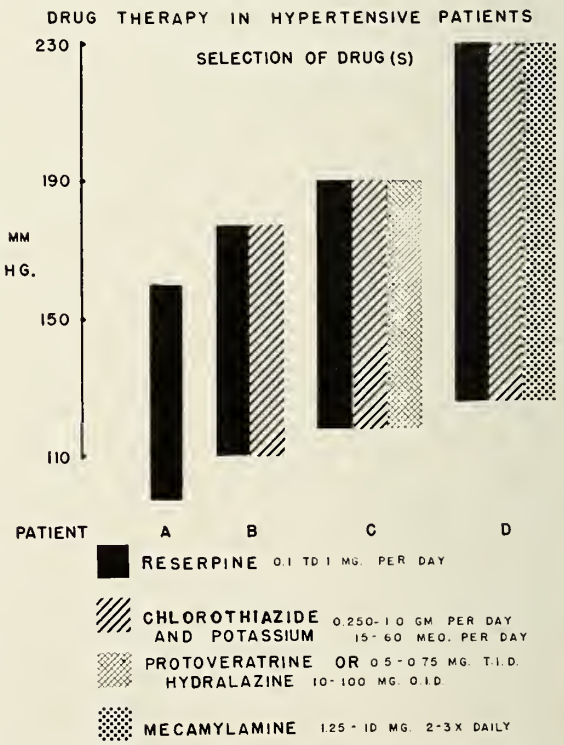


Fig. 2. Most patients with mild and moderate hypertension can be controlled with reserpine, chlorothiazide and potassium. Severe hypertension frequently requires the addition of a ganglionic blocking agent.

and results in a more profound effect of those drugs producing reflex vasodilatation. In individuals in whom "desalting" is accompanied by a reduction in blood volume, this supplements the pooling effect of ganglionic blockade. It is also possible that under the influence of these agents, blood pressure maintenance is dependent to a greater extent on neurogenic mechanisms causing the individual to be more susceptible to blood pressure lowering effected through an interference in neurogenic outflow from the central nervous system.

No rigid rules can be set forth for what drug or drugs are "right" for a given patient. There appears to be no uniform practice in regard to which drug to try first in a mild to moderate hypertensive patient. Figure 2 shows the pattern of drug selection used currently in the Hypertension Clinic of the Lilly Laboratory at Marion County General Hospital. It will be noted that routinely the patient with mild hypertension is started on reserpine, and chlorothiazide added only if the response is not adequate. Others have preferred to first give a trial on chlorothiazide. In this diagram, it is indicated that the patient who does not respond to reserpine plus chlorothiazide is frequently given, as a third drug, either a veratrum alkaloid or hydralazine, resorting to ganglionic blockers only if such a program has failed. It often is advisable to bypass this step in a severe hypertensive patient. Still another point of controversy is whether or not potassium need be given routinely to patients receiving chlorothiazide or hydrochlorothiazide. In our clinic, we have chosen to give at least 15 milliequivalents of potassium for each 25 mg. of hydrochlorothiazide or 250 mg. of chlorothiazide, mainly justified by the premise that it may prove important to avoid even subclinical potassium deficiency in hypertensive patients.

There are certain important considerations that alter the general scheme of drug selection presented. It seems unwise, for example, to impose the appetite stimulating effect of rauwolfia alkaloids on a patient who has mild hypertension and marked obesity. This picture is frequently complicated by the error of blood pressure measurement in the case of an extremely obese arm which may give one a high error of as much as 20 mm. of mercury for both systolic and diastolic pressures. In such a patient it seems wise to rely on barbiturates rather than rauwolfia alkaloids for therapy. Large doses of rauwolfia alkaloids have been reported to activate peptic ulcers and an occasional patient finds the effect of increased gastric motility or nasal congestion so unpleasant that other therapy must be sought. Factors in predisposition to rauwolfiia depression are not sufficiently clear-cut to select those rare patients who are going to encounter this serious side effect. It seems wise to routinely warn patients in whom rauwolfia therapy is instituted of this occasional side effect so that at the earliest appearance of warning signs of restlessness, early morning wakefulness or early despondency, the physician will be contacted. Otherwise, symptoms may be interpreted by the patient as evidence of mental deterioration associated with his disease.

Veratrum alkaloids should not be given to patients who already have the problem of anorexia and nausea, and since they can add to the arrhythmia effects of digitalis, should probably not be used, at least in high dosage when digitalis dosage is being increased.

In many patients, hydralazine, in effective hypotensive doses, produces tachycardia associated with increased heart work. Left ventricular failure can be precipitated and angina can be induced. This drug, therefore, must be used cautiously in patients with marked left ventricular strain, angina or borderline heart failure.

The greatest danger with "desalting" drugs and ganglionic blockers is that with these agents in combination, one can produce in some patients a level of standing blood pressure which is insufficient to maintain adequacy of cerebral, coronary and renal blood flows. In the case of the cerebral and coronary circulation, this is rather readily discernible. Unless, however, rather frequent measurements of adequacy of renal function are obtained, there may be no warning until serious deterioration of renal function has occurred. An NPN or BUN is satisfactory for the assay of renal function for this purpose and these should be obtained at frequent intervals (occasionally as often as every few days) when marked blood pressure changes are being produced. With "desalting" and ganglionic blockade, as with sympathectomy, a marked diminution in standing pulse pressure frequently is observed. A fairly reliable sign of excessive diminution in cardiac output is a marked increase in the standing pulse rate. Having the patient

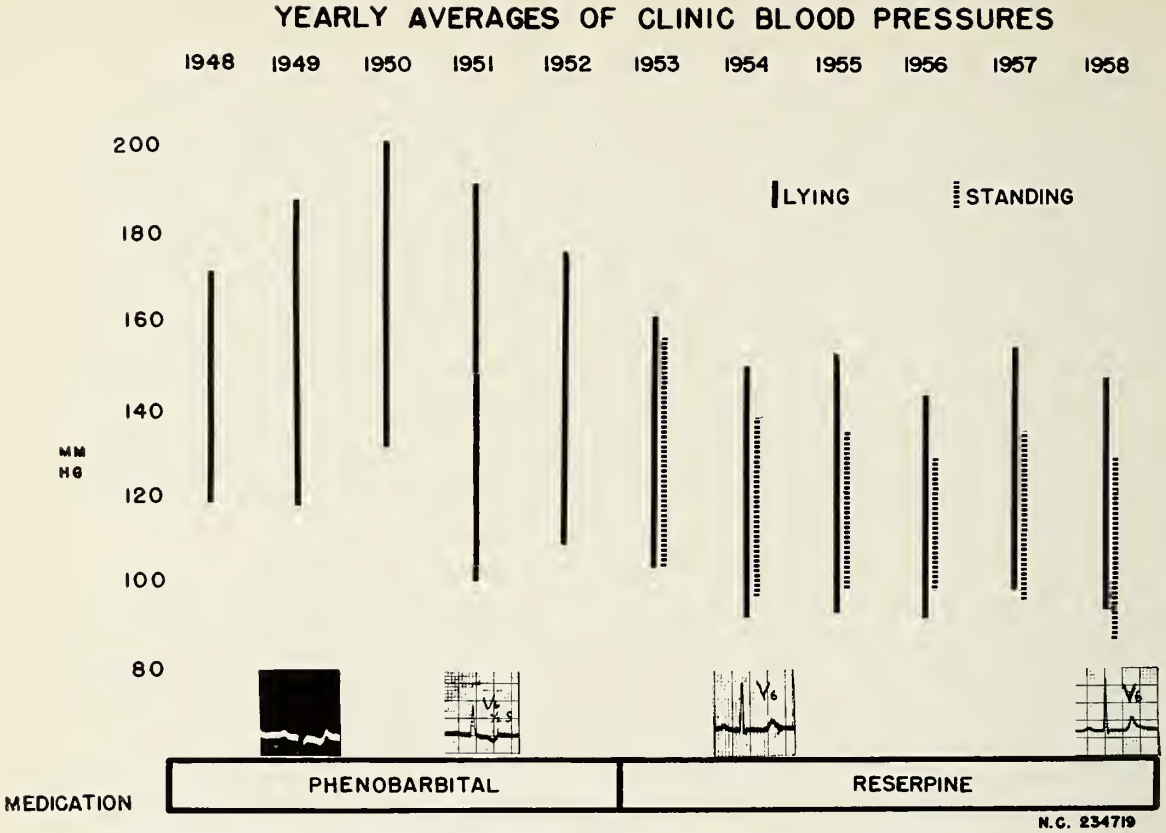


Fig. 3. A "strain pattern" present consistently on the electrocardiogram of this patient disappeared with reserpine-induced blood pressure lowering.

count his standing pulse may provide a useful guide in avoiding an excessive standing blood pressure decrease.

It is usually wise to institute therapy with ganglionic blockers in the hospital. If this is not possible, it has been our practice to have the patient come to the clinic for hourly blood pressures (for 5 or 6 hours) on several days to establish the dose schedule. One needs to find the dose required to lower pressure (at time of maximal action of the drug—usually 2-3 hours) and the duration of the effect produced.

As was emphasized in the introduction, additional studies comparing untreated hypertensive patients and groups treated with current drug programs are badly needed. There is at present ample documentation that the so-called strain pattern of the electrocardiogram can be reversed by blood pressure control. An example of this is shown in figure 3. This patient's record illustrates a reversal of the EKG "strain pattern" by blood pressure lowering induced by reserpine. Previously a program of activity restriction, dietary restriction of sodium, and phenobarbital had resulted in less satisfactory blood pressure control. Equivalent documentation of the beneficial effects of blood pressure control on the progression of atherosclerosis and arteriolar nephrosclerosis is still needed.

Still another controversial aspect of the management of hypertensive patients currently has to do with fat metabolism.

If one accepts serum cholesterol as an accurate index of predisposition to atherosclerosis, recognizing the marked increased risk of the hypertensive patient to atherosclerotic complications, one is obligated to recommend to the hypertensive male, especially, those alterations in diet and/or those therapeutic agents which at the present time appear to be capable of lowering serum cholesterol levels. Again, an evaluation is needed of the value of a high intake of unsaturated fat with a low intake of saturated fat, and sitosterols, on the incidence of atherosclerotic complications in hypertensive patients. Many physicians will choose, on the basis of current knowledge, to recommend to severe hypertensive men a treatment program designed to lower their cholesterol.

The Journal

of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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DALLAS AMA CLINICAL MEETING

THE AMA Clinical Meeting this year is scheduled on December 1 to 4 in Dallas. In addition to the attractions of a trip to the great state of Texas and to fabulous Dallas, the meeting is designed, as former clinical meetings have been, to help the family physician meet his daily practice problems.

Chief among the clinical subjects to be discussed will be soft tissue injury, whiplash injuries of the neck, diabetes, heart murmurs in children, new laboratory procedures, new resuscitation technics, premarital and marital counseling, and the problem child.

Space age medicine will be expounded by Dr. Hubertus Strughold of the School of Aviation Medicine at the opening session on December 1.

That afternoon Dr. Michael E. DeBakey will participate in a symposium on the surgical considerations of cerebrovascular insufficiency.

Dallas County Medical Society is sponsoring the "world's largest health fair," to be housed in the Dallas Memorial Auditorium, the site of the AMA meeting. The fair will run from November 27 to December 7, and will be open to the public.

Another innovation will be a national conference on the medical aspects of sports, on Monday, November 30, the day before the Clinical Meeting. This conference is open to athletic directors, coaches and trainers as well as physicians.

The scientific program will include lectures, symposiums, medical motion pictures, color television, nearly 100 scientific exhibits and 251 industrial exhibits.

The Clinical Meeting itself and its satellite conferences will be sure to attract a large audience of physicians and others, mostly from regional states, but also from all over. Easy to get to by any means of transportation and equipped to entertain vast crowds, Dallas will be the place to be in early December.

BLOOD DYSCRASIA REGISTRY

THE AMA has instituted a new registry on blood dyscrasia for the purpose of studying the possible causal relationship between certain drugs and abnormalities of the blood, and to alert the profession to the possibilities of such drug reactions.

The study is not designed to determine the incidence of drug-caused dyscrasias; its main purpose is to acquaint physicians with the possibilities and to accumulate enough reported cases to facilitate a decision as to whether, in the case of each individual drug, a causal relationship does or does not exist.

The number of potent drugs in clinical use has increased rapidly during the past few years. Drugs are released for clinical use only after exhaustive studies have indicated that they are safe. However, with widespread employment, some are found to produce an occasional untoward effect. It is these rare instances of toxicity in relation to the formed elements of the blood which are under investigation through the new registry.

Already several hundred drugs have been registered as having been employed either singly or with other drugs in a patient who developed a blood dyscrasia. In the case of multiple use of drugs, some of the reported agents, obviously, may be innocent bystanders, and probably are. Some of the drugs with slight potential for adverse effects may be associated with the dyscrasia by coincidence. These are some of the problems which it is hoped the registry study will solve.

The Subcommittee on Blood Dyscrasias of the Committee on Research of the Council on Drugs which is sponsoring the registry and research project has issued the following statement: "It is pointed out again that the fact that the name of a drug appears on the list does not mean necessarily that the drug is potentially harmful or that it was the cause of the reported dyscrasia."

Physicians are requested by the committee to report instances of blood dyscrasias in which a drug or combination of drugs is suspected as being the etiologic agent.

Copies of the initial report form and self-addressed postage free envelopes for this purpose may be obtained by addressing the secretary, Norman De Nosaquo, M.D., 535 N. Dearborn St., Chicago, 10.

ORAL FUNGICIDE

APPARENTLY another epoch-making discovery in medical therapeutics has been made. The announcement of an orally administered treatment for many of the dermatomycoses by Harvey Blank, M.D., and his associates of the University of Miami has finally brought a long desired and sought for remedy of the common and at times disabling fungus infections of the skin.

His paper presented at the Academy of Dermatology in December, 1958, gave the first inkling of a breakthrough in this form of therapy. Now, after 10 months of further study and observation, the reality of the hopes are at hand.

Two pharmaceutical companies here in the United States are marketing Griseofulvin under the trade name of Fulvicin[2] and Grifulvin.[3]

The only drawback to the whole situation which has come to mind with the discovery is the all too free and unwarranted use of the drug without a definite diagnosis being established by laboratory means.

Fungus infection or infections of the skin and its appendages can only be made with certainty by two methods: the direct examination of materials taken from the involved area or areas and by culture of them.

Even the most astute and clinically wise physicians cannot rely with certainty on inspection alone for a definite diagnosis of the dermatomycoses.

Just because an eruption of the foot or feet, hand or hands, the groins or ear appears clinically to be a fungus infection, no definite diag-

nosis of it can be made until the organisms are demonstrated.

Many vesicular, bullous, intertrigenous or scaling lesions found in the areas of predilection of fungus infections never are proven to be such even after repeated potassium hydroxide preparations and cultures are made.

Simply because lesions of the skin show a clearing in the center or have a vesicular, arci form border, or even are macerated and have appeared during hot, humid weather, is not justification for a diagnosis of dermatomycosis. To diagnose fungus infections the organisms must be demonstrated one way or another.

Undoubtedly, many cases of pityriasis rosea, psoriasis, moniliasis, secondary syphilis, nummular or eczema, dyhlidrosis, seborrhoea and a host of other dermatological entities will be treated with Griseofulvin without results because a correct diagnosis has not been made.

Right now we are being given a new remedy based on thorough scientific research and observation. A therapy which will either stand or fall in the coming years according to how thoroughly the individual physician is in his or her diagnostic approach.

SAMUEL R. MERCER, M.D.
Fort Wayne

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2. Schering Corp.
3. McNeil Co.

From California:

RELATIVE VALUE

SINCE ITS beginning in 1954 the California Medical Association's Relative Value Study has been used, mis-used and abused and, say CMA officials, there ought to be reviewed by all who use it of what the Study is, what it is to be used for, and how it should not be used.

The most common misuse, consciously or otherwise—premeditated or through lack of information—is to interpret the work as a definite, frozen, official *fee schedule* rather than using it, as originally intended, as a guide to show the relative pecuniary values of various procedures.

The Committee on Fees has proposed the following statements as reminders of the limitations of the Study:

1. The work is properly referred to as the Relative Value Study, not Relative Value Fee Schedule. As stated in the foreword of the second edition which was adopted by the Council on Nov. 10, 1957: "This study in no way sets anyone's fees or anyone's schedule of fees. The Relative Value Study is in no sense a fee schedule."

2. Contrary to any claims that may be made by individuals or insurance companies, no dollar factors have been assigned, designated or suggested by the California Medical Association for private insurance.

3. Units shown for certain surgical procedures do not include complete after-care.

4. Conversion factors that may apply in one section do not necessarily apply to the other sections.

Can Be Used as a Guide

Section #2 of the foreword further explains:

"Health insurance in California today requires fee schedules and indemnity schedules at many different dollar levels. California Physicians' Service needs different fee schedules for different income ceiling plans. Many groups want to buy indemnity insurance that pays benefits approximating the usual fees charged by physicians. Others want adequate protection at a low premium and will accept an element of co-insurance. The Relative Value Study, expressed in units, may be used as a guide in setting any and all of these schedules with widely varying dollar levels but retaining a constant relationship between fees."

Newsletter, Vol. 4, No. 8, published by Public Relations Committee, California Medical Association.

From Kentucky:

THE EVER-CHANGING SOCIAL SECURITY SYSTEM

SOCIAL SECURITY is not insurance: it is a compulsory tax for public charity.

In 1935 the law was passed entitled "Federal Old-Age Benefits." As soon as the Supreme Court upheld the tax and welfare program in 1937, the administrators began a propaganda campaign to make people believe their system is insurance.

Two years later, in 1939, the original law was scuttled and a whole new system was enacted with the title "Old-Age and Survivors Insurance Benefits." Some extension of the system has been passed every two or four years since.

People feel that the money deducted from their salary is for their own benefit; but that money is used long before they draw benefits. Your children and their children will be paying for your handout.

When the government tells a citizen, "you are being taxed to provide an income for yourself or your family," the statement is categorically and purposefully false. The citizen, in fact, is being taxed to provide an income for somebody else, a stranger and for a family of strangers.

There is no insurance contract. Congress has the power to alter, amend or repeal. That power leaves the citizen no legal right to any benefits.

If not legal rights, what about moral rights? Surely our government will respect them. So one would like to think. But, the fact is, they have not been respected, but have been dishonored time and again.

The first Social Security Act promised the people "permanent" coverage if they paid taxes for five years. In 1939 this was raised to 10 years.

The act of 1935 guaranteed every person brought under the Social Security Act at least his money back. The Congress took this away in 1939 and in the 15 years that followed, 6,400,000 died without getting either pensions or refunds for themselves or their families.

During the 1940's thousands of people 65 years of age retired and started drawing Social Security benefits, then started little businesses of their own.

The 1950 Congress extended Social Security coverage to self-employed. In one year 22,208 were stripped of their pensions and forced to pay "contributions" out of their earnings "to build up security for their old age."

The government broke faith, but it did not break it's contract. There is no contract.

The Social Security experiment is the most colossal gamble with the peoples money undertaken by any government in human history. It began as a device to enforce thrift upon those who work for others. Now after 24 years, 19 out of every 20 workers are paying Social Security taxes.

David Cox, M.D.

Reprinted from The Journal of the Kentucky State Medical Association, August 1959, p. 968.

President's Page

This will be the last president's page that I will have the privilege of writing. I hope that I have stimulated some thought and action on some of the subjects that I have written about during the year. It has been a great pleasure to me to have received the fine cooperation extended to me by the members during my term of office. We physicians are part of the greatly honored medical profession. We are especially fortunate in having the privilege of serving our fellow man to enable him to maintain health and cure or heal his wounds or illnesses. To all the men of the various specialties and especially to the general practitioner, who spend many hours of devoted service at the expense of their families and their own recreation or hobbies, I give a special salute and hope that you receive special rewards in the years ahead in life and in heaven too.

I want to thank you all for helping make my year a pleasant one and I hope that some progress has been made for the betterment of health of the people and of the status of the physician in Indiana.

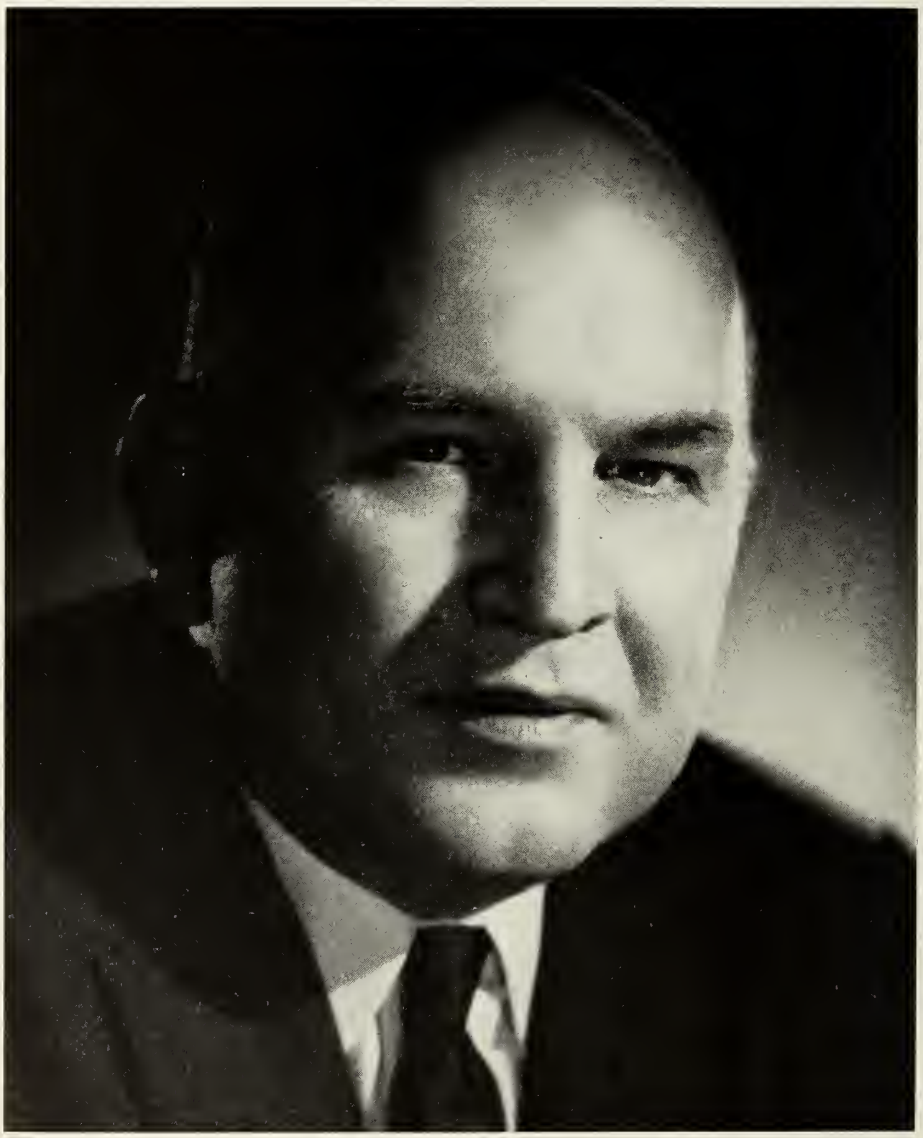
I especially want to thank Mr. Waggener and the entire headquarters staff for their excellent help. I hope everyone will continue to give as good cooperation and help to my successor, Dr. Earl Mericle.

I wish Dr. Mericle a very successful year for himself and the association.

Kenneth L. Olson M.D.

PRESIDENT—1959-60

Indiana State Medical Association



EARL W. MERICLE, M.D.

Indianapolis

Earl W. Mericle, M. D.

President

Indiana State Medical Association

1959-60

Doctor Earl Mericle of Indianapolis was inducted into the office of president of the Indiana State Medical Association at the Annual Convention Dinner on October 7.

Dr. Mericle was born in Anderson, Ind., on Nov. 30, 1903. He attended Indiana University and received the B.S. degree in Medicine in 1932, and the M.D. degree in 1934.

After serving his internship in the Indianapolis General Hospital, he was resident in neuropsychiatry in the same hospital, and then served as resident at Norways Foundation Hospital, Indianapolis, from 1936 to 1940. He attended the University of Pennsylvania Graduate School of Medicine in 1940.

Since that time, Dr. Mericle, with the exception of military service during World War II, has practiced in his specialty of neuropsychiatry in Indianapolis. He is a diplomate of the Board of Psychiatry and the Board of Neurology.

Dr. Mericle's military service was with the Fourth Armored Division, U. S. Army, from March 1941 to December 1945. During this time he served 21 months in the European Theater.

Dr. Mericle is a member of the Central Neuropsychiatric Association, the American Academy of Neurology and the World Medical Association, and a Fellow of the American Psychiatric Association.

He is a past-president of the Indianapolis Medical Society. He has served as president of the medical staffs of the Methodist Hospital and the Indianapolis General Hospital.

Dr. Mericle has served as a delegate from the state association to the American Medical Association. He has been chairman of the Committee on Public Relations. He is also a member of the Professional Advisory Committee for the Indiana Association for Mental Health, and the Mental Health Long Range Planning and Building Commission for the State of Indiana.

Dr. Mericle was married to Ruth Fink on June 27, 1936. Dr. and Mrs. Mericle have four children, three girls and one boy.

The Woman's Auxiliary

REPORTS TO I.S.M.A.

Dear Doctor:

YOUR AUXILIARY'S NEW PROJECT

Rules and Regulations Governing the Health Citation Award
of the
Woman's Auxiliary to the Indiana State Medical Association

1. The Award shall be known as the Health Citation Award of the Woman's Auxiliary to the Indiana State Medical Association.
2. The purpose of the award shall be to recognize and encourage lay activities in the promotion of health and health education. Recipients shall be given state-wide publicity.
3. It shall consist of a parchment certificate with the proper inscription.
4. The award shall be given to a lay person who by his or her voluntary activities has made an outstanding contribution to the advancement of health and health education in Indiana, or who has contributed to health and health conditions in his or her respective community. (Members of medical auxiliaries and doctor's wives excluded.)
5. Recipients of the award are limited to those not holding medical degrees nor engaged in any work closely identified with medicine for personal financial gain.
6. Nominations:
 a. Each county auxiliary may nominate one candidate for the award.
 b. The nomination must be accompanied by a brief, substantiating the reason for the nomination. This may be in the form of a copy of a publication or a report describing the scope of the work for which the award is to be given.
 c. Nominations must be in the hands of the Executive Committee of the auxiliary to the ISMA on or before February 15, 1960.
 d. The Executive Committee shall review all the nominations and submit the names of the five top candidates to the ISMA advisor of the Women's Auxiliary for final decision.
7. Presentation of the award—the parchment Certificate of Appreciation will be presented at the House of Delegates meeting at French Lick in April, 1960.
8. We suggest that county auxiliaries, with the *approval* of their county medical society, may give a citation to their local winner. Send the name of the local winner to the state Committee.

If you know of a good candidate for this award, please advise your own auxiliary. We think that this might help in some small way with our public relations.

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*Pratt, R. T. C., and McKenzie, W.: Anxiety States Following Vestibular Disorders, Lancet *2*:347 (Aug. 16) 1958.

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Psychological Indoctrination Efforts Among Prisoners of War in Korea

LT. COL. FREDERICK A. ZEHRER*

U. S. Army Medical Service Corps

SINCE the repatriation of troops who were prisoners of the North Koreans and the Chinese Communists from 1950 to 1953, there has been much interest in how they were treated; how, and to what degree they changed in the course of their retention as prisoners; and strong concern in relation to the nature of the pressures used by their enemy captors. Also, there has been much misinformation and consequent misapprehension concerning the nature and degree of success (or better, lack of success) of the diabolical human behavior experiment of the Chinese Communists. I hope that this presentation will help to clarify some of these items.

Information on the unique, somewhat bizarre project of the Communist Chinese is essential for those who are responsible for the training and guidance of youth, as well as for military personnel. We need to know how other people who live in a different culture act when led by men whose concepts are markedly different from ours—who, under our cultural criteria, appear to be perverted in their values of human life and concepts of decency. To be informed permits us to be forewarned.

This afternoon, we shall review a grim application of psychological principles in a human laboratory where—in Korea—the Chinese Communists used American prisoners of war as subjects in a grotesque effort to indoctrinate them, if not to imbue them with a partisan point of view, at least to see how far they could travel along that line—and with what sort of methods, and with what kind of subjects. The American

* Chief, Clinical Psychology Service, Letterman Army Hospital, Presidio of San Francisco, Calif. Lecture presented in January 1959 before faculty and students of a western university.

Drawings from Letterman Army Hospital *Fog Horn* by Miki Wilson.

prisoners of the Chinese Communists were treated with a lack of respect for persons unequalled in modern warfare.

In order to maintain proper perspective and to evaluate what happened, it is well to be aware of some fundamental bits of information to provide points of reference and contrast.

A total of 1,600,000 Americans served in the Korean war. Six thousand, six hundred and fifty-six personnel were captured by the enemy.

In basic training, U. S. Army doctrine has long included emphasis upon aggressive action with full resistance of the enemy; never to surrender of one's own free will. If all resources have been used fully and unprotected men are taken captive, they are taught to make every effort to escape, to make no promise to the enemy that they will not escape, to give no information to aid the enemy and to give only name, rank, date of birth and serial number to the enemy.

The Geneva Convention rules include this latter as the only requirement in yielding information but the international agreement does not bar questions. It does, however, include the rule that "no physical violence or mental torture nor any other form of coercion may be inflicted to secure information of any kind. Prisoners of war who refuse to answer may not be threatened, insulted or exposed to unpleasant or disadvantageous treatment of any kind."

In every previous war the conduct of American soldiers who were held in enemy prison camps presented no unusual problems. They had been victims of starvation and disease, but there was no real collaboration with the enemy, no real breakdown of morale. They escaped when they could.

When the United Nations forces engaged in conflict in Korea in 1950, nations other than the United States sent hand-picked but small units composed primarily of World War II veterans. The British Empire sent one division; Turkey sent a brigade, the Philippines sent a regiment, Thailand, one regiment; the others a battalion or less. In contrast, in the early days of the conflict, the comparatively very large U. S. strength was made up largely of young men who had been sent to Japan with the Occupation forces. In the opening days of conflict, they were sent to Korea abruptly to bolster the battle line. Most lacked the maturity which would have taught them the value of hard core discipline. At the time of their capture, the average age of the Americans who became prisoners was 21 years. Many ranged down to 18 years. Most prisoners were taken in the early days of the war before seasoned, better equipped troops arrived in Korea.

From the early days of July 1950 when Communist propaganda used tape recordings ostensibly made by U. S. prisoners, until the end of July 1955, the Department of Defense and particularly the Army, made a rigorous, objective study of all aspects of treatment and behavior of the prisoners of war. The responsible officials did not accept the then often-stated reason that the behavior of some of the prisoners was solely caused by the cruelty of the Chinese Communists. Information taken from taped broadcasts and published documents was supplemented by questioning upon repatriation. The studies included intensive sampling examinations and appraisals by psychiatrists and clinical psychologists. Teams of well-qualified Army medical personnel not only were at the point of repatriation in August and September 1953, but returned in nine ships with the men released from prison camps. At the time of their imminent release, there was much pressure to have the men be returned to the United States by way of aircraft. However, the military medical recommendation was that the men who had been imprisoned for so long a period would need time to make adjustment to their new status. A second reason was to allow time for psychiatric-psychologic evaluation plus re-orientation. This procedure was adopted;



POW's in Korea

Continued

hence the return by way of sea. It should be noted that the few seriously ill, in need of intensive medical care, were returned by ambulance plane.

On the ships there were psychiatrists, a clinical psychologist and enlisted clinical psychology and social work technicians. For two more years the data was studied, checked, cross-validated and summarized. Since the process of indoctrination was primarily a psycohlogical one, the psychiatric team was able to assist in strong measure in this multi-avenued evaluation by military and civilian specialists. As a result of this study, definite constructive action was taken by the Department of Defense to obviate any repetition among soldiers who might become captives in the future as well as to enhance the possibility of greater resistence to capture.

To round out this background sketch we should be reminded of a few basic pertinent psychological principles which are well validated in scientific studies of behavior. Every person has some basic needs for acceptance, activity, approval and security as well as for food, shelter and warmth. We are born with a drive for self-preservation. The need for social belongingness is a key item in the survival and adjustment chain. A sense of inter-dependency is fostered from birth onward. We know, too, that feeling tones are attached to situations which result in pleasure or pain and that frustration, when repeatedly experienced, develops a sense of defeat. Pavlov (a Russian scientist) long ago demonstrated that hunger, pain, rage and fear (basic sensations) could be conditioned and manipulated. When a person is in extreme fright, definite predictable physiological reactions occur. The skin becomes moist, the mouth becomes dry and the heart beats faster, intestinal response is tight, the body prepares to fight or run, more red cells are pumped into the blood, and the brain's customary process of receiving and sending messages is short-circuited and results in a nearly purely emotional reaction—all to meet a real or supposed emergency.



We know too, that chronic fatigue lessens the strength of a person to combat repetitious suggestion. This can lead to false perceptions, false beliefs and/or phantasies.

Tension is one aspect of fear. Fear is an unsatisfied need for security and survival. Continuous tension, in turn, can lead to fatigue and depressed feelings. If kept up for a prolonged period, this can lead to confused thinking.

Persons who feel very insecure and anxious, tend to set up a defense by projecting their beliefs and feelings to others. We know that people who develop resentful feelings in their developmental years are susceptible to suggestion and can be led to project their own shortcomings on to others.

In "brainwashing" (technic Communists have used so well among their own people) the aim is to arouse in a person hatred and then project it against selected targets, to focus this hatred against persons or groups and then against friends, society or country. It is intended to develop the belief, *they,* not *he,* are to blame for his troubles. This creates self-doubt and guilt. Guilt feelings arise from failure to meet self-standards of attainment or conduct. To save himself from guilt feelings, the defense is to be put on others. The basic needs earlier outlined are key items of attention in this process to select means of pressure, *isolation, interrogation, endless assertions, fatigue, malnutrition* and *suggestion.* This, kept up, can lead to confession, when a person no longer can distinguish his own beliefs from reality, his own original concepts from those suggested to him. Essentially, this process is a man-made disease. The methods developed in medicine to understand and combat illness are used in reverse to create it.

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POW's in Korea

Continued

includes the term *indoctrination* rather than *brainwashing*. It is believed the former (indoctrination) better describes the process used on the American POW. Many aspects of the two methods are similar but the key difference is that indoctrination is an effort to change a man's attitudes, thoughts and actions through manipulation while he is still a *rational* person. In brainwashing, irrationality is the means to the end. With these items as reference points let us now consider what took place.

When the conflict began in mid-1950, the North Korean Army was the enemy. Americans who were captured were often killed when the North Koreans retreated. Forced marches of the prisoners in the early days of the conflict were often death marches. In the winter of 1950-1951, on one of these marches back of the lines, 700 troops of the U. N. Forces who were captured were headed north. Before a camp was reached 500 men had died. Reports of atrocities committed were not unusual in the first months of combat. During this period, after the Inchon landing in 1950, the U. S. Forces had taken about 60,000 North Koreans as prisoners. They generally needed few guards; in fact, many asked for the return of their rifles so they could join in fighting their former comrades. Of course, this request was denied them by the soldiers who were their guards. Such action of "turning against" is an ancient oriental custom practiced by China's mainland warlords. The prisoners taken by the U. N. Forces were from the ranks of the Army which captured U. S. personnel. Reference is made to this remnant of archaic thinking to underscore the social-cultural-traditional concept in the thinking among men who found it difficult to treat their prisoners with anything but harshness and disrespect for person.

When Americans were captured in the late summer and autumn of 1950, they were force-marched back of the lines and maltreated. During this period, the North Koreans often took a prisoner's clothing, gave him little or no food and met any sign of resistance with immediate severe punishment or death. The meager food offered to the American prisoners was unpala-

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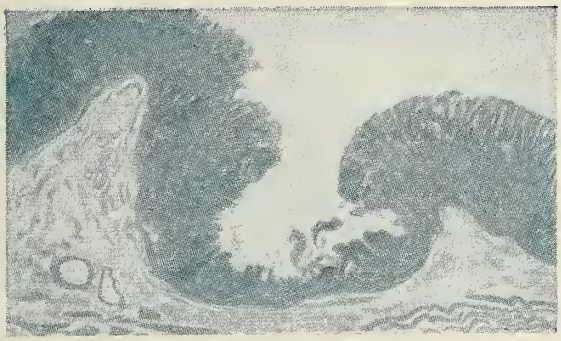
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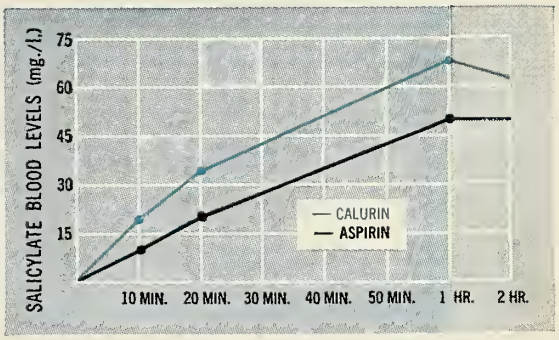
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*TRADEMARK

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POW's in Korea

Continued from page 1802

table to them. Many refused to eat it. Many complained about the way it was prepared by self-appointed cooks. As a result, malnourishment was a critical problem. Health suffered. There were no medical supplies. Repeated requests by the Army Medical Corps officers who were prisoners resulted only in insults and no supplies. When pressed for food, the captors blamed U. N. planes for destroying food and disrupting transportation, yet loads of progaganda literature were brought into the camps.

In one of the prison camps set up by the North Koreans where the sick and wounded came in in large numbers, over 400 out of about 1,500 of our men died. (The figures are estimates, not exact, due to the lack of registration by the enemy.) It is an important statistic to note that in the same camp *all* 229 Turkish prisoners survived. (About 50% of them were wounded when captured.) There were no deaths among them. Later, there will be occasion to refer to the Turkish prisoners of war for other comparative purposes.

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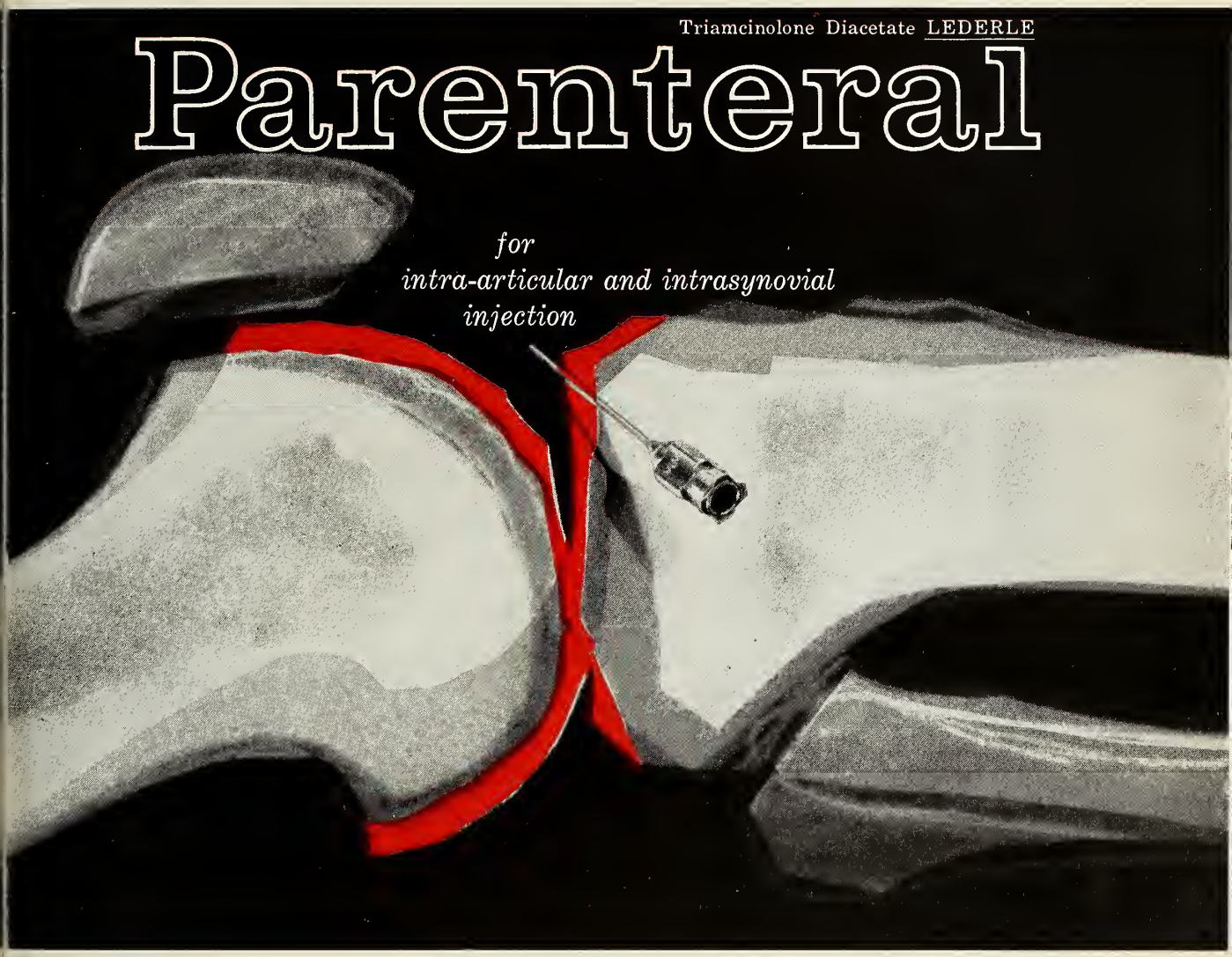
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The very high death rate aforenoted took place during the first 10 to 12 months of the conflict. In fact, about 99% of all prisoner deaths occurred during this period. The death rate was particularly high among the younger men (under age 20). Some died of pneumonia, often of diarrhea; others of dysentery and pellagra. The lack of proper diet and medicine took its toll coupled with a loss in will to live among the younger men. An army doctor, who was taken prisoner while caring for combat casualties and was decorated for his heroism and refusal to leave the wounded when others withdrew, reported that at a certain point in his starvation, a young soldier would complain he was too weak to get his food. He would lie down, pull a blanket over his head and shut out the world. He would refuse food even if it was brought to him; then he would refuse water and in a few days he would be dead. He usually died in a fetal position—just as he was prior to birth. This train of events happened so often in the early months of captivity death could often be predicted a few days in advance. This doctor stated that many of the younger men had no real discipline; they even resisted orders intended to keep them alive. This phenomenon (the loss of will to live among the younger soldiers in the early months of captivity) may well lead to speculation concerning the dynamics of a personality wherein the basic drive for self-preservation was lost. Feelings of hopelessness and severe depression wherein no future goal in life is of interest usually leads to such a state of resignation. One might consider an hypothesis that a firm belief and faith in oneself or mission was lacking, a set of personal-social values was distorted or poorly integrated, this permitting vulnerability; an overly strong sense of dependency on others with a sudden loss of social and physical supports contributing to a feeling of helplessness; an inadequately-formed acceptance of responsibility for others; a lack of religious (of whatever form) faith in power beyond oneself; plus an ineffective degree of self-discipline may well have combined to set in motion the series of symptoms leading to death. Any one of the aforenoted areas of vulnerability, in itself, might not be sufficient to lead to death via withdrawal, but a combination of several of them could very well be fatal. A consideration of what did take place does provide us with some guides in the early rearing and education of youth. I shall

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POW's in Korea

Continued

refer to these factors later. It was only when the death rate (February 1951) reached 29 a day in one of the larger camps that the Chinese Communists showed concern: at that rate all prisoners would be dead in two months! They called in the American doctors and demanded the death rate be stopped in two weeks and promised medication. This turned out to be enough to care for about five men but there was some slight improvement in the food supply as time went on.

The denial of food and medication appeared to be part of a larger plan—its objective to kill prisoners by hunger and disease or to weaken them—to make them ready for other things.

When the Chinese Communists entered the conflict in late 1950, there was a marked change in receiving new prisoners. The new enemies often tried to create a friendly atmosphere. It was not unusual for an American prisoner to be greeted with outstretched hands and "Congratulations! You have been liberated. You can now join with the other fighters for peace." Having learned to expect death, he was greated instead by the Chinese Communists who emphasized peace! Usually the prisoner was in a semi-shocked state at the time of capture and it was difficult to integrate what he perceived. This form of reception typically served as an incomprehensible shock with some overtones of relief. However, in the succeeding weeks and months, he was subjected to great physical and psychological stress. Marches to different camps—always at night—averaged about 20 miles. Most men had diarrhea; many had dysentery. Most suffered from exposure in the mid-winter months. Each day some men died. Physical weakness plus the terrain in a non-Caucasian populated country resulted in few escape attempts, although prisoners on the march were poorly guarded.

The first thing the Chinese Communists did, upon the arrival of the prisoner at camp, was to find out everything they could about him. He was immediately put through an initial questioning session and then ordered to complete a detailed questionnaire with the false heading "International Red Cross." He was told the Chinese

Continued on page 1812



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POW's in Korea

Continued from page 1808

needed the information to let his next-of-kin know of his capture. The form called for all possible aspects of his family background, his occupation, schooling, social status, economic situation, etc. Other detailed forms followed. Later each was required to write an autobiography. It appears that with this voluminous material assembled on each prisoner, the enemy staff was able to begin to select the most promising candidates for their purpose.

A captured Chinese field guide for interrogators indicated what they were seeking: "The prisoners most cooperative in working with us will be chiefly young enlisted men of higher quality. They will accept our way of thinking and have the courage to speak—we may ask them to write in any way they wish on subjects we present to them. In this way they can express themselves freely and we can obtain more information." The autobiographies permitted identification of areas susceptible to communistic approach, feelings of discrimination of any kind, financial deprivation in a family, strong bias, frequent frustrations in efforts to attain recognition, resentment to authority—these are a few probable samples of what Chinese Communist intelligence officers were seeking. As many returned prisoners said, they could see no harm in writing their own life histories in their own words. They were unprepared for the later intensive reference to all things they wrote, for the searching follow-up inquiry on certain items; for the repetitive re-statement of what they had said and for many, the demand to write again more accurate and detailed accounts of their life histories.

By the second and third week after capture, it was typical for prisoners to develop a plodding gait in walking. This postural attitude was a symptom of broken-down lines of authority. The enemy told those captured that since they were prisoners, their rank no longer meant anything. With positive re-assertion of this, the younger men were particularly susceptible to accepting and believing this. It was an effective enemy wedge to break down any lines of discipline among the captured soldiers. Therefore, instead of mutual help, an "every man for himself" feeling appeared to prevail. Open competition for food, clothing and shelter made group ties almost impossible and, of course, was encouraged by the Communist captors.

The Chinese Communists soon (starting about March 1951) divided the American prisoners into "progressives" and "reactionaries." The "progressives" were those who were potential material for communistic partisanship, collaborators, workers for peace. The "reactionaries" were those who would give nothing but their name, rank, serial number and date of birth. They were outwardly hostile and at times even attacked their guards; some who were outwardly non-resistant were judged to be inwardly strong, thus possible saboteurs of any indoctrination program.

The Communists soon segregated the officers from enlisted men and further segregated reactionaries from progressives. This was done within some camps; others were set up in separate camps. As time went on, little real indoctrination was attempted in reactionary units. However, in the progressive camps, a full-scale indoctrination system was established.

In each camp, prisoners were grouped into

Continued on page 1818



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POW's in Korea

Continued from page 1812

companies (about 4 to 7 companies in a large camp) with an average of 200 in each company. The companies were divided into three or four platoons; the platoons into three or four squads. In the squads (with six to 15 members) most of the camp routine was centered. Chinese personnel or selected prisoners, regardless of rank, were in charge of the squads. In the progressive camps the squad members attended classes together, studied together and held discussions among their own members. The prisoners rarely had any contact with the military; they saw much of their political instructors and interrogators. The camps, incidentally, had a political as well as military division.

When any "subversive" prisoner (that is, resister among "progressives") appeared in a group, he was moved out of the unit quickly and often was unheard of again by his squad.

In a progressive camp, a typical day called for the prisoners to arise at 7 in the morning and retire at 7 in the evening. Five of the working hours were devoted to listening to lectures and in discussion groups. Prisoners who wanted more time to study could delay retiring until 9 o'clock and could spend the two hours in the camp library. The library was generally well supplied with Communist materials, printed in English, in addition to some few other books of fiction by non-Communist writers.

Meanwhile, the resisters were given hard-labor details, poorer food and generally left to their own resources. The hard labor kept them busy and was conducive to better physical and mental health. A review of statistics for the 3-year period showed that the death rate among reactionaries was not significantly higher than among the collaborators (or progressives).

In all camps there was a persistent emphasis upon undermining friendships, emotional ties and group activities—other than group activities conducive to learning about the Communists' concept of brotherhood and peace. All forms of religious expression were prohibited and chaplains who tried organizing services were persecuted severely. Mail from home was generally withheld except for collaborators. Chinese spies were planted and used systematically. During the first year particularly, recreation was limited to reading Communist literature. The captors emphasized the idea that rank was of no significance now among the prisoners, all were now part of the "brotherhood," all were equal. To underscore this, they generally put young enlisted men in charge of squads. Some malcontents and immature youths used this opportunity to get favorable treatment.

During the enforced lectures and reading of Communistic literature, the young American prisoners were at a marked disadvantage. Some had never known anything about Communism except its name; many never heard of Karl Marx—yet here he was held up as mankind's benefactor. Also, many knew so little about United States history, its ideals and traditions, that they were unable to offset the advantage of the Chinese indoctrination who knew so much more about American history and its political doctrine. They could not answer arguments in favor of Communism with arguments in favor of Americanism. Knowledge, for those who possessed it, was a valuable weapon of self-defense.

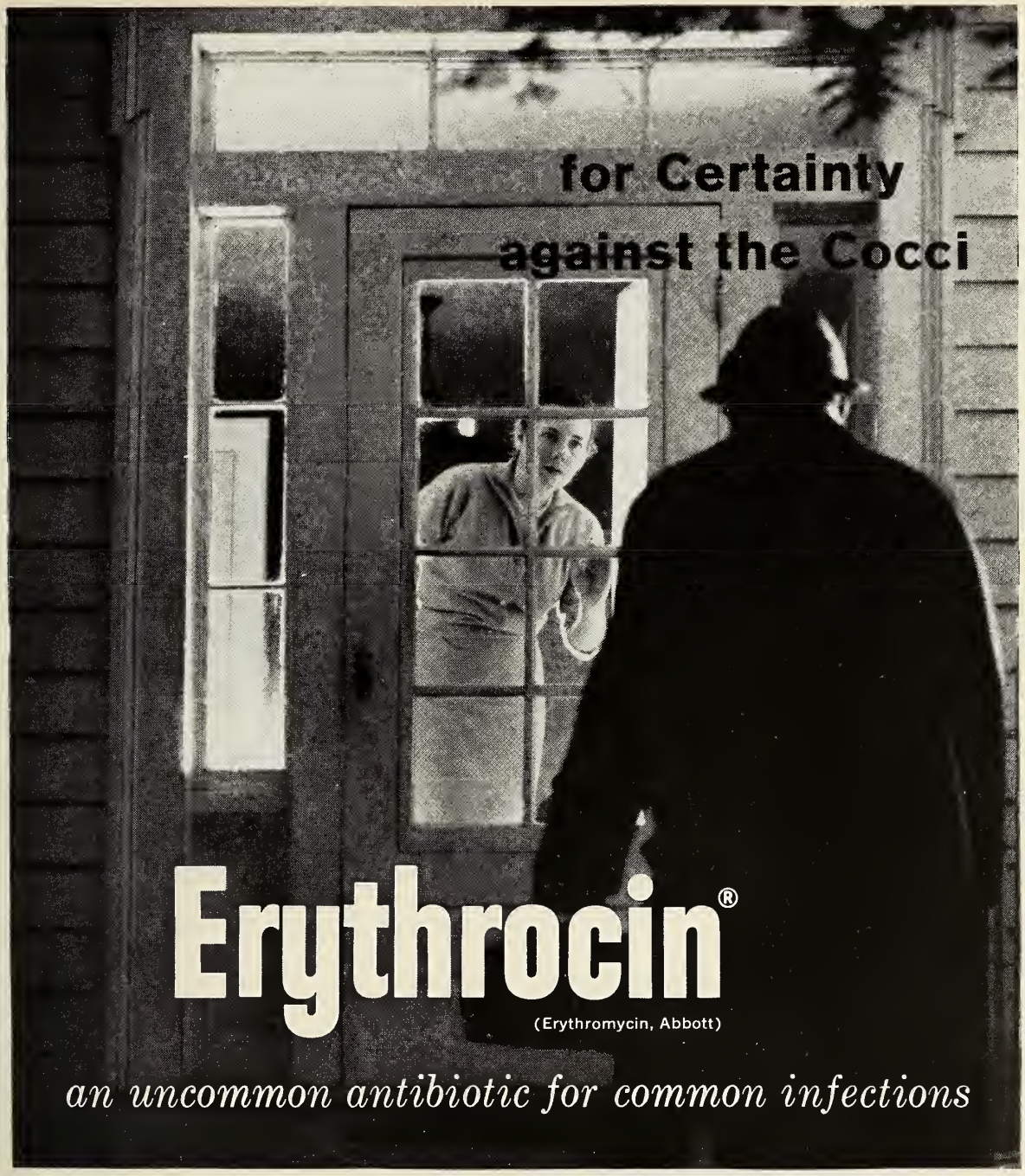
Some more intelligent prisoners played dumb. For example, an officer described himself as the most stupid man in the Army and stuck to it. He was insulted and got a slap in the face, but was not bothered further.

This method of management had the effect of breeding suspicion; one could not be sure when expressing his ideas whether an informer was listening and would report him. Social isolation became the order of the day. In turn, there was emotional isolation which kept a man from validating and reinforcing his beliefs, attitudes and values through social interaction. This, when he was cut off from accurate information and was under pressure from many sides and needed such effective support.

In this setting, let us consider the process of indoctrination. The key technics of this psychological process were *harassment, humiliation, repetition, isolation, deception* and *fear* imposed on generally mal-nourished and essentially leaderless prisoners. Some were guilt-ridden. Those who became captives while still able to fight but did not do so, generally had such feelings.

The primary method of direct indoctrination was mandatory attendance at daily lectures which

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POW's in Korea

Continued

lasted two to three hours. The major trend of thought stressed in such lectures was that of social and economic merits of Communism against the alleged sins of American capitalism. Also, the prisoners were told repeatedly they were used as tools of the capitalists to fight in a civil war which was no concern of the United States. Materials had to be memorized; doctrine had to be repeated accurately. Partisan ideological principles were repetitiously presented. Then, on the same day, a two-hour discussion was held. Participation was required. Those who were inattentive or nonconformists were reported and penalized. Penalties included cut in food ration, more hours of study or isolation for a day to two weeks in a hole just big enough to squat in. Alertness, good reproduction or recall of Communist principles meant better treatment, better food, more freedom of activity.

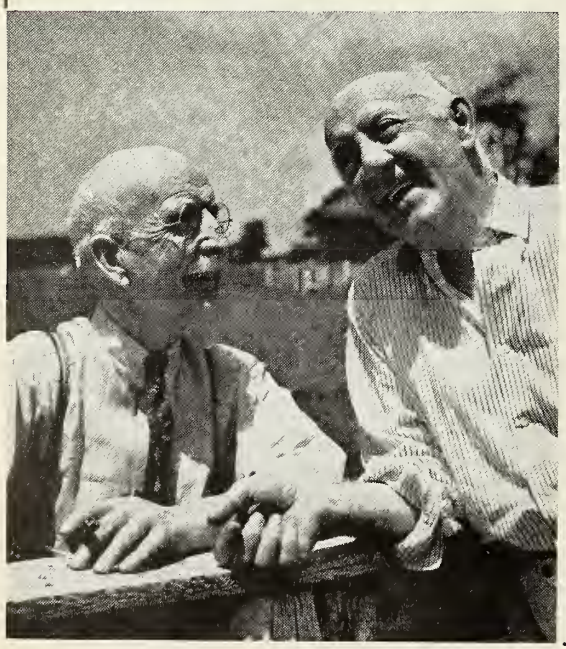
Harassment was used on all prisoners, progressive and resisters. The most minor infraction of a rule—and rules were plentiful—would set the wheels in motion. Typically, one who broke a rule (intentionally or unintentionally) was ordered to headquarters where he had to listen to a long lecture on the necessity to conform. He would be recalled—probably at midnight for a second lecture. The next day he would be called in for a third lecture on his shortcomings. About 1 or 2 o'clock the next morning his offense was again reviewed in great detail. He often would be called upon to apologize to the assembled group for his misdeeds and to criticize himself in great detail. Often he had to write a long confession of guilt. This technic interfered with a prisoner's desire to be left alone; it caused anger, frustration, irritability and was a drain on his self-esteem.

Humiliation was used as often as possible along with harassment. Not only would an objector or rule-violator have to criticize himself before all others, but he would often need repeat his self-critique daily for a week. In turn, his classmates were ordered to criticize him. This round-robin served to set up a system of informers and led to distrust as well as humiliation of the individual. In a repetitious, harassing setting one need have strong self-discipline and rigid personal value principles to avoid the easy step

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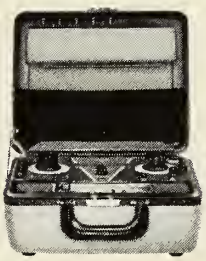
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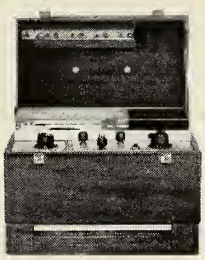
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POW's in Korea

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from self-criticism to criticism of those with whom he lives and are critical of him.

In addition to harassment, insults by the Chinese Communists were common. Threats were frequent. The threats most often used included nonrepatriation, conviction as a war criminal, death, withholding of food, isolation, physical abuse. Mock executions wherein a prisoner was made to dig his own grave were not uncommon.

It was standard procedure in any interrogation for an interrogator to lay a pistol on the table at the start of a session. Questioning would continue for a few minutes or several hours. Tape recordings would often be made and a prisoner would be re-questioned. If there were further discrepancies it was not unusual to have the man write a few hundred pages about himself, his friends, his community, the army, etc. These documents would then be used to probe deeper into any aspect to suit the whim of the interrogator. Some prisoners were questioned a half a hundred times. The odds were against any false statements going undetected.

A system of rewards and punishments was put into effect early in the program. This was based on the recognized principle that it is natural to seek pleasure and avoid pain. Collaboration resulted in preferential treatment; resistence meant abuse and mistreatment. Progressives could go to town, had better quarters, better food. This cut them off from the others.

The plan to divide has already been mentioned; actual segregation, sowing seeds of mistrust among the prisoners, mutual criticism and removal as possible leaders.

Sources of familiar ideas and news was cut off or distorted; the area of thought, stimulation of free thinking, was invaded by a controlled environment which precluded any but alien information to reach the prisoners.

Enforced idleness or solitary confinement was used as means of encouraging prisoners to consider the rightness of the Communist viewpoint.

Another effective scheme was that of pacing of demands. This would start with having the prisoner respond to trivial or innocuous requests or demands until he got into the habit of responding in a pattern. This would be stepped up slowly to the degree that he would respond to important requests. The use of confessions for minor rule-breaking followed by self-criticism could well lead into saying things self-critically frequently enough to habituate thoughts wherein self-doubt becomes a pattern of response.

The Communists made quite an effort to insert their ideas into old and meaningful contexts. This, however, appeared to be effective only with those who had been unhappy at home in the United States.

The positive plea for peace was a key concept. This could have an appeal for war-weary combat soldiers. It was an effort to identify with a generally accepted ideal for which all people stand. Signing of petitions for peace; writing to families to plead for an end of war; to stand for peace. The naive could have little objection to this procedure. The Communists pushed this strongly; again to hope to entice identification, even with the enemy, in common goal striving.

Deception was an indirect means of indoctrination. Prisoners, upon arrival, would sign a camp roster and later find that it was a peace petition on which their signatures appeared.

These then were the technics; the use of basic psychological learning principles to attain their ends.

Taken one by one, the Chinese Communists invented no new technics or methods. However, the use of a combination of the various technics with simultaneous application to gain complete control over very significant portions of the physical, social, emotional and mental adaptations of a group of people was unique. Before we consider the degree of success—or failure—it will be well to consider briefly some problems each American prisoner had to deal with and try to solve. How to remain alive and well integrated as a person and a soldier? How to deal adequately with his fears of non-repatriation, death and torture? How to maintain a consistent life viewpoint under conditions where his basic values and beliefs were being undermined and his self-respect was threatened daily? How to maintain a solid, dependable position in the group and salvage friendships under conditions of mistrust, lack of sound leadership and social

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POW's in Korea

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disorganization? How to deal with his feelings when he became aware of his weaknesses (real or fancied)? These were severe stresses to place on any mature, well-disciplined person over a long period of time; the less maturity and less personality integration to begin with, the greater the weight of decision. This was an individual dilemma. The way it was resolved was no doubt conditioned by the fundamental personality dynamics and structure of each prisoner of war.

A review of data developed in the long-range and intensive studies wherein facts and opinions were checked and re-checked can now be considered to determine the degree of success of the indoctrination program and highlight certain areas which need be given attention not alone by the military establishments but, also, by all other citizens in our republic.

Nearly 3,000 U.S. Army personnel who became prisoners of North Korean and Chinese Communists forces died in Korea. Some who died in marches to prisoner camps were not recorded and those who died of wounds before being registered are not included in this total. Translated into percentage, at least 38% of Americans who became prisoners died in captivity; *4,428* were repatriated.

As a comparison, in WW II of Americans who became prisoners of the Nazis (who generally respected the Geneva Convention articles) 3% died in captivity, 79% were repatriated and 18% escaped and returned.

The average age of American troops at time of becoming prisoners of war, as mentioned earlier, was 21 years; the average formal educational level was 9th grade; 5% were officers, 38% were non-commissioned officers; 57% were men below the rank of sergeant; 50% had less than one month of foreign military duty prior to Korea; 84% had had no prior combat service and 1% had been prisoners of war previously.

Ninty-seven per cent of returned POWs were subjected to enemy indoctrination during their internment. Only 10% of the PWs received non-communistic news of any type during their captivity; this from local news clippings and sports news sent to them from home. Fifteen per cent had been given suggestions for Com-

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munist-oriented activities to be carried on after their release; in formal interrogation by their captors less that ½ of 1% had been asked ONLY their name, rank and serial number; 91% had written autobiographies as part of the interrogation procedures.

Many of the returned PWs had contributed (wittingly and unwittingly) to communistic psychological warfare efforts in Korea. The major contributions of those men were: signing communistic propaganda petitions, making propaganda recordings, writing articles for newspapers, writing propaganda petitions, circulating petitions, performing full-time propaganda duties (e.g., cartoonist or writer).

In reviewing records, it was determined that among the U.S. personnel 10 to 15% had resisted Communist indoctrination vigorously, 70 to 75% had not gone beyond signing some propaganda items and 13% (1 in 7) had collaborated actively with the Chinese Communists; 21 (or ½ of 1%) refused repatriation. (A few of these have since returned home.)

The resisters among the POWs had received a high number of battle wounds, indicative of resistance to capture. Very few active collaborators had been wounded in combat. Those who collaborated actively came out of prisoner camps in much better physical condition than did the resisters but psychiatrists agreed that the mental health of resisters was much better.

Psychiatrists found more collaborators with symptons of psychiatric disorder than among resisters. British doctors came out with the same findings among their returned prisoners. In estimates made by competent civilian authorities of mental illness among the general population, the rate of 8% (or 1 in 12 people) has been quoted to indicate those who at some time in their lives will need psychiatric care. It is interesting to note the active collaborator rate (13 to 15% or 1 in 7) among the prisoners of war is very much in line with this estimate. The inference can be drawn with a fair degree of accuracy, that the emotionally unstable and mentally ill were most likely to respond to the continued, planned stress of indoctrination procedures.

It is well to stress that the 13% (1 in 7) who were in the category of "collaborators" did so in varying degrees. When all facts were weighed only 192 or a ratio of *1 in 23* (or 4%) of the

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POW's in Korea

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American POWs was suspected of serious offenses directly against comrades of the U.S. This data should help clarify the misconceptions about the stamina and basic stability of American youth. As a point of reference, we should realize that 1 in 15 persons in the civilian population of the U.S. has been arrested and fingerprinted for the commission, or alleged commission of criminal acts. In sifting the data, *82 of the 192* were considered for trial by court martial, but after final screening only *47* were approved for this action.

From statistics, the typical collaborator has been described as a "man of unstable character who might have become a psychiatric casualty and who let himself be captured with little struggle, blaming his plight on others."

On repatriation the psychiatric diagnoses were summarized as follows: 80% in good mental health, 9% psychoneurotic, 5% character and behavior disorders, 3% transient personality defects; 2% mentally deficient, 1% psychotic. It is interesting to note that the incidence of psychiatric disorder to the degree requiring hospitalization was no higher than that of the civilian population of the country as a whole.

When evaluated at repatriation (August-September 1953) and enroute to the U.S. the men did show markedly the effects of their ordeal. Typically they were lacking in interest in their environment, had a restricted outlook, were uncommunicative and fearful, expressed few plans or interests in the present and future, and discussed their lives in an unemotional way. Most were apathetic; many were limited in their capacity to elaborate ideas which they did express. Beneath the surface, they were turbulent, ready to be very aggressive and capable of a strong emotional reaction.

In retrospect, a few other pertinent factors became apparent. Those who collaborated generally did so for materialistic rather than ideological reasons. Actually, many of the active resisters were subjected to more severe maltreatment than were many of the active collaborators.

The Turks who were captured had no collaborators; they maintained a solid front and morale was always high. They adapted themselves to the diet and scrounged for food. They maintained rigid discipline with rank respected as it was prior to capture; they refused to participate in indoctrination sessions; they stressed the point that if a leader was removed, the next in rank would be in command so that segregation would be useless; they believed in their cause; they cared for one another. The had a language barrier in their favor but when an interpreter was located, he was sent away rapidly. This comparison is cited as an example of how the psychological approach to convert men's minds was dealt with effectively.

Finally, consideration must be given to such questions as: If stress and methods were generally employed to reach all American prisoners, what characteristics were evident among those who collaborated actively? Among those who resisted effectively and actively and among those who took a middle-of-the-road stand while prisoners of war?

A psychiatrist who played a key role in studies made of returned prisoners and examined a very large number of them, proposed working hypotheses drawn from his assembled data and clinical impressions. These are worthy of consideration to epitomize conclusions drawn in the area of psychological dynamics.

Among the 10 to 15% of the repatriated prisoners who met all criteria of definite active collaborator, he believed three descriptive groups emerged:

(1) One group was made up of individuals who had little capacity to tolerate continuing stress. These gave up readily. They were persons who had an earlier history of quitting when under pressure. The degree of moral stamina was low.

(2) Another group was made up of opportunists: individuals of weak self-concepts who always look for an edge to gain a favorable position even at the expense of others. It was noted that these individuals rather typically attempted to play the role of the informer even on repatriation and tried to impress officers with their offers of assistance. None of these really had accepted Communist doctrine nor had they really grasped the technics to which they had been exposed.

(3) The smallest group of collaborators were those who really accepted Communism. Typi-

Continued on page 1836

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POW's in Korea

Continued from page 1826

cally, they were persons who had been unable to form any strong personal relationships or loyalties in their earlier life. They were emotionally immature and very insecure as persons. Apparently they were motivated to become identified with any other social plan than the one in which they had been reared wherein they had been unsuccessful and unsatisfied.

The largest group (middle-of-the-road neutral) was made up of men who chose what seemed to them the line of least resistance yet retained a basic intactness. When group discipline was not evident they took individual means to protect themselves. They complied outwardly with the lesser demands. They would not participate in traitorous acts, yet they were unrealistic in their adaption. By their passive compliance they enhanced the success of their indoctrinators.

The men who were strong resisters fell into two groups. The smaller group was made up of persons who had a long history of resistance to and unwillingness to accept any authority. In the prison camp they were consistent in their pattern of adjustment (just as at the other end of the scale the collaborators were rather consistent in terms of their personality dynamics). This small group was not too effective, as their means of resistance was often too blatant and often served no effective purpose. For example, in anger over something they did not like they might burn down a few cottages. They knew they would be punished and they were, but so were some others who lacked the shelter which was burned down. By active physical resistance they brought on harsher retaliation.

The last group (about 10% of those repatriated) of active resisters was composed of mature, well-integrated, intelligent, adaptable men who knew how to deal with others effectively. They refused to submit to indoctrination and maintained this personal and military integrity throughout the period spent as prisoners. Typically, these men possessed a good set of personal values; firm faith, acceptance of themselves, consideration for others and a willingness to assist others whenever possible, thus enhancing their own integrity and manifested a clear concept of their role and status as adult military men.

Conclusion

It was good to have had this opportunity to review the problem of indoctrination as employed by the Communist Chinese. Through understanding we eliminate fear, and are better able to take definite preventive action to deal with such efforts if they should ever be used again. Analysis has shown there is nothing mysterious about the process. Definite action has been initiated to include what has been learned about indoctrination in training of soldiers in the army. In the training guide issued by Hqs., 2nd U.S. Army at Ft. Meade, there is included: "The soldier must be trained to use knowledge and information as weapons . . . Determined resistance to enemy indoctrination technics is not only logical and possible but is the only honorable course of action open to an American soldier." In my opinion the groundwork for knowledge must be laid well before a man is enrolled in the military service—as an enlisted man or officer. This responsibility for youth is one shared by parents, church and educators. In a Republic it is a citizen's responsibility to be informed, to make deci-

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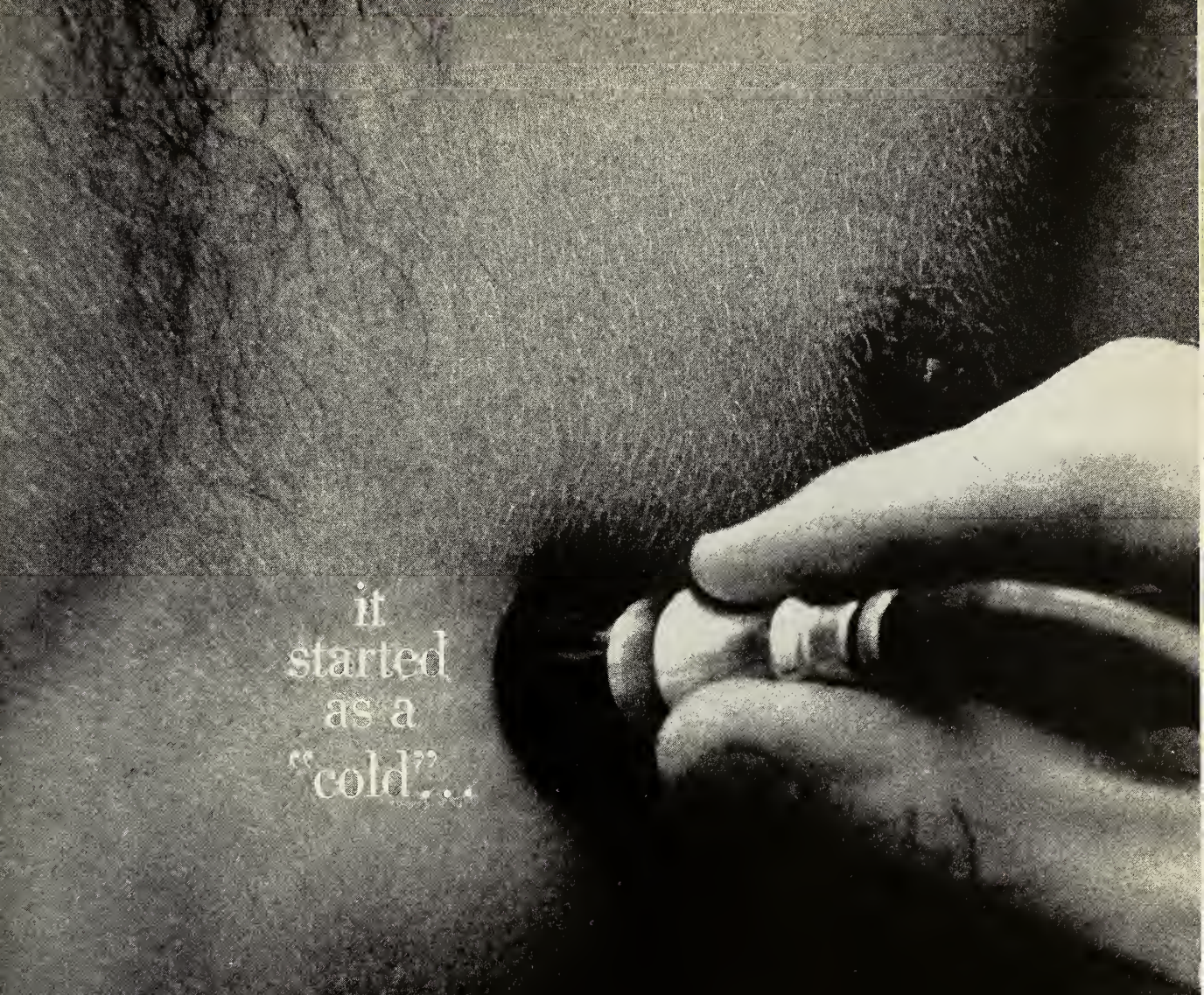
Operating

Maplecrest—

Restful, congenial homelike surroundings are combined with the most modern diagnostic and therapeutic equipment.

Maplewood—

Most comfortable home for individuals requiring rest, scientific diagnosis and treatment. Fireproof construction.



to prevent the sequelae
of u.r.i. ... and relieve the
symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Pneumonitis, otitis, tonsillitis, adenitis, sinusitis or bronchitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

POW's in Korea

Continued from page 1836

sions on sound facts, to know and accept the privileges of his heritage in a free nation; but also he must, from his early years, learn and accept his responsibilities and obligations as a citizen.

It is quite apparent that fine group morale, understanding of mission, firm group and self-discipline, silence and non-cooperation with the enemy, knowledge of stresses to which one may be subjected, awareness that firm knowledge and belief in our democratic society provides a bulwark of strength when challenged, a basic fortitude developed throughout early life by exposure to example and precept and a basic system of personal values instilled from infancy onward with belief in the soundness of one's convictions can withstand onslaughts from perverted enemies and provide an effective character-basis for aggressive defense-offense if threatened.

We may well recall the code of conduct which was formulated as a result of the studies made by the Department of Defense and approved by the President. It epitomizes exceedingly well the positive concept adopted by our Armed Forces: "I am an American fighting man. I serve in the forces which guard my country and our way of life. I am prepared to give my life in their defense.

"I will never surrender of my own free will. If in command, I will never surrender my men while they have the means to resist.

"If I am captured I will contiue to resist by all means available. I will make every effort to escape and to assist others to escape. I will accept neither parole nor special favors from the enemy.

"If I become a prisoner of war I will keep faith with my fellow prisoners. I will give no information or take part in any action which might be harmful to my comrades. If I am a senior, I will take command. If not I will obey the lawful orders of those appointed over me and will back them up in every way.

"When questioned, should I become a prisoner of war, I am bound to give only name, rank, service number and date of birth. I will evade answering further questions to the utmost of my ability. I will make no oral or written statements disloyal to my country and its allies or harmful to their cause.

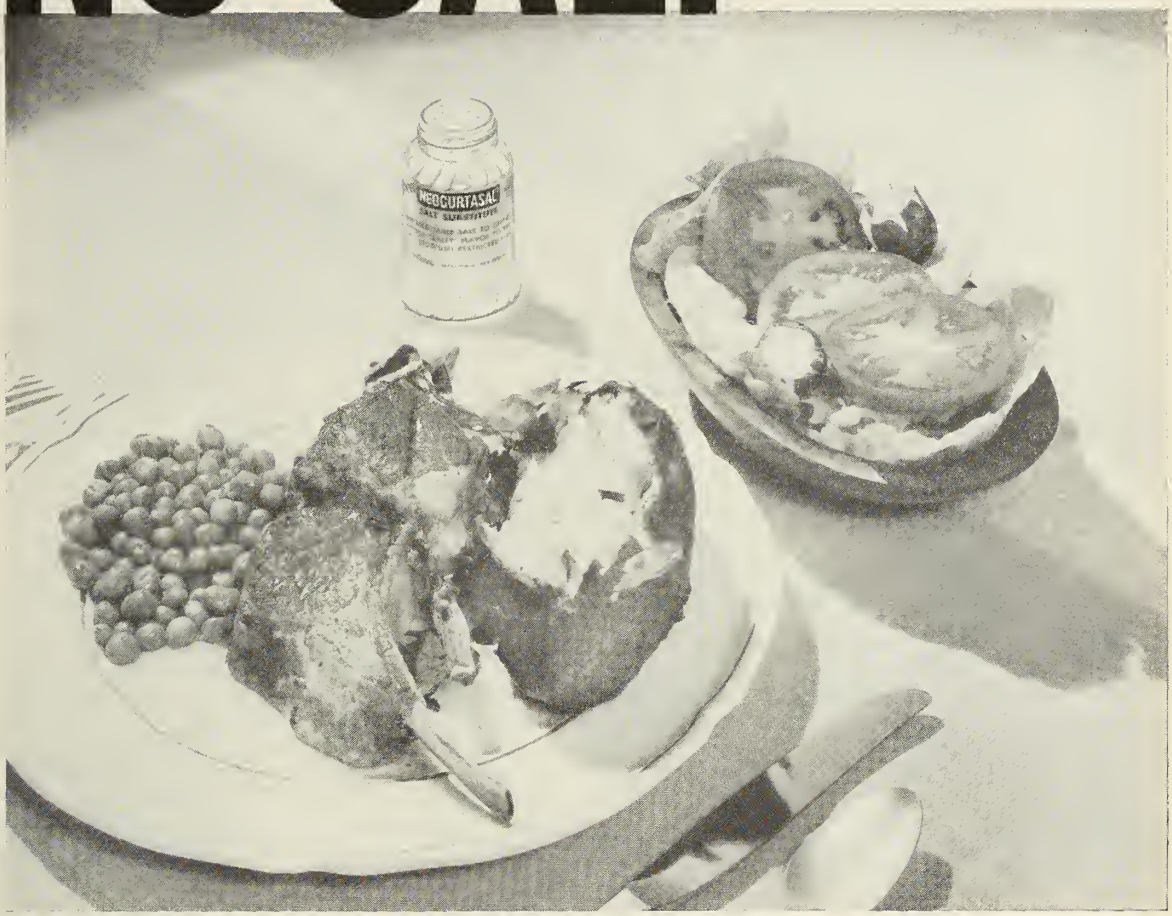
"I will never forget that I am an American fighting man, responsible for my actions, and dedicated to the principles which made my country free. I will trust in my God and in the United States of America." ◄





Would you mind getting those statements out, Miss Carmody, and see if you can work twice as fast as aspirin!"

NO SALT ..*but seasoned*



A meal of even the most colorful and the most meticulously prepared food can be dreary eating without salt. Neocurtasal, for the patient on a low-sodium diet, brings back flavor to foods—makes eating a pleasure once more.

Neocurtasal®

An excellent salt replacement
for
"Salt-Free" (Low Sodium) Diets

Contains potassium chloride, potassium glutamate, glutamic acid, calcium silicate, potassium iodide (0.01%).

2 oz. shakers and
8 oz. bottles

Sold Only Through Drugstores

Winthrop LABORATORIES
New York 18, N.Y.

Assures patient's cooperation

Cesarean Section Rates in Indiana 1955 Through 1957

The Indiana State Board of Health,* in cooperation with the Indiana State Medical Association, has presented in the *Journal* of the Indiana State Medical Association on 2 previous occasions** the Cesarean section rates in Indiana hospitals. The rates for the years 1949 through 1954 were given at those times.

The present figures are for the years 1955, 1956 and 1957. In 1955, there were 104,565 live births in hospitals and 4,067 Cesarean sections which gives a rate of 3.89%. In 1956, there were 110,175 live births and 4,188 Cesarean sections for a rate of 3.8%, and in 1957, there were 112,954 live births and 4,152 Cesarean sections for a rate of 3.68%. Table I shows the percentage by year from 1949 through 1957.

* An activity this year of the Commission on Governmental Services.

** September, 1954, Vol. 47, No. 9; May, 1956, Vol. 49, No. 5.

TABLE I
CESAREAN SECTION RATES FOR ALL HOSPITALS
1949-1957

1949	1950	1951	1952	1953	1954	1955	1956	1957
4.13	4.18	3.92	3.98	3.84	3.91	3.89	3.80	3.68

Table II shows the section rates for 1955 through 1957 for hospitals according to the number of live births in the hospitals.

TABLE II
CESAREAN SECTION PERCENTS GROUPED ACCORDING TO SIZE OF MATERNITY SERVICE

Number of Live Births per pear	1955	1956	1957
Less than 500	4.63	4.35	3.96
500 to 999	4.49	4.43	4.21
1,000 to 1,999	3.68	3.93	3.72
2,000 or more	3.45	3.28	3.29

Table III gives the Cesarean section rates by hospitals for the years 1955 through 1957.

TABLE III
CESAREAN SECTION RATES IN INDIANA
By Hospitals
1955, 1956 and 1957

HOSPITAL AND LOCATION	1955 Live Births	1955 Cesarean Sections	1955 Percent Sections	1956 Live Births	1956 Cesarean Sections	1956 Percent Sections	1957 Live Births	1957 Cesarean Sections	1957 Percent Sections
Adams County									
Decatur									
ADAMS COUNTY MEMORIAL	671	25	3.7	719	18	2.5	672	31	4.6
Allen County									
Fort Wayne									
ST. JOSEPH	1,961	38	1.9	2,012	45	2.2	1,967	42	2.1
PARKVIEW MEMORIAL	2,258	61	2.7	2,404	55	2.3	2,336	64	2.7
LUTHERAN OF FT. WAYNE	1,429	44	3.1	1,747	45	2.6	1,842	54	2.9
Bartholomew County									
Columbus									
BARTHOLOMEW COUNTY	1,136	43	3.8	1,166	43	3.7	1,311	47	3.6
Blackford County									
Hartford City									
BLACKFORD COUNTY	413	10	2.4	403	12	3.0	429	10	2.3

Continued



"... and with your **Blue Shield** *you will have no worry!"*

BLUE SHIELD was organized by the physicians of Indiana for the express purpose of removing the economic shock of unexpected surgery and medical care by providing a method for prepaying a part or all of the cost.

Your patient who is a BLUE SHIELD member can look forward to prompt payment of his claim for your services. For patient satisfaction you can be safe in recommending membership in your own Plan.

THE DOCTORS PLAN — SPONSORED BY INDIANA STATE MEDICAL ASSOCIATION

Blue Shield

Surgical, Obstetrical, and Medical Coverage

110 North Illinois Street, Indianapolis 9, Ind., ME. 5-9411

Cesarean Section Rates

Continued

HOSPITAL AND LOCATION	1955 Live Births	1955 Cesarean Sections	1955 Percent Sections	1956 Live Births	1956 Cesarean Sections	1956 Percent Sections	1957 Live Births	1957 Cesarean Sections	1957 Percent Sections
Boone County									
Lebanon									
WITHAM MEMORIAL	820	30	3.7	826	26	3.1	855	31	3.6
Cass County									
Logansport									
CASS COUNTY MEMORIAL	545	27	5.0	524	26	5.0	506	16	3.2
ST. JOSEPH	585	19	3.2	584	11	1.9	589	17	2.9
Clark County									
Jeffersonville									
CLARK COUNTY MEMORIAL	1,006	36	3.6	1,023	40	3.9	1,065	44	4.1
Clay County									
Brazil									
CLAY COUNTY	437	20	4.6	474	17	3.6	467	16	3.4
Clinton County									
Frankfort									
CLINTON COUNTY	577	27	4.7	540	30	5.5	579	19	3.3
Daviess County									
Washington									
DAVIESS COUNTY	778	71	9.1	817	51	6.2	849	48	5.7
Decatur County									
Greensburg									
DECATUR COUNTY MEMORIAL	452	32	7.1	451	18	4.0	502	23	4.6



they deserve

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CAPSULES—14 VITAMINS—11 MINERALS

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AMERICAN CYANAMID COMPANY, Pearl River, New York

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natural bowel corrective

Senokot®

STANDARDIZED CONCENTRATE OF TOTAL ACTIVE PRINCIPLES OF CASSIA ACUTIFOLIA PODS PURDUE FREDERICK

TABLETS/GRANULES

REHABILITATES THE CONSTIPATED PATIENT— HELPS RESTORE NORMAL BOWEL TONE, RHYTHM, AND SENSITIVITY.

SUPPLIED: **TABLETS: Small and easy to swallow, in bottles of 100.**
GRANULES: Cocoa-flavored, in 8 and 4 ounce canisters.

PF *The Purdue Frederick Company* DEDICATED TO PHYSICIAN AND PATIENT SINCE 1892
NEW YORK 14, N.Y. | TORONTO 1, ONTARIO

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Cesarean Section Rates

Continued

HOSPITAL AND LOCATION	1955 Live Births	1955 Cesarean Sections	1955 Percent Sections	1956 Live Births	1956 Cesarean Sections	1956 Percent Sections	1957 Live Births	1957 Cesarean Sections	1957 Percent Sections
DeKalb County									
Auburn									
DR. BONNELL M. SOUDER	74	3	4.1*	214	6	2.8	209	12	5.7
SANDERS GENERAL	46	4	8.7*	75	3	4.0	42	4	9.5
Garrett									
SACRED HEART	469	24	5.1	431	24	5.6	441	13	2.9
Delaware County									
Muncie									
BALL MEMORIAL	2,587	157	6.0	2,668	147	5.5	2,714	141	5.2
Dubois County									
Jasper									
MEMORIAL HOSPITAL OF DUBOIS COUNTY	561	28	5.0	566	25	4.4	609	23	3.8
Huntingburg									
THE STORK MEMORIAL	485	19	3.9	554	26	4.7	537	25	4.7
Elkhart County									
Elkhart									
ELKHART GENERAL	1,594	52	3.3	1,596	77	4.8	1,675	66	3.9
Goshen									
GOSHEN GENERAL	820	44	5.4	811	57	7.0	879	50	5.7
Fayette County									
Connersville									
FAYETTE MEMORIAL	734	40	5.4	766	46	6.0	788	51	6.5
Floyd County									
New Albany									
MEMORIAL HOSPITAL OF FLOYD COUNTY	711	51	7.2	785	58	7.4	759	46	6.0
ST. EDWARD	756	56	7.4	831	48	5.8	766	53	6.9
Fulton County									
Rochester									
WOODLAWN	399	46	11.5	422	40	9.5	443	36	8.1
Gibson County									
Princeton									
GIBSON GENERAL	459	1	0.2	462	7	1.5	429	10	2.3
Oakland City									
OAKLAND CITY	95	4	4.2	51	1	2.0*	97	---	--
Grant County									
Marion									
MARION GENERAL	1,675	91	5.4	1,715	71	4.1	1,872	85	4.5
Greene County									
Linton									
FREEMAN GREENE COUNTY	492	71	14.4	508	61	12.0	486	52	10.7
Hamilton County									
Noblesville									
RIVERVIEW	605	37	6.1	694	36	5.2	771	35	4.5
Hancock County									
Greenfield									
HANCOCK COUNTY MEMORIAL	508	12	2.4	594	22	3.7*	671	14	2.1
Harrison County									
Corydon									
HARRISON COUNTY	395	11	2.8	401	14	3.5	388	7	1.8
Henry County									
New Castle									
HENRY COUNTY	1,293	30	2.3	1,299	45	3.5	1,230	43	3.5

HOSPITAL AND LOCATION	1955 Live Births	1955 Cesarean Sections	1955 Percent Sections	1956 Live Births	1956 Cesarean Sections	1956 Percent Sections	1957 Live Births	1957 Cesarean Sections	1957 Percent Sections
Howard County									
Kokomo									
ST. JOSEPH MEMORIAL	1,540	63	4.1	1,681	84	5.0	1,888	96	5.1
Huntington County									
Huntington									
HUNTINGTON COUNTY	709	17	2.4	771	16	2.1	751	10	1.3
Jackson County									
Seymour									
JACKSON COUNTY SCHNECK MEMORIAL	994	53	5.3	1,080	44	4.1	1,085	37	3.4
Jasper County									
Rensselaer									
JASPER COUNTY	494	26	5.3	501	22	4.4	519	21	4.0
Jay County									
Portland									
JAY COUNTY	472	28	5.9	446	22	4.9	509	21	4.1
Jefferson County									
Madison									
KING'S DAUGHTERS'	871	38	4.4	707	21	2.9	680	25	3.7
Johnson County									
Franklin									
JOHNSON COUNTY MEMORIAL	841	23	2.7	978	15	1.5	1,085	26	2.4
Knox County									
Vincennes									
GOOD SAMARITAN	943	52	5.5	983	55	5.6	1,010	72	7.1
Kosciusko County									
Warsaw									
MURPHY MEDICAL CENTER	230	15	6.5	254	8	3.1	574	20	3.5
LaGrange County									
LaGrange									
LA GRANGE COUNTY	475	15	3.1	479	24	5.0	549	20	3.6
Lake County									
Gary									
ST. MARY'S MERCY	2,882	60	2.1	3,318	66	2.0	3,481	72	2.1
METHODIST OF GARY, INC.	3,987	97	2.4	4,269	130	3.0	4,444	117	2.6
East Chicago									
ST. CATHERINE	2,468	93	3.8	2,690	96	3.6*	2,842	105	3.7
Hammond									
ST. MARGARET	3,884	146	3.7	4,079	137	3.3	4,440	142	3.2
LaPorte County									
Michigan City									
ST. ANTHONY	858	24	2.8	872	22	3.8	929	19	2.0
DOCTORS' HOSPITAL	37	2	5.4*	105	5	4.8*	378	18	4.8
LaPorte									
FAIRVIEW	607	33	5.4	554	45	8.1	523	43	8.2
HOLY FAMILY	508	36	7.1	465	30	6.5	522	28	5.4
Lawrence County									
Bedford									
DUNN MEMORIAL	917	48	5.2	991	47	4.7	991	62	6.3
Madison County									
Anderson									
ST. JOHN'S HICKEY MEMORIAL	2,234	123	5.5	2,403	158	6.6	2,379	135	5.7
Elwood									
MERCY	520	6	1.2	524	10	1.9	513	14	2.7

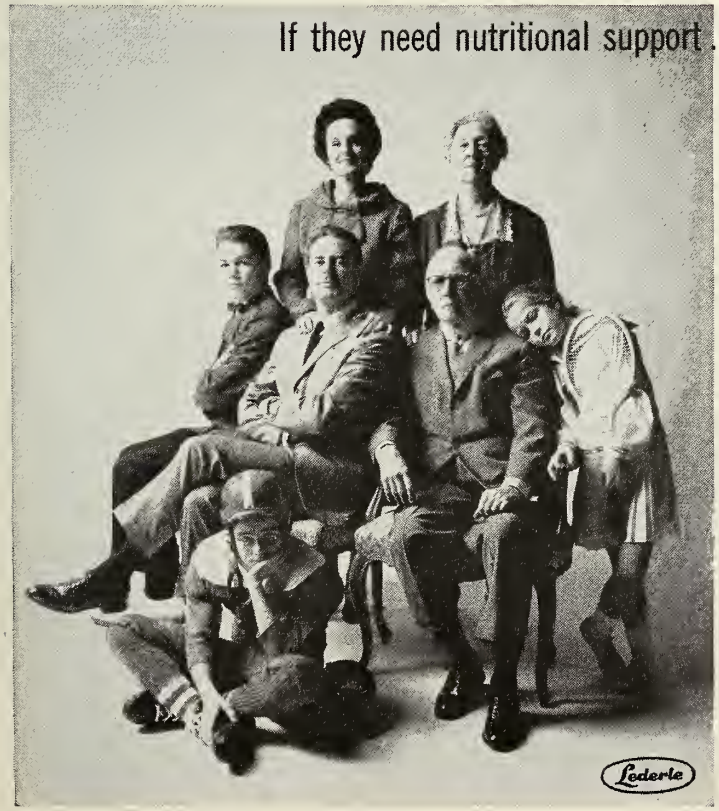
Cesarean Section Rates

Continued

HOSPITAL AND LOCATION	1955 Live Births	1955 Cesarean Sections	1955 Percent Sections	1956 Live Births	1956 Cesarean Sections	1956 Percent Sections	1957 Live Births	1957 Cesarean Sections	1957 Percent Sections
Marion County									
Beech Grove									
ST. FRANCIS	3,332	52	1.6	3,426	50	1.5	3,135	55	1.8
Indianapolis									
METHODIST	6,484	238	3.7	6,628	212	3.2	5,723	222	3.9
ST. VINCENT'S	2,466	60	2.4	2,712	54	2.0	2,519	58	2.3
INDIANAPOLIS GENERAL	2,449	35	1.4	2,644	67	2.5	2,722	51	1.9
I. U. MEDICAL CENTER	2,754	168	6.1	2,863	145	5.1	2,731	155	5.7
ST. ELIZABETH'S MATERNITY	49	---	--	38	---	--	51	---	--
COMMUNITY	----	---	--	362	12	3.3*	2,605	72	2.8
Marshall County									
Plymouth									
PARKVIEW	433	29	6.7	396	18	4.5	418	13	3.1
Bremen									
COMMUNITY HOSPITAL OF GERMAN TOWNSHIP	235	---	--	267	---	--	259	---	--
Miami County									
Peru									
DUKES MEMORIAL	635	8	1.3	708	24	3.4	---	---	--
Monroe County									
Bloomington									
BLOOMINGTON	1,263	56	4.4	1,439	63	4.4	1,466	51	3.5
Montgomery County									
Crawfordsville									
MONTGOMERY COUNTY CULVER UNION HOSP.	593	23	3.9*	656	28	4.3*	862	24	2.8
Morgan County									
Martinsville									
MORGAN COUNTY MEMORIAL	402	7	1.7	461	2	0.4	496	2	0.4
Noble County									
Kendallville									
MC CRAY MEMORIAL	341	41	12.0	328	34	10.4	342	21	6.1
Wolflake									
LUCKEY	74	3	4.0*	49*	---	--	---	---	--
Perry County									
Tell City									
PERRY COUNTY MEMORIAL	418	2	0.5	473	10	2.1	444	7	1.6
Porter County									
Valparaiso									
PORTER MEMORIAL	924	40	4.3	1,075	57	5.3	1,057	44	4.2
Pulaski County									
Winamac									
CARNEAL'S PRIVATE	150	3	2.0	148	---	--	130	1	0.8
Putnam County									
Greencastle									
PUTNAM COUNTY	552	24	4.3	621	24	3.9	589	19	3.2
Randolph County									
Winchester									
RANDOLPH COUNTY	457	29	6.3	493	41	8.3	461	41	8.9
Union City									
UNION CITY MEMORIAL	2.19	22	10.0	238	19	8.1	183	13	7.1

HOSPITAL AND LOCATION	1955 Live Births	1955 Cesarean Sections	1955 Percent Sections	1956 Live Births	1956 Cesarean Sections	1956 Percent Sections	1957 Live Births	1957 Cesarean Sections	1957 Percent Sections
Ripley County									
Batesville									
MARGARET MARY	840	15	1.8	906	31	3.4	860	20	2.3
Milan									
WHITLATCH CLINIC	317	2	0.6	305	6	2.0	372	8	2.2
Rush County									
Rushville									
RUSH MEMORIAL	622	12	1.9	630	12	1.9	633	10	1.6
St. Joseph County									
South Bend									
MEMORIAL OF SOUTH BEND	2,143	94	4.4	2,115	95	4.5	2,105	73	3.5
ST. JOSEPH'S	2,009	76	3.8	2,260	82	3.6	1,967	73	3.7
SOUTH BEND OSTEOPATHIC	878	26	3.0	862	33	3.8	882	42	4.8
Mishawaka									
ST. JOSEPH	1,106	27	2.4	1,042	27	2.6	1,069	33	3.1
Scott County									
Scottsburg									
NAPPER	---	---	--	---	---	--	427	---	--
Shelby County									
Shelbyville									
WILLIAM S. MAJOR	715	17	2.4	760	20	2.6	764	12	1.6
Starke County									
Knox									
STARKE MEMORIAL	503	30	6.0	469	28	6.0	480	25	5.2

Continued to page 1850



GEVRAL®

Vitamin-Mineral Supplement Lederle

CAPSULES—14 VITAMINS—11 MINERALS

Each capsule contains:	
Vitamin A	5,000 U.S.P. Units
Vitamin D	500 U.S.P. Units
Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate	1/15 U.S.P. Oral Unit
Thiamine Mononitrate (B_1)	5 mg.
Riboflavin (B_2)	5 mg.
Niacinamide	15 mg.
Folic Acid	1 mg.
Pyridoxine HCl (B_6)	0.5 mg.
Ca Pantothenate	5 mg.
Choline Bitartrate	50 mg.
Inositol	50 mg.
Ascorbic Acid (C)	50 mg.
Vitamin E (as tocopheryl acetates)	10 I.U.
l-Lysine Monohydrochloride	25 mg.
Rutin	25 mg.
Ferrous Fumarate	30 mg.
Iron (as Fumarate)	10 mg.
Iodine (as KI)	0.1 mg.
Calcium (as $CaHPO_4$)	157 mg.
Phosphorus (as $CaHPO_4$)	122 mg.
Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF_2)	0.1 mg.
Manganese (as MnO_2)	1 mg.
Magnesium (as MgO)	1 mg.
Potassium (as K_2SO_4)	5 mg.
Zinc (as ZnO)	0.5 mg.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

NIAMID*

the mood brightener

EFFECTIVE AND WELL TOLERATED

in depression

NIAMID has been found to be strikingly effective and well tolerated in a broad range of depressive states including a wide variety of the milder depressive syndromes, as well as the masked depression so frequently seen in general practice. These syndromes include: depression associated with the menopause, postoperative depressive states and senile depression; depression accompanying chronic or incurable illness, such as gastrointestinal and cardiovascular disorders and inoperable cancer.

in angina pectoris

NIAMID, in intensive clinical tests, has proved to have a high degree of safety and to be a valuable adjunct in the management of the anginal syndrome. NIAMID produces striking symptomatic improvement in angina patients—markedly reduces the pain, severity and frequency of anginal episodes, reduces nitroglycerin requirements, and provides an increased sense of well-being. Since dramatic improvement is seen in some patients, it is wise to advise the patient against overexertion—his disorder still holds potential dangers despite relief of symptoms.

DOSAGE: Start with 75 mg. daily in single or divided doses. After a week or more, adjust the dosage, depending upon patient response, in steps of one or one-half 25 mg. tablet. Once improvement is seen, gradually reduce dosage to the maintenance level. Many patients respond to NIAMID within a few days, others in 7 to 14 days. A few patients may require as much as 200 mg. daily over a longer period of time before significant improvement is seen.

PRECAUTIONS: Side effects are infrequent and mild, and often lessened or eliminated by a reduction in dosage. Hypotensive effects have rarely been noted and no jaundice or other evidence of liver damage has been reported in patients receiving NIAMID. However, in patients with a history of liver disease, the possibility of hepatic reactions should be kept in mind.

SUPPLY: NIAMID is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

Already clinically proved in several thousand patients—

Complete references and a Professional Information Booklet giving detailed information on NIAMID are available on request.

Pfizer *Science for the world's well-being*

*Trademark for brand of nialamide

PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York



Cesarean Section Rates

Continued from page 1847

HOSPITAL AND LOCATION	1955 Live Births	1955 Cesarean Sections	1955 Percent Sections	1956 Live Births	1956 Cesarean Sections	1956 Percent Sections	1957 Live Births	1957 Cesarean Sections	1957 Percent Sections
Steuben County									
Angola									
CAMERON	188	4	2.1	241	6	2.5	229	6	2.6
ELMHURST	264	2	0.7	279	5	1.8	240	6	2.5
Sullivan County									
Sullivan									
MARY SHERMAN	441	10	2.3	460	14	3.0	409	21	5.1
Tippecanoe County									
Lafayette									
ST. ELIZABETH	1,546	68	4.4	1,695	59	3.5	1,842	76	4.1
LAFAYETTE HOME	1,451	87	6.0	1,343	84	6.3	1,286	83	6.5
Tipton County									
Tipton									
TIPTON COUNTY MEMORIAL	505	42	8.3	480	40	8.3	526	37	7.0
Vanderburgh County									
Evansville									
PROTESTANT DEACONESS	2,914	89	3.0	2,867	83	2.9	2,706	82	3.0
ST. MARY'S	1,305	28	2.1	1,443	44	3.0	1,850	46	2.5
WELBORN MEMORIAL BAPTIST	845	28	3.3	814	30	3.7	673	27	4.0
Vermillion County									
Clinton									
VERMILLION COUNTY	556	37	6.7	594	31	5.2	562	28	5.0
Vigo County									
Terre Haute									
ST. ANTHONY	1,172	25	2.1	1,152	19	1.6	1,140	17	1.5
UNION	1,473	57	3.9	1,592	49	3.1	1,581	43	2.7
HOOVER SANATORIUM	28	---	--	5*	---	--	---	---	--
Wabash County									
Wabash									
WABASH COUNTY	623	35	5.6	685	42	6.1	649	41	6.3
Warren County									
Williamsport									
COMMUNITY	180	---	--	150	1	.67	160	15	9.4
Washington County									
Salem									
WASHINGTON COUNTY MEMORIAL	496	19	3.8	506	27	5.3	583	33	5.7
Wayne County									
Richmond									
REID MEMORIAL	1,648	88	5.3	1,637	82	5.0	1,560	70	4.5
Wells County									
Bluffton									
WELLS COUNTY	302	15	5.0	312	20	6.4	256	7	2.7
CLINIC	172	3	1.7	204	7	3.4	181	4	2.2
White County									
Monticello									
WHITE COUNTY MEMORIAL	---	---	--	251	4	1.6*	366	17	4.6
Whitley County									
Columbia City									
WHITLEY COUNTY MEMORIAL	397	25	6.3	446	15	3.4	536	17	3.2
TOTALS (State of Indiana)	104,565	4,067	3.89	110,172	4,188	3.80	112,954	4,152	3.68

* Does not include a full year's report.

NEWS NOTES—from State and Nation

Annual Civil Defense Convo Slated for November

The 10th annual County Medical Societies Civil Defense Conference will be held in Chicago, Nov. 7-8, at the Morrison Hotel.

Purpose of the conference, which is sponored by the American Medical Association's Council on National Defense, is to inform and assist medical and health personnel for their roles in the event of a disaster.

According to Dr. Carl J. Sprunk, Detroit, conference chairman, the conferees will have an opportunity to:

—Participate in workshop sessions concerning medical preparedness to cope with disasters.

—Discuss and exchange information dealing with emergency medical services.

—Gain information on the availability of pamphlets and articles devoted to the medical and health aspects of civil defense.

—Hear outstanding speakers report on appropriate civil defense and disaster topics.

Methods employed in handling two disasters which occurred within the past year will be discussed during the two-day meeting. These include the fire in Chicago's Our Lady of the Angels' school and the tornado which struck St. Louis.

Congressman Melvin Price (D., Ill.), a ranking member of the Joint Congressional Committee on Atomic Energy, will report on recent findings on the environmental and biological effects of nuclear warfare.

Additional information regarding the conference can be obtained from Mr. Frank W. Barton, Secretary, Council on National Defense, American Medical Association, 535 N. Dearborn, Chicago 10, Illinois.

Dr. Walter U. Kennedy, New Castle, past-president of ISMA, has been appointed by President Eisenhower to the National Advisory Committee for the White House Conference on Aging. The conference will take place in Washington in January, 1961.

Dallas Site of Sports Injuries Meeting

The first national Conference on the Medical Aspects of Sports, sponsored by AMA will be held Nov. 30 in Dallas, Texas.

The one-day meeting is for college and high school athletic directors, coaches, trainers and doctors. "These are the individuals who are charged with responsibility for the health of athletes," said Dr. Allan J. Ryan, Meriden, Conn., chairman of the AMA Committee on the Medical Aspects of Sports.

Dr. Ryan pointed out that the conference will deal with a wide variety of medical subjects which affect the athlete's total well being. These include training, conditioning, prevention and treatment of injuries, and the physiology of exercise.

Highlights of the program will be panel discussions of on-field responsibilities of the team physician and prevention of head injuries in athletics. Other discussions will concern amphetamines and the attitudes of athletes; a medical program for high school football; exercise and the oxygen debt; the biodynamic potential of the American male; exercise and the kidney, and the pathology of trauma.

The national Conference on the Medical Aspects of Sports will precede the clinical meeting of the AMA, which begins December 1 in Dallas and continues for four days.

Allergy Forum Scheduled

The annual meeting of the Mid-West Forum on Allergy is scheduled for Oct. 31 and Nov. 1, 1959, at the Sheraton-Blackstone Hotel, Chicago. The meeting is sponsored by the Chicago Society of Allergy.

For further information, contact Leon Unger, M.D., 185 North Wabash Avenue, Chicago 2.

Dr. George S. Porter has announced the opening of an office in Richmond, Ind. His practice is limited to obstetrics and gynecology.

Dr. "Bill" Ferree Named to National Post

John W. "Bill" Ferree, M.D., graduate of Indiana University School of Medicine, formerly with the Indiana State Board of Health, and State Health Commissioner from 1940 to 1942, has been appointed executive director of the National Society for the Prevention of Blindness. Dr. Ferree has been in charge of community service and educational activities for the American Heart Association the past 11 years; since 1957 he has been associate medical director of the Heart Association.

A recently retired North Vernon physician, Dr. John H. Green, has received the "Golden Deeds Award," the highest honor accorded a citizen by the North Vernon Exchange Club. Dr. Green is a senior ISMA member.

An Indianapolis physician, Dr. James H. Gosman, will serve as chairman of the steering committee of the Indiana division of the American Cancer Society in Marion County.

Dr. Gosman is also a member of the American Cancer Society board of directors.

Dr. Gilbert Rhea, long-time Greencastle physician, is retiring from his practice to go into student health work in a mid-western university.

Dr. George L. Regan, Sellersburg physician, has been named "outstanding graduate" of the Silver Creek High School by the school's alumni association.

Dr. Carl W. Bassler, Mishawaka, senior ISMA member, has retired from active practice. He maintained his office in Mishawaka for over 40 years.

Lighter Vein—

The American people are so tense that it is impossible to put them to sleep with a sermon.—Norman Vincent Peale, *Hoard's Dairyman.*

History of Transportation:

1860—Dear Teacher: Please excuse Mary for absence from school yesterday because it was her brother's turn to wear the shoes.

1900—Dear Professor: John missed school today because the horse succumbed to an attack of glanders on Murder Hill.

1910—Dear Principal: Jane was absent yesterday because her father broke his arm cranking the Ford.

1950—Dear Suptd: Willie overslept and the school bus wouldn't wait for him.

1960—Dear Announcer: Karen missed her lesson yesterday because the TV tube blew out.—Frederick J. Moffitt, *Nation's. Schools*

The first thing a driver should learn is the difference between a freeway and a runway.—Steve Still.

One good turn deserves another, but just try getting someone to start the whole thing going.—Chas. Ruffing.

This isn't the beat generation, it's the gone generation. Every time anyone tries to put his foot down they aren't there.—Vesta M. Kelly.

Anybody who can live on love probably runs a drive-in movie.—Franklin P. Jones.

The good old days were when policemen didn't hide at the side of a busy road, but took their chances in traffic like anyone else.—Terry McCormick, *Link.*

Watch out for temptation—The more you see of it, the better it looks.—Arnold H. Glasgow.

To find out what your doctor recommends these days, watch telcvision.—Frank G. McInnis.

The poorest man is not he who is without a cent, but he who is without a dream.—Eugene P. Bertin, *Pennsylvania School Journal.*

Civilization can be measured by the degree of helplessness when the electricity goes off.—Dan Bennett.

Distressed and bewildered over the way her favorite neighbors, young Mr. and Mrs. Doyle, were selling their collie's entire litter of cuddly pups, 4-year-old Lynn took to avoiding her usual drop-in visits with them. But one day they called her over for a chummy cookie-and-milk session from which she ran home bright-eyed and happy, proclaiming wonderful news: "Mommy, Mommy, Mrs. Doyle's going to have a baby, and guess what—they're going to keep it!"—Martha H. Freedman.

One of the great advantages of success lies in the fact that you don't have to listen to good advice any more.—French Painter Bernard Buffet.

Add 1

by corki

Indiana Progresses in Economic Blast; Human Element in Technology; Special Memo

Indiana is a real going state. Progressive, that is. A good place to be. Like, man, it's on wheels that are rolling along to a real economic blast; a good solid future, that is!

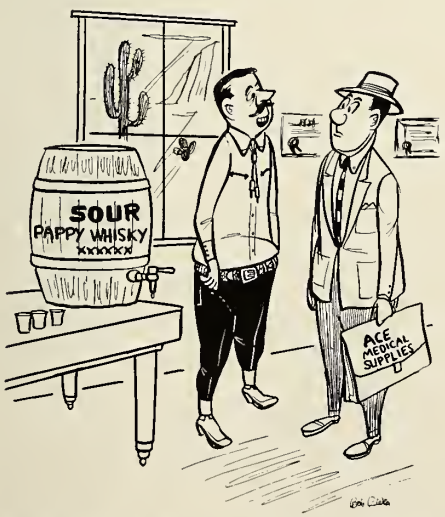
Business is booming with a total of 103 new industries moving into Indiana during the first six months of 1959—an average of 17 a month.

This certainly has its effects on physicians, not only as *physicians* but as *individual citizens!*

Bruce Hunt, executive director of Indiana Department of Commerce, Industry and Public Relations, told a gathering of Indiana Industrial Editors Association members that all of this is in addition to expansions of existing industry.

According to Mr. Hunt, records show that Indiana has led the nation in industrial expansion on a per capita basis for the past six consecutive years.

Reasons for this are explained in a provocative little booklet published by Mr. Hunt's department. On the cover it says "Where in Debt-Free Indiana Does Industry Prefer to Locate?" Turn it upside down and over, and you have a new cover saying "Why so much industry prefers to locate in Debt-Free Indiana."



"Well, I'll tell you, son. I haven't needed any supplies in a long time! The only thing I've been treating in this town is snakebite cases!"

Those titles give one of the main reasons industry is on the upswing in our Hoosier state. Seems we're some sort of a phenomenom in modern economics. WE'RE DEBT FREE! Other state and local governments, according to the booklet, are billions in debt, "up to 200% in 10 years" (and most of you know of the plight of Michigan).

Seems Indiana's Constitution forbids bonded state debt, which means "Hoosiers still 'Pay as they go.'" And which means new industries "don't pay yesterday's bills!"

All of which *would* be mighty appealing to industry!

Other reasons include the fact that Indiana is comparatively tax-free, that "moderation and home rule" has been the keyword of the state, there is "No big city domination," it is a "Balanced state" with all kinds of industry in all parts of the state. This according to the booklet in question.

Indiana's Right-to-work law is given a big chunk of the credit for inducement to new industry, along with a good labor market that is "versatile, responsible, adaptable, capable and plentiful." And, "Indiana is now the Center of almost Everything."

Well, like as not to bore you too much, the book goes on and on to explain this tremendous expansion of industry in Indiana.

Any average citizen-economist can see what this means to the economy of the state and to the individual citizen.

I especially liked the bit about Hoosiers not using "gimmicks to woo new industry," but are genuinely warm and friendly to newcomers. The old Hoosier hospitality paying off in cash for its citizens.

So, doctor, expect a surge of growth in your

Add 1

Continued

state—all of which isn't going to hurt the medical profession. A healthy local economy will make itself felt in all our lives . . . and might even set the pace for the nation.

A Cure Not a Prevention. In line with this note on Hoosier progress comes a front page story in the *Indianapolis Star* by Edward H. Frank to the effect that Mayor Boswell has unveiled plans to revamp the city's entire traffic system . . . and about time! That's a point of progress needed like a polio shot is needed by individuals. Only instead of a shot in the arm for *prevention*, this is a prescription for a *cure*. We hope.

It's a new traffic light system. "The ultra-modern, highly versatile system will provide remote control and constant synchronization of every signal, enabling signal time to be changed to meet fluctuating traffic with the flick of a dial." That's what the man says.

Like space has been set aside in the new City-County Building to house the station for this "ultra high frequency" radio control system.

Won't go into the whole story—it's a long one—but will quote Mr. Frank on one paragraph. "At Washington, where the control station and 86 intersections were equipped for $157,000, residents report they can drive downtown without being stopped by a red light."

I say great . . . but would like to remind one and all that any technical system still depends upon the *human element*.

Like I've traveled Michigan or New York streets (one-way west and east respectively) without catching a stop light during off-traffic hours. It can be done. But it can't be done when a few one-horse shay drivers cause traffic jams by going 20 mph!!

When our traffic officers make a habit of tabbing drivers who go too slow as quick as they stick them for going a couple miles over the speed limit, even our inadequate system now in effect would work better in moving the too-heavy volume of Nap Town traffic!

Memo to County Societies: The *Journal* would like to let the rest of the state know what you're doing . . . but we have to receive a report from *you* first. Most of the notes we run on county society activities have to be picked up from the little report form you send the executive secretary, or those filed by field secretaries. Usually they are all too brief . . . and, hang onto the temper now, the longhand writin' reads more like a prescription in Latin!

For an instance of a good report, take a peep at the report from Vanderburgh County in this issue. That was sent in special and typed. Makes a good account of that county's activities. Let's have more of it.

And, doctor, before you have a coronary saying it doesn't get in for months, etc., please remember the *Journal* is in press a full month or better before it reaches your desk. It takes a great deal of time for the volume of copy the *Journal* now features to be set in type, copy read, sent for corrections to authors (in the case of scientific articles), made up into page form, line checked, corrected printed and bound. And all of this gives no mention of the time and details involved in the advertising pages.

The sooner you get your reports to us, the more chance of it being printed before it's dead copy.

And a Chuckle. To the lighter side after all this serious soap boxing! And to *Quote* for our chuckles.

I heard about a fellow who was trying to fix a door that didn't hang right. "Hey, son," he called to his boy, "get me a screwdriver, will you, please?"

After what seemed like a terribly long time, the youngster came back and said apologetically, "Gee, Dad, I've got the orange juice, but I can't find the vodka."

(Jerome Beatty, Jr.—*Saturday Review.*)

I'll take a martini, very dry!



"Yes, I write . . . but you won't see my work in the Book-of-the-Month Club. I've titled my latest effort 'Don't Cultivate the Peptic Ulcer.'"

Deaths...

William N. Duvall, M.D.

Dr. William N. Duvall, Mishawaka, a practicing physician for 55 years, died Aug. 20, at the age of 86.

A senior ISMA member, Dr. Duvall practiced in Mishawaka from 1926 until his retirement in 1955. He began his medical practice in Beech Grove and Sebree, Ky., where he served for 26 years.

Dr. Duvall was a graduate of Atlanta Medical College, Atlanta, Ga., and Chicago Medical School. He was past president of the St. Joseph's Hospital Medical Association and the Mishawaka Exchange Club.

Cecil E. Johnson, M.D.

A Rensselaer physician and surgeon, Dr. Cecil E. Johnson, died Aug. 2 from injuries suffered in an auto accident. He was 70.

Dr. Johnson graduated from Northwestern Medical School in 1910 and began his practice in Rensselaer in 1912. He served as physician at St. Joseph's college for 40 years.

Byron Kilgore, Sr., M.D.

Dr. Byron Kilgore Sr., 77, a pioneer in industrial medicine, died August 29 in an Indianapolis hospital.

Dr. Kilgore practiced for over 40 years in Indianapolis. He was a graduate of the Indiana University School of Medicine, a veteran of World War I, and former Shortridge High School physician.

Daniel R. McDevitt, M.D.

Dr. Daniel R. McDevitt, Indianapolis general practitioner, died Aug. 15 at the age of 62.

Dr. McDevitt practiced in Indianapolis for nearly 35 years. He attended the University of Notre Dame and the University of Louisville before being graduated from Indiana University School of Medicine. He was a charter member of St. Pius Knights of Columbus.

Harold O. Williams, M.D.

A Kendallville physician for 46 years, Dr. Harold O. Williams, died Aug. 1 at the age of 69. He represented the fourth generation of his family to serve the medical profession.

Dr. Williams was active in civic affairs, having served 20 years on the Kendallville City Council. He was a former surgeon for the New York Central and Pennsylvania railroads, and past president of the Twelfth District, Noble County and Kendallville medical societies.

A graduate of the Indiana University School of medicine, Dr. Williams was a World War I Navy veteran, a 32nd degree Mason, and a member of the Shrine.

District and County Society Reports

Ninth District

Members of the Ninth District Medical Society met May 21, at the Tippecanoe Country Club, Monticello.

The 60 doctors in attendance heard a scientific program presented by Thomas N. Moss, M.D., and Paul Elliott, M.D.

A. E. Stouder, Tipton, was elected alternate councilor for the district society.

Eleventh District

The Cass County Medical Society was host to the Eleventh District meeting on May 20th, at the Eagles Club, Logansport.

Representatives of the Indiana University School of Medicine gave the scientific program, a symposium on Lymphadenopathy. Dr. Kenneth Olson, ISMA president, reviewed current state and national medical legislative issues for the 75 members in attendance.

E. N. Bailey, M.D., Logansport, was elected alternate councilor for the district.

Boone

Dr. Arthur Richter presented a scientific program on "Coronary Artery Disease" at the Boone County Medical Society Meeting, September 1, at Witham Memorial Hospital, Lebanon. Ten members were present.

Clark

Fifteen members of the Clark County Society gathered at Henryville on May 19 for a business meeting and informal discussion of current medical-economic problems.

Continued on page 1860

relieve the tension—and control its G.I. sequelae



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for relieving tension and curbing hypermotility and excessive secretion in G. I. disorders

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Adjust dosage to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

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County Societies

Continued from page 1857

Clay

At June 16, July 21 and September 15 meetings of the Clay County Medical Society, members discussed results of recent AMA meetings, relative value schedules, tuberculosis and problems of the aged.

Fountain-Warren

Seven members of the Fountain-Warren Society met September 3 at the Attica Hotel, Attica.

Gibson

Dr. Gilbert J. Himebaugh, Evansville, spoke on "Diseases of the Colon" at the September 9 meeting of the Gibson County Medical Society held at Princeton.

Greene

Fourteen members of the Greene County Medical Society met September 10 at the Freeman-Greene Hospital, Linton.

Harrison-Crawford

The Harrison-Crawford Medical Society met September 8 at the Harrison County Hospital for a business meeting and discussion of scientific programs for the coming year.

Marshall

Eleven members of the Marshall County Medical Society met for a business meeting on September 2. Dr. L. W. Vore was elected to serve as alternate delegate to the ISMA meetings in October.

Montgomery

Dr. Edward V. Schaffer, Indianapolis, spoke on athletic injuries at a dual meeting of the Montgomery County Society and coaches and trainers from the Crawfordsville Community, September 17.

Owen-Monroe

Twenty-six members of the Owen-Monroe Medical Society met at Bloomington on May 28. Dr. William DeMyer, I.U. School of Medicine, spoke on "Headache."

Putnam

The Putnam County Medical Society met at the Elks Lodge, Greencastle, on September 11. Guest speaker was Mrs. Theophiline Bee, county nurse, who discussed the need for additional public health personnel in the county.

Starke

Five members of the Starke County Medical Society met July 7 at Starke Memorial Hospital for a business meeting.

Vanderburgh

An outline of the San Joaquin County (Calif.) Medical Society's Foundation for Medical Care program was presented to the Vanderburgh County Medical Society in a regular meeting at Hotel McCurdy September 8. More than 100 members heard Dr. Patrick Corcoran, immediate past president, describe the California program and the Relative Value Fee Scale. Dr. Corcoran is chairman of a study committee on the San Joaquin Foundation and Relative Value Fees Scales.

Dr. W. T. Barnhart was installed as president of the society. Vanderburgh has changed the terms of its officers to start on July 1 and terminate on June 30 of the following year. Purpose of this was to make an uninterrupted series of monthly meetings by avoiding the summer recess period of June, July and August. Formerly officers terms corresponded with the calendar year.

Whitley

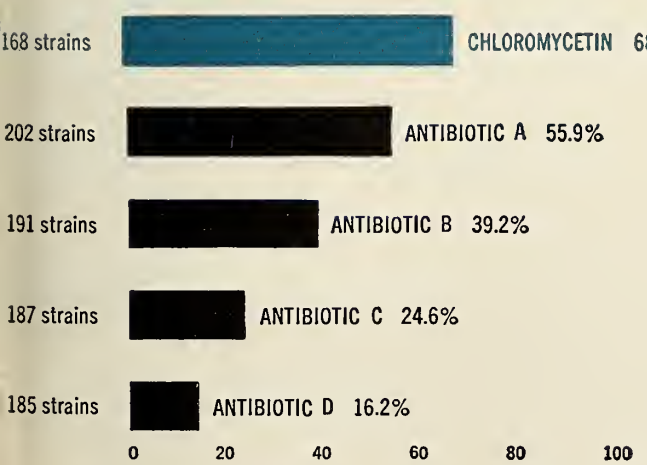
Dr. Arthur Ferguson, Fort Wayne, spoke on "Fluid and Electrolyte Balance" at the September 8 meeting of the Whitley County Medical Society. Fourteen members were present.



"You say you crammed your wife and five kids in a little foreign car and went on a 2-week trip? Ye gods, man, you do need a vacation!"



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November 1959

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Systemic Lupus Erythematosus, Simon S. Rubin, M.D., Gary 1952
A Case Report: The Marfan's Syndrome, D. S. Seto, M.D., E. C. Khoo, M.D., Indianapolis 1956
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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at descretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 1019 Hume Mansur Building, Indianapolis 4, Indiana.

Advertising rates will be furnished on request. Copy must be received by the 10th of the month preceding month of issue.

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ANNUAL CONVENTION — OCT. 3-5, 1960, FRENCH LICK

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2	J. H. Crowder, Sullivan	Oct. 1960
3	John M. Paris, New Albany	Oct. 1961
4	Joseph M. Black, Seymour	Oct. 1962
5	Robert K. Webster, Brazil	Oct. 1960
6	Harry P. Ross, Richmond	Oct. 1961
7	Ralph V. Everly, Indianapolis	Oct. 1962
8	Guy A. Owsley, Hartford City	Oct. 1960
9	K. O. Neumann, Lafayette	Oct. 1961
10	J. P. Vye, Gary	Oct. 1962
11	Max R. Adams, Flora	Oct. 1960
12	Maurice E. Glock, (Chairman) Fort Wayne	Oct. 1961
13	G. O. Larson, LaPorte	Oct. 1959

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Terms expire December 31, 1960:

Delegates	Alternates
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E. S. Jones, M.D. Hammond	Robert M. Brown, M.D. Marion
Francis L. Land, M.D. Fort Wayne	George W. Willison, M.D. Evansville

Terms expire December 31, 1961:

Delegates	Alternates
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Wendell C. Stover, M.D., Boonville	John M. Paris, M.D., New Albany

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Secretary, Richard Davis, M.D., Marion.

Section on Medicine:
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Section on General Practice:
Chairman, Edward C. Voges, M.D., Terre Haute
Vice-chairman, Burton E. Kintner, M.D., Elkhart.
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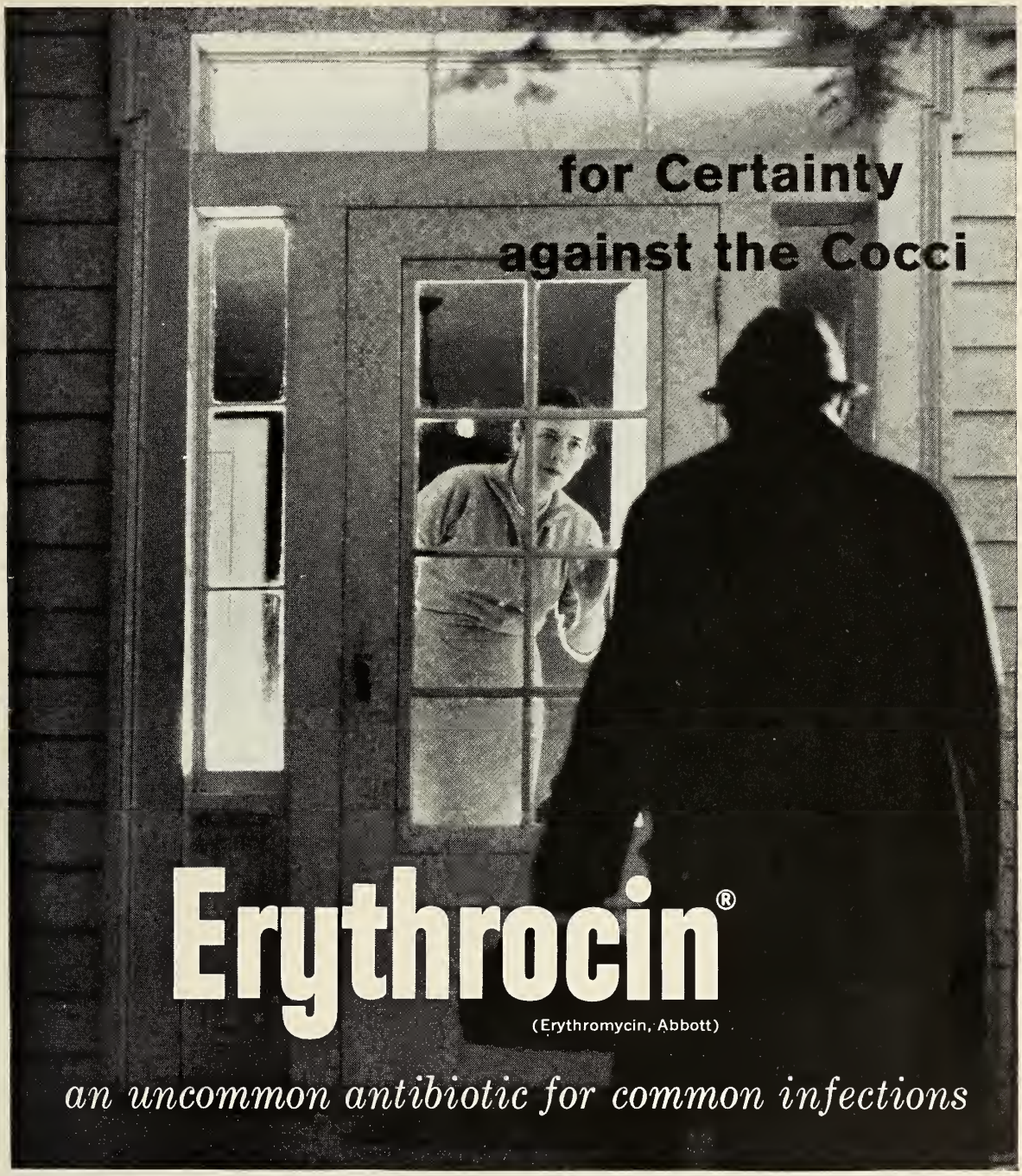
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Secretary, David Wheeler, M.D., Indianapolis

1959-1960 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	Noel Neifert, M.D., Tell City	Gilbert Wilhelmus, M.D., Evansville	1960
2.	Herbert O. Chattin, M.D., Vincennes	J. S. Brown, M.D., Carlisle	1960
3.	P. T. Hodgin, M.D., Orleans	(to be appointed)	Fench Lick, 1960
4.	Robert M. Reid, M.D., Columbus	David L. Adler, M.D., Columbus	Columbus, May 11, 1960
5.	Gilbert Rhea, M.D., Greencastle	James B. Johnson, M.D., Greencastle	Greencastle, 1960
6.	Kenneth G. Hill, M.D., Newcastle	John A. Davis, M.D., Flat Rock	Shelbyville, May 11, 1960
7.	Arthur Records, M.D., Franklin	Herbert L. Egbert, M.D., Indianapolis	1960
8.	Richard C. Swan, M.D., Anderson		Anderson, June 8, 1960
9.	Harry E. Klepinger, M.D., Lafayette	Forrest J. Babb, M.D., Stockwell	Lafayette, May 18, 1960
10.	Martin O'Neill, M.D., Valparaiso	John R. Frank, M.D., Valparaiso	1960
11.	George Jewell, M.D., Kokomo	C. L. Wise, M.D., Camden, Wabash	1960
12.	Harold F. Zwick, M.D., Decatur	Stephen C. Michaelis, M.D., Fort Wayne	1960
13.	Richard W. Holdeman, M.D., South Bend	James M. Wilson, M.D., South Bend	South Bend, Nov. 18, 1959



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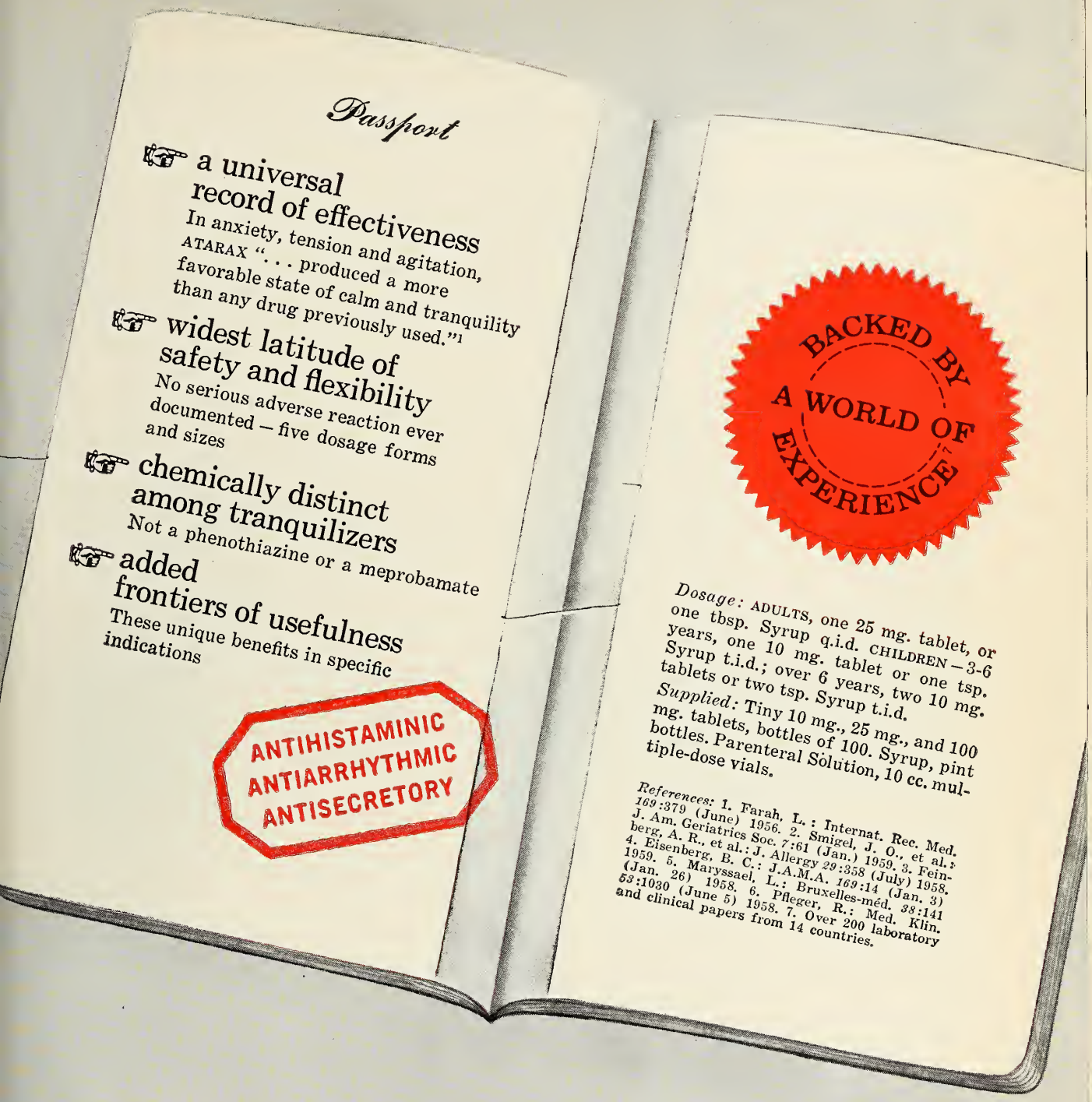
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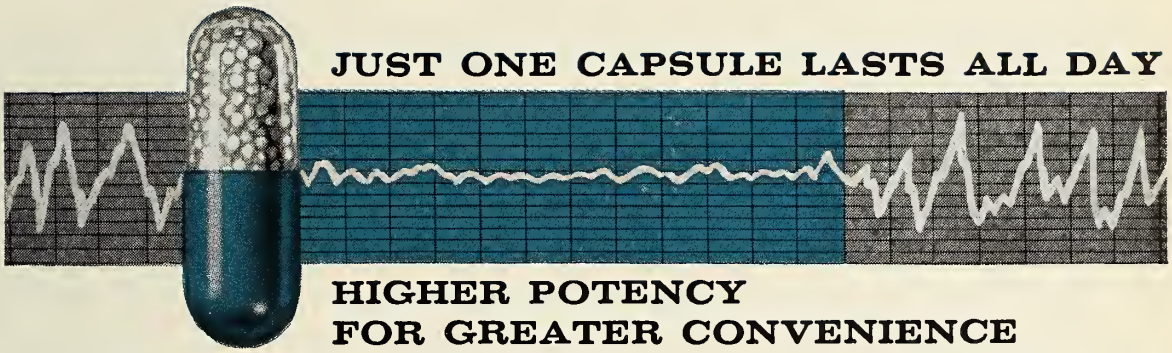
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THE MONTH IN WASHINGTON

Washington, D. C. -- The U.S. Chamber of Commerce and two key Congressmen, all opponents of the so-called Forand bill, recently issued separate warnings that an all-out effort will be made to get the controversial legislation through Congress next year.

In its weekly report to members, the Chamber predicted there will be "a powerful attempt" in the next session of Congress to enact the bill (H.R. 4700) which would increase social security taxes to help pay for the cost of the Federal government providing surgical and hospital care for social security beneficiaries.

The Chamber warned that passage of the legislation would mark "a major break-through into the welfare state." It "probably would lead to a compulsory Federal program providing complete medical care for everyone," the Chamber said.

There would be "no stopping" of such a program once it got started, the report said.

The Chamber called upon communities to find orderly solutions to the problems of the aging. Otherwise, solutions "will surely be imposed from Washington," the report added.

Similar warnings were voiced by Reps. Richard M. Simpson (R.,Pa.) and Thomas B. Curtis (R.,Mo.), key members of the House Ways and Means Committee where the bill was put on the shelf last session.

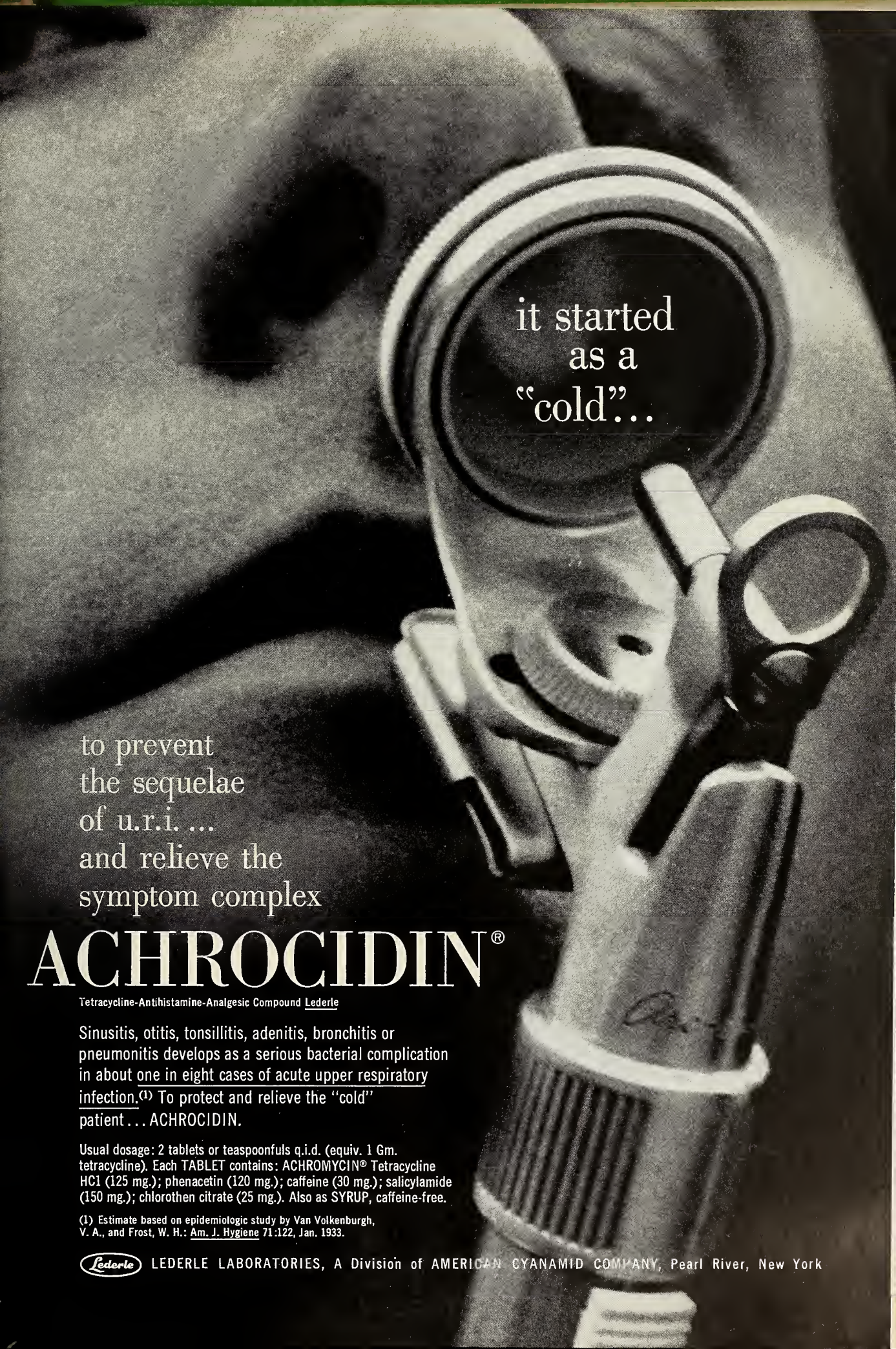
Representative Curtis urged that the medical profession and other leading opponents make a strong counter-drive in an all-out effort to block passage of the bill next session. Unless there is such action, he said he would have to "regretfully" predict that legislation along the lines of the pending bill probably will be enacted in 1960.

Representative Simpson said that H.R. 4700, and similar legislation affecting the medical profession "make it imperative that every doctor keep informed on legislative issues before Congress." He also urged that physicians "become patriotic political forces" by giving "their informed viewpoint" to lawmakers at all levels of government.

Representative Simpson said it "is important" that opponents of H.R. 4700 develop "appropriate alternatives" to solve the health care needs of the aged.

He promised to continue to cooperate with the medical profession to guard "against the disastrous consequences of compulsory national health insurance."

House Democratic Leader John McCormack of Massachusetts expressed hope that Congress next year will stamp final approval on another bill of particular interest to physicians. He praised the Keogh-Simpson bill (H.R. 10) as "meritorious legislation" and said it "should be enacted into law next year." The measure, which was passed by the House last



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(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122, Jan. 1933.

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Continued

spring but left hanging in the Senate Finance Committee, would provide income tax deferrals for self-employed persons setting aside money for private retirement plans.

A National Republican Committee on "Program and Progress" proposed a far-reaching health program to be carried out by the Federal government in partnership with states and local governments.

Its goals would include: enlarging the capacity of medical schools so that 3,000 more doctors could be graduated each year, providing more hospital and nursing home beds, and supplementing hospital facilities with clinics, day-care centers and more visiting nurses to care for patients in their own homes.

The progress of medical science would be furthered by continued Federal support for basic medical research. But such Federal support would be given under conditions to encourage maximum non-Federal spending on medical research and to prevent "too great a diversion . . . of doctors required for the equally urgent needs of teaching and medical practice." It was estimated that expenditure of $1 billion a year--equally divided between the Federal Government and non-Federal sources--would be required by 1965.

Other recommendations included: vigorous Federal support of preventive health programs, and expansion and greater flexibility of voluntary health insurance programs.

"A free people and a free medical profession can achieve these goals with the wise support of government, without bureaucratic restrictions or interference with the physician-patient relationship which has made American health services a model for the free world," the Republican Committee stated.

The Committee proposed a five-point "partnership" program: 1) short-term Federal aid for construction of medical school buildings, 2) changes in the present hospital construction program to encourage renovation and repair of outmoded hospitals, 3) Federal guarantees for mortgages to finance construction of private nursing homes on a basis assuring high standards of quality in construction and operation, 4) encouragement of construction of diagnostic and outpatient facilities in rural area and the building of mental health clinics, and 5) Federal aid to cities "in more effective planning and coordination of health services."



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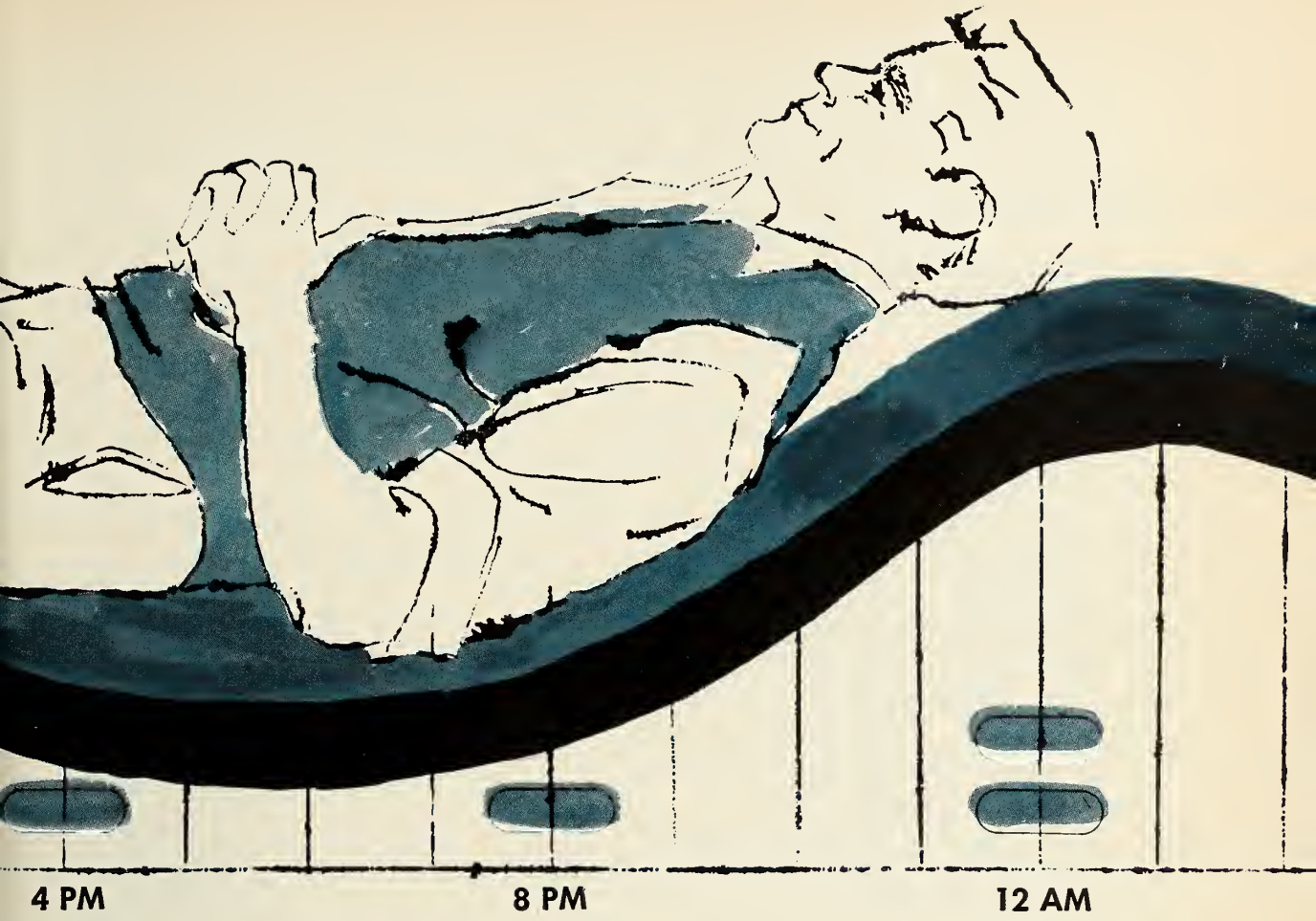
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Phenaphen and Phenaphen with Codeine provide
a wide range of analgesia, plus complete dosage flexibility,
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Yours to prescribe:

The **right** dose of the **right** potency at the **right** time.

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Basic non-narcotic formula

For mild to moderate pain

Each capsule contains:

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Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

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For stubborn or intense pain—to obviate or postpone use of morphine or addicting synthetic narcotics

DOSAGE: One or two capsules as required.

The Fourth Estate Looks at Medicine

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Welfare's New 'Medical Plan'

We are not too greatly concerned over fears we have heard expressed that the new "medical plan" proposed in county welfare here may become a "racket."

Obviously any spending of public money can be made a racket in the wrong hands . . . as one quite like this seems to have been in a less careful county of Indiana. But the ethical standards of the medical profession of this county, which will be closely involved in this program, are about as high as they come, and we consider the chances insignificant that our doctors would join in any such looting of the public till.

There are, however, some other aspects of this proposal we feel ought to have realistic appraisal before it is rushed into being.

Up to now Marion County patients on public charity have been treated at General Hospital, an institution maintained mostly for that purpose by city and county tax money.

The cost of treating there those under care of the Marion County Welfare Department, also a public tax-supported county institution, has been about $500,000 a year.

Under the proposed new plan, however, such a patient may go to any hospital or doctor he may select for himself and his bills will be paid from county, state and federal funds, with the federal government chipping in half. There appears to be no other important difference from the present system than this freedom of choice. It was the basic condition for getting "federal aid."

The new program will cost, by the most conservative of several estimates, more than $1 million a year.

Thus, once the federal government moves in, the cost of the operation is immediately doubled for what appears to be essentially identical services.

Aside from this element of personal choice nothing indicates medical treatment will be in any way improved. Some of the finest medical talent and facilities in Indiana are, and have always been, available free at General Hospital for those unable to pay for them.

The proposed new program is to be shared, 20 per cent by the state, 30 per cent by the county, and 50 per cent by the federal government. At the $1 million-a-year level that means Marion County would pay $300,000, the state of Indiana $200,000 and the federal government $500,000 of its annual cost.

Meanwhile, however, General Hospital still will have to be maintained, probably at about the same level of expense, but with $500,000 of its present operating income diverted elsewhere. Marion County taxpayers will be expected to make up that $500,000 shortage, too. There is no other place to get it. So a county welfare medical bill that was $500,000 a year without state and federal aid becomes a direct levy of $800,000 a year on the county under the "aid" program.

Actually the "federal aid" and the "state aid" in this program is pure delusion anyway. It ignores entirely the obvious fact that all this money . . . federal, state, and county . . . comes from the very same taxpayers right here in Marion County. There are no others. As the state's major industrial center, Marion County, indeed pays a disproportionate amount of both state and federal taxes per capita already. It will ultimately put up every penny of the cost of this entire program, either directly or indirectly.

Directly it will supply $800,000 in local taxes.

Indirectly it also will supply an additional $200,000 in state taxes and an additional $500,000 in federal taxes that this program will cost each year.

So the County's care for its indigent ill that has been costing $500,000 a year may under this new "aid" program cost the people of this county $1,500,000 a year for the same welfare services.

However desirable it may be for the ailing individual to have complete freedom to choose the hospital and the doctor he prefers to treat

him . . . it occurs to us to wonder whether that privilege is going to be worth a cool million dollars a year to the taxpayers of this county who have his bills to pay.

The danger in this medical welfare project is not, it seems to us, primarily that somebody might conceivably steal the money.

Marion County Council appears to be highly skeptical of the whole thing.

With, we believe, very sound reason.

Indianapolis Times
Aug. 21, 1959

Two Kinds of Protection

The Mental Hygiene Committee of the New York Bar Association has endorsed some changes in the state law concerning crimes by people who plead insanity.

One suggestion seeks to make mandatory the incarceration in a mental institution of any person who successfully pleads mental illness as a defense against a crime. As the present law now stands, judges have discretion either to commit or to free such defendants.

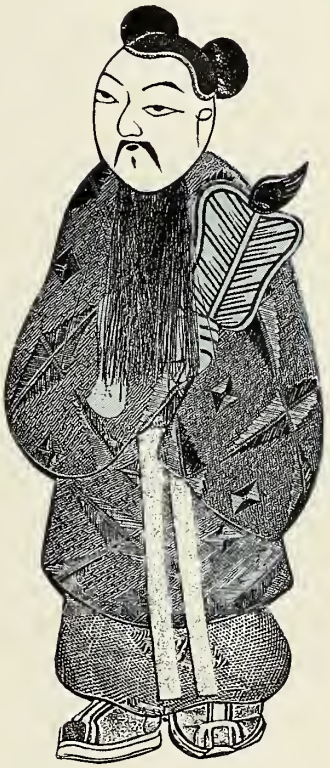
The other change would broaden the present law to include as a defense the inability of a defendant to "conform his conduct to the requirements of the law." As the law now reads, a defendant must be judged not to know the "nature and quality of the act he was doing" or not to "know that the act was wrong."

As a package, the suggested change in the law may serve the purpose of protecting both the mentally ill defendant and society—but only as a package. We make the point because if the men who make the laws were to broaden the legal concept of insanity and fail to tighten society's safeguards a rather large loophole for criminals would have been created.

For if a man may plead temporary insanity, say, on the ground that he couldn't conform his conduct to the law that requires everyone else to conduct themselves in a peaceable manner, isn't he really pleading more a lack of self-control than a lack of sanity? And if inability to "conform his conduct to the requirements of the law" is to be an acceptable reason for letting a transgressor go free, will the next development be arguments by defense counsel that since a man committed a crime he obviously couldn't conform his conduct to the law and therefore he must have been temporarily insane when the gun

Continued on page 1900

immortals of chinese mythology:



Chung-li Chu'an

This powerful magician revived the souls of the dead with a wave of his fan and gained a lasting place in Taoist legend

...this pioneer corticosteroid has proved invaluable in treating *millions* of living patients

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You will soon receive in your mail a full-color, handmade, three-dimensional figure of this Chinese Immortal, mounted and suitable for framing.

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when a tranquilizer is warranted...

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TENTONE® Methoxypromazine Maleate is a new, distinctive phenothiazine... highly active ...for general use in mild and moderate emotional and psychosomatic disorders.

TENTONE elicits a striking, positive calming response[1,2]...with marked reduction of psychic disorientation, and low risk of blood, liver or other organic toxicity and intolerance.[1-4]

TENTONE parallels the weaker ataractics in low incidence of side effects. Freedom from induced depression is apparently even greater.[5]

TENTONE provides a broadly adaptable dosage range (30 to 500 mg. daily) to permit maximum control in cases of varying severity.

TENTONE is also indicated to relieve emotional stress in surgical, obstetric and other hospitalized patients.



Dosage: Mild to moderate cases—average starting dose, one 10 mg. or one 25 mg. tablet three or four times daily. *Moderate to severe*—average starting dose, one 50 mg. tablet four times daily. *Supplied:* 10 mg., 25 mg., and 50 mg. tablets.

Bodi, T., and Levy, H.: Clinical report, cited with permission. 2. Wetzler, R. A., and Phillips, R. M.: Clinical report, cited with permission. 3. Prigot, A.: Clinical report, cited with permission. 4. Gosline, E., *et al.*: *Am. J. Psychiat.* 115:939 (April) 1959. 5. Turvey, S. E. C.: Clinical report, cited with permission.

Tentone

ethoxypromazine Maleate

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Lederle

Fourth Estate

Continued from page 1897

he carried during the robbery he couldn't help went off and killed another man?

It would be well, we think, for the lawmakers to remember, in considering legislation on this subject, that the laws aren't enacted altogether to protect the criminal. They are enacted because society has decided that certain acts are not to be tolerated. The purpose of the laws is to dissuade people from committing acts against the peace or person of a neighbor of the community, and to restrain the transgressors if they are not to be dissuaded. And, moved by compassion, lawmakers sometimes fail to strike a balance between the aggressor and society.

We would certainly not like to be numbered among those who think defendants ought to be left unprotected by the law, nor among those who think the mentally ill don't deserve consideration.

But we would not like to be numbered, either, among those who think that in compassionate protection of the criminally insane society itself should be less protected.

Wall Street Journal
July 27, 1959

Foundation for Safe Driving

The effectiveness of the auto crash injury research program conducted by the state police department is to be increased even further.

Through cooperation with the state Superintendent of Public Instruction, the results of the research program will be made available to high schools throughout the state beginning next month.

This is a wise move as the high school audience is particularly receptive. Teen-age boys and girls are impressionable as well as mentally alert and should quickly absorb the lesson in safe driving that is taught by the research project.

The work of the state police in this field has been so good that it has drawn national recognition. By presenting the grim facts on the causes of injury and death to youngsters who will be drivers of tomorrow, the cosponsors of the program are building toward traffic safety.

It is hoped that all high schools will take advantage of the plan.

Indianapolis News
Aug. 14, 1959

A Terrible Lesson

Every person in Marion County who is keeping a lethal war souvenir in his home must share the blame for the pitiful tragedy in the Beech Grove basement.

The grenade that exploded there killed two little boys and riddled the bodies of five other children with shrapnel.

It is ironic that this occurred on the last day of a drive by ordnance authorities at Ft. Harrison to collect dangerous war relics in this community and to render them harmless.

Regrettably, civilian response to the drive was negligible. The grim reminder in Beech Grove should now awaken all our people to the deadly peril that lurks in these "souvenirs."

And, entirely aside from the repeated pleas by military people, common sense should dictate to civilians, especially veterans, that such undenatured devices cannot be kept safely in any home.

A terrible lesson has been given. Let us all heed.

Indianapolis News
July 27, 1959

New Rules for Pilots

The American Medical Association's committee on aviation medicine has performed a notable public service by bringing about tighter medical regulations for airline captains. Although the new federal rules may ground a few of the several thousand captains over 35, this move will considerably elevate the safety standards observed on commercial flights.

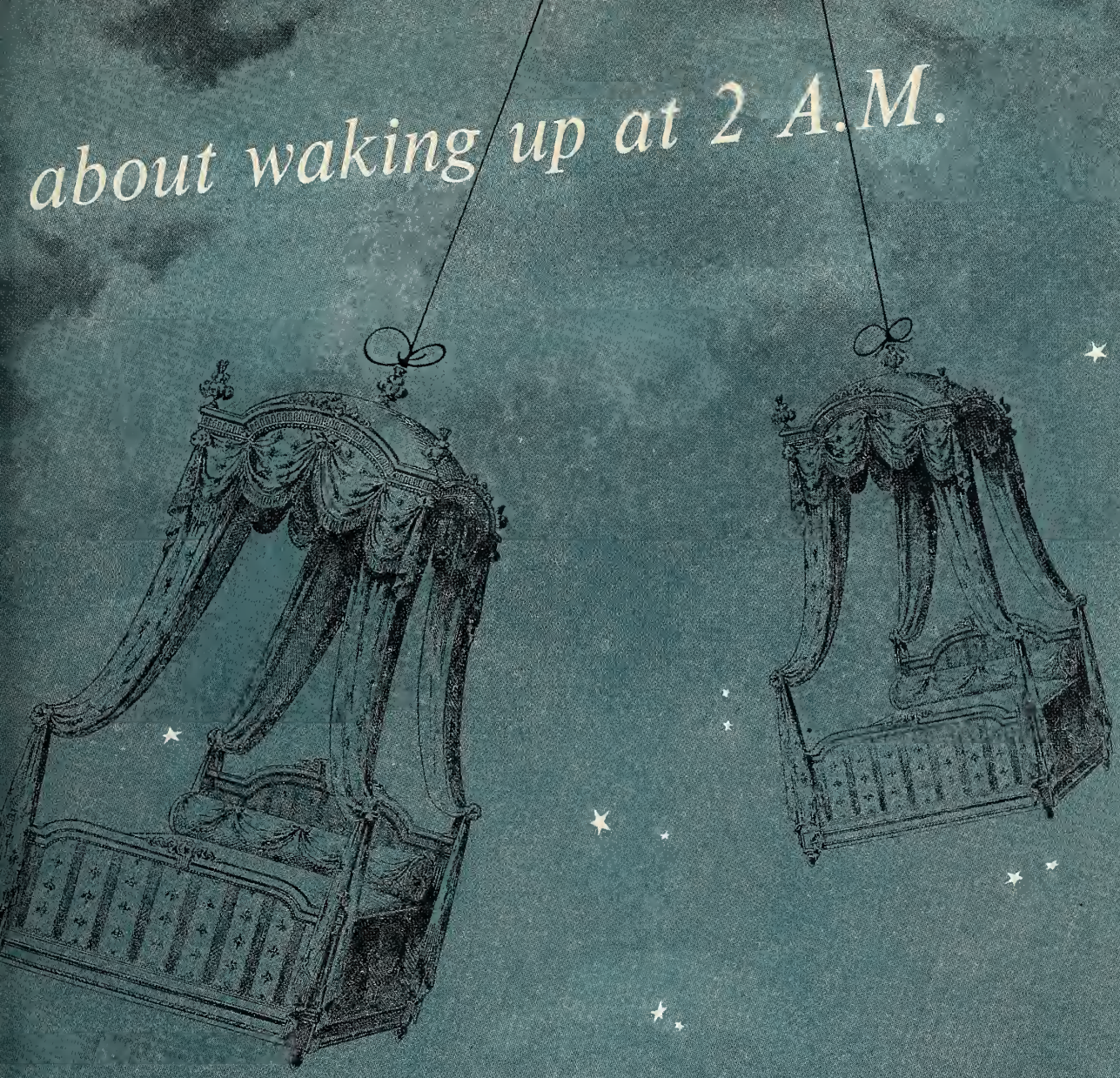
The more stringent regulations are not based merely on hypothetical fears of what might happen if the pilot of a big passenger plane suffered a heart attack or some other disabling illness. A number of incidents suggesting the wisdom of the new rules have occurred in recent years.

In September, 1957, for example, the pilot of a plane carrying 63 passengers was stricken by a heart attack and died in the cockpit. His copilot landed the Chicago-bound plane at Madison, Wis. The pilot had had a federal examination only two months before his death, but according to the chairman of the AMA committee, had not had a company examination "for some time."

It would be unfair to leave the impression

Continued on page 1904

about waking up at 2 A.M.



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timed-release tablet

timed-release action for a full night's sleep

NEBRALIN is designed to duplicate the normal sleep pattern. It encourages muscular relaxation and induces sustained, relaxed sleep by the release of Dorsital and mephenesin in a timed-release tablet. Rapid-acting mephenesin quickly relaxes skeletal muscles to overcome "fatigue-tension" and conditions the body for sleep. Dorsital provides CNS sedation to induce sound, relaxed sleep. The initial and sustaining dosages are designed to keep the amount of barbiturate to be inactivated at any one time at a low level tapering toward morning. Evidence indicates that mephenesin is capable of producing sleep,[1] and when combined with a barbiturate enhances barbiturate action.[2] [3] Moreover, the integrated action of the two components permits smaller dosages of each,[4] assuring your patients refreshed awakenings without "morning hangover."

1 Schlesinger, E. B.: Tr. New York Acad. Sc. 2:6, (Nov.) 1948.
2 Richards, R. K., and Taylor, J. D.: Anesthesiology 17:414, 1956.
3 Shideman, F. E.: Postgrad. Med. 24:207, 1958.
4 Berger, F.: Pharmacol. Rev. 1:243, 1949.

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Fourth Estate

Continued from page 1900

that the airlines have been notably lax about physical exams for pilots. Some airlines already apply standards as strict as those of the new federal rules. Enforcement of standards has not been high even in all of the major airlines, however, and some of the smaller lines have been relatively casual about physical fitness of pilots.

The new federal standards will tighten up the whole system, not only with regard to heart disease and other serious medical conditions but also in relation to mental illness. As a result, air travelers will be more secure than in the past.

Kokomo Tribune
Aug. 11, 1959

Krebiozen Again

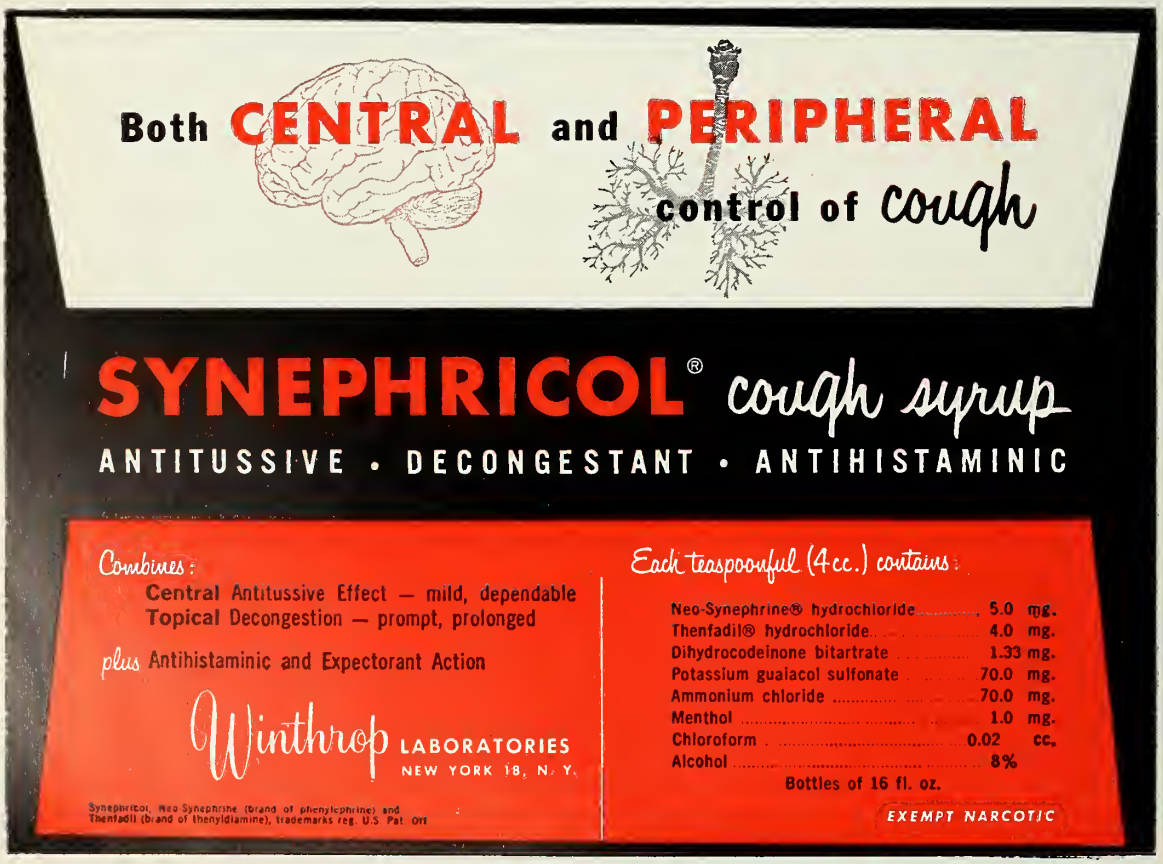
Krebiozen continues a subject of controversy and seems destined to remain so unless some kind of definitive test can be devised that will be acceptable to leading cancer experts on the one hand and to the krebiozen advocates on the other.

It isn't going to be easy to arrange such a test because Dr. Andrew Ivy, chief among the drug's advocates, has persuaded himself that cancer experts are so strongly prejudiced against the treatment that special precautions must be taken to keep their preconceptions from controlling their verdict. On the other hand, the cancer specialists quite naturally resent his attitude, have doubts about his competence in their special field, and see no urgent need to reevaluate a treatment which they believe has already been tested and found wanting.

Difficult as it may be to find a way out of this impasse, we hope that one can be discovered. We say this on behalf of the victims of cancer and their families, who crave an authoritative declaration either that krebiozen offers some hope of cure or alleviation not otherwise available, or that it offers no hope.

Perhaps such a test could be arranged if Dr. Ivy, the Durovics—Dr. Stevan and his brother, Marco—and their friends would agree to cease agitating on behalf of krebiozen if the finding is adverse. On these terms, the Cancer society or the National Cancer institute might see fit to undertake a restudy of the drug.

Chicago Daily Tribune
May 22, 1959



Important Employes of a Hospital

Hospitals should not be accredited unless they have "decent" personnel practices for their nonprofessional employees, said Leo Perlis, director of community services activities of the AFL-CIO, in a speech here. In setting hospital standards, the commission on accreditation "covers everything from the physical plant to the medical library, but overlooks the most important element of all—personnel," Mr. Perlis complained.

The nonprofessional personnel to which he referred includes the maintenance staff members, some of whom belong to craft unions, and various unskilled and semi-skilled workers who have been the target of union organizing campaigns. The employes engaged in housekeeping tasks in a hospital are performing a useful function, but it may be doubted that they are "the most important element" of a hospital, as Mr. Perlis seems to think.

More important than the janitorial staff are the physicians, surgeons, interns, anesthesists, orderlies, nurses, nurses' aids, pharmacists, laboratory and X-ray technicians, physical therapists, dietitians, librarians, business staff, chaplains, and administrators. A hospital could get along for days without its nonprofessional help. It could not operate for five minutes without the professionals.

Chicago Daily Tribune
June 8, 1959

Tension in Suburbia

Life in the newer suburbs, according to a studious report in the Journal of the American Medical Association, is very tough on the inhabitants. A few blades of crabgrass in the lawn and they come down with ulcers. A speck of dirt on the coffee table and the lady of the house falls prey to some "tension-related psychosomatic disorder."

High taxes lead to coronary thrombosis, essential hypertension, and hypertensive cardiovascular disease. Asthma is rampant, and gasping, watery eyed husbands jam the commuter trains, snuffling as they fumble with the load of home work in their briefcases.

This dismal picture is drawn by Dr. Richard E. Gordon, who practices in Englewood, N. J., and his wife, Elizabeth, but we dare say that similar findings could be reached if studies were made of Hinsdale, Winnetka, Flossmoor, Elk Grove, or any other outlying Chicago parish.

The Gordons make a good deal of the "status" factor, which used to be known as keeping up with the Jonses. "Upward social mobility" dictates that the suburbanite, whom we shall designate the patient, seeks to climb from the middle middle class to the upper middle class.

Well, with one thing and another, it is a pretty hellish life, and the peaceful sweep of the greensward before the traditional ranch style house (that's the one with brass carriage lamps flanking the entrance) conceals lots of heartbreak in a heap o' livin'.

We can testify from observation and experience that there is much truth in all this. The lady of the house is reduced to a taxi cab driver, meeting trains and ferrying the young to and from school. One never knows when a catty neighbor will sick the cops onto the Airedale for roaming at large, or whether the standard poodle will bash in the screen door and track mud over the living room carpet.

Tuck pointers, we have learned, earn $4.08 an hour, and that isn't the half of it—or, rather, as the bill attests, the tenth of it. The plumber is with us, late or soon.

The boys from the army post who, in off duty hours, cut such of the crabgrass as father couldn't reach over the week-end, disappear for 10 days and finally straggle back with the explanation that they had been "alerted." Contemplating their degree of alertness, we utter a silent prayer for the safety of the country.

Well, only 12 more years to go on the mortgage. Then maybe we escape back to the comforts of the city and the joys of exhaust fumes, with hardly an elm bark beetle with any material to munch on within miles. Meanwhile, with our fellow suburbanite, Dr. Gordon, we shall try to stick it out, occasionally pausing to wonder why he doesn't move back to town.

Chicago Daily Tribune
Aug. 11, 1959

Doctors and Taxes

When one doctor entertains another doctor, is the money it costs him a business expense?

Until a few years ago, the Internal Revenue Service policy was to say "No" when such entertainment was claimed as a business expense for income tax deductions. The Service claimed such expenses, if allowed, would be "unethical."

Now, the Service says it won't automatically

Fourth Estate

Continued

disallow such claims, but examine each one on its merits. The revenue men say the doctor, to claim costs of entertaining another doctor as an income tax exemption, must give the name of the doctor entertained and whether the doctor entertained referred more patients as a result.

We doubt that many doctors will take advantage of this new ruling, since the code of medical ethics would make the practice of soliciting patients via the entertainment route a highly dubious procedure. We can see some senator or congressman of the future, investigating the nation's medical services, digging up a batch of old income tax returns.

The medics, who have consistently fought the advance of what they call "socialized medicine," won't be tempted by the new Internal Revenue Service ruling, to our way of thinking.

Hammond Times
Aug. 4, 1959

Picking Up Bats

As if there were not enough dangers in this life already, public health authorities have discovered another one: rabid bats. The subject is in the news because a dead bat, implausibly discovered recently in a corridor of the Brooklyn borough hall, has been found to have had rabies.

Most healthy bats, unless found hibernating in a cave, do not permit handling. Any bat that permits itself to be picked up probably should not be. Certainly not in City hall. This goes for young bats as well as old bats.

Chicago Daily Tribune
July 25, 1959

Polio Hasn't Been Beaten

Polio is supposed to be the beaten scourge. Since 1955 we have had the Salk vaccine, effective in from 75 to 90 per cent of cases where it has been administered as a preventive.

But 1959 so far has turned out to be the worst polio year since the vaccine was introduced. Cases on record are nearly double 1958 totals for the comparable period.

Reports of the increased incidence are coming in from all sections of the nation. Worst hit was Iowa, especially in Des Moines and vicinity.

Surveys there and in Kansas City suggest that the chief victims are individuals in the lower economic groups. This was also found to be true in an outbreak some time back in Chicago.

In these groups, the evidence indicates, the Salk vaccine is most widely ignored as a protective measure.

The full story is, of course, that across the nation many millions of youngsters in the most susceptible age brackets still have no Salk shots or too few. It is one of the really sad chapters in modern U.S. medical history.

Kokomo Tribune
July 29, 1959

The Cost of Free Medicine

The latest tab for socialized medicine in Britain shows that taxes intended specifically to cover the national health service bill defrayed only 24 per cent of the cost. The remaining 76 per cent must be met by general taxes collected by the government.

In the 10 years since socialized medicine was inaugurated, costs have risen by one-third, and in the last year hit a record of 1¾ billion dollars.

Continued on page 1913



provides therapeutic levels . . . for 24 hours . . .
with low incidence of sensitivity reactions . . .
WHENEVER SULFAS ARE INDICATED ®
KYNEX
Sulfamethoxypyridazine Lederle
0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION
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Continued from page 1906

We hope that these facts will not be lost upon Congress, where a Democratic group led by Rep. Forand of Rhode Island is pushing for an extension of social security so that medical care and hospitalization would be provided by the government to elderly people drawing benefit checks. That this would be another step toward socializing medicine is obvious enough. That it would also embody a cost which eventually would be staggering should be equally plain, tho the conclusion is disputed by Forand and those of like mind.

The British experience demonstrates that the initial estimate of cost was far too low, and that the taxes to cover the supposedly free service were correspondingly inadequate. But, once the taxes were fixed, the prospective beneficiaries had a vested interest in keeping the price cheap on what they expected to get. Inevitably deficits accumulated and were passed on to the treasury.

Rep. Forand contends that the additional charge for his socialized medicine would be "only" an additional one-quarter of 1 per cent added to present social security taxes falling both on employer and employe. Those who oppose this departure say that it would either break the social security fund or lead to increases in the tax which would soon be insupportable.

The steadily rising membership in voluntary medical insurance plans suggests that the Forand bill is primarily another scheme to corral the votes of a growing segment of the population. We trust that both Congress and the public will consider it in that light and will have the honesty to recognize that only fools expect something for nothing.

Chicago Daily Tribune
Aug. 10, 1959

Safety Is Money

The testimony of experts shows that there is added incentive to safe driving. It turns out that driving which is safe is also money-saving.

Among the tips pased out by an economy-run winner recently were these:

—Drive at moderate speeds. Driving at speeds over 60 can reduce gas mileage as much as 50 per cent over what you'd get sticking to the 40-45 m.p.h. range.

—Avoid sudden stops. When you see a traffic light turn red or a stop sign coming up, take your foot off the accelerator and glide to a stop.

—Stay away from hot-rodding getaways. Accelerate slowly, and shift gears quickly rather than gunning it up to 50 in second gear.

This and other economy practices could save you up to $250 a year in gas costs, the experts say.

Of course, those who can't bear to abandon their black leather jacket mentality—their penchant for using an automobile as an instrument for satisfying an animal yearning for power won't change their hot-rod habits just because it saves money, or is safer, or more polite.

Just the same, it is nice to know that the man who drives as if he had a head on his shoulders, rather than a monkey on his back, is making himself money as well as driving safely.

—Denver Post

Viruses Causing Cancer?

Fortune magazine says that a cure for cancer, a disease which will strike one out of every four Americans now living, may be found through virus research even before the causes of the dread killer are fully understood.

The half-century-old theory that the origin of human cancer is in some way associated with viruses has only recently gained wide acceptance, and cancer virologists feel themselves engaged in "a race to save lives," the magazine says.

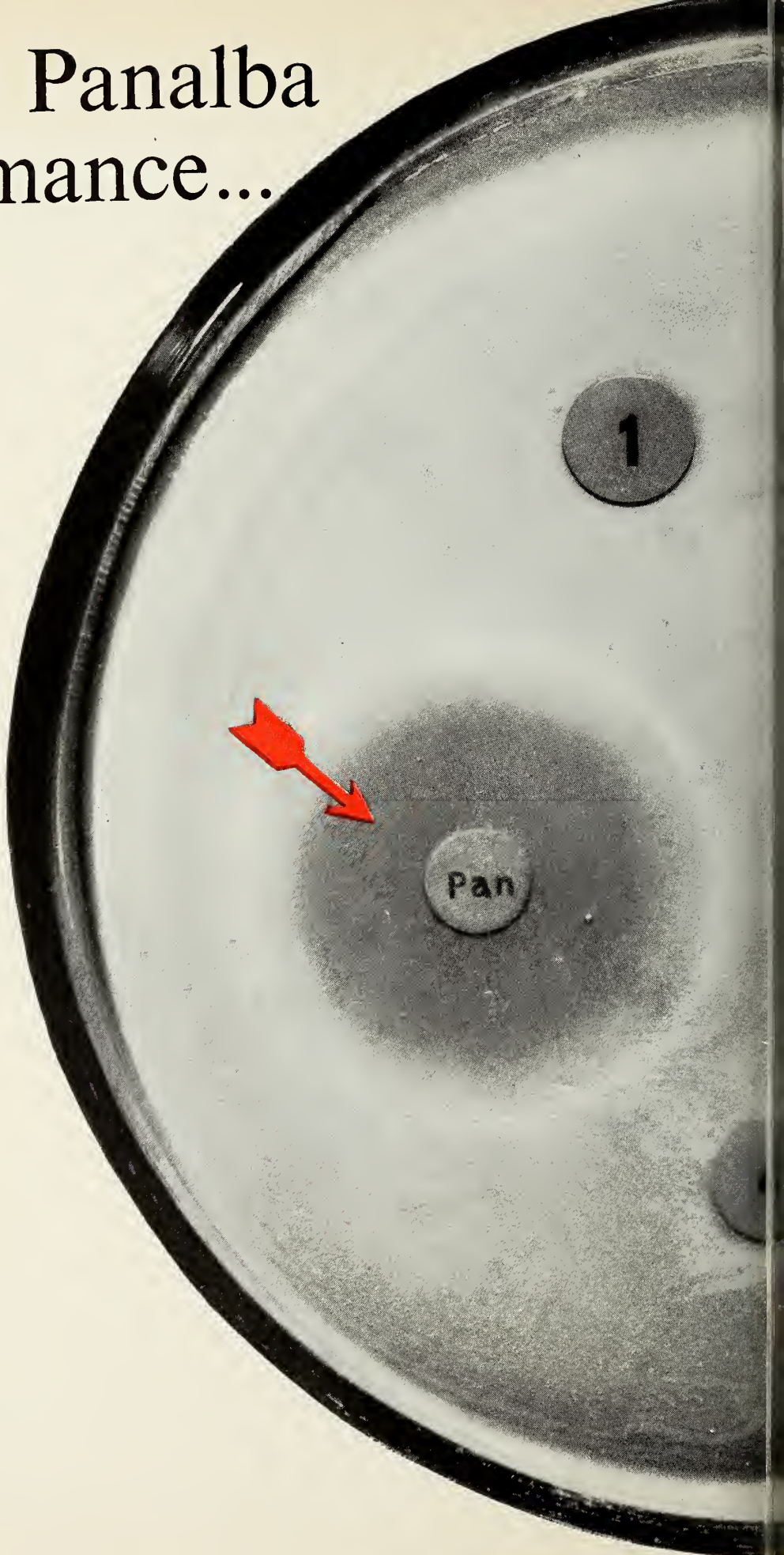
Viruses, particles so small that they are visible only under a powerful electron microscope, cause a great number of dangerous illnesses ranging from yellow fever to polio, as well as as the lesser aches and pains associated with the common cold and ordinary flu. By 1959, more than 100 viruses had been definitely connected with human diseases.

At present, says Fortune, laboratory proof that viruses can cause cancer comes only from experiments with animals. The virus theory of human cancer is based upon likenesses between animal and human cancers and on the likeness of cancer viruses to other viruses.

"The virus hypothesis of human cancer does not argue that viruses are the cause of cancer in a simple cause-and-effect manner," the magazine says. "Virologists are convinced that gentics, hormones, chemical carcinogens, and irradiation

Continued on page 1916

This is Panalba performance....





in pneumonia

. . . into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

In your next pneumonia patient . . . in *all* your patients with potentially-serious infections . . . provide this extra protection with your prescription:

Dosage—1 or 2 capsules 3 or 4 times a day.
Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.
Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.

Panalba*

(Panmycin® Phosphate plus Albamycin®)

The broad-spectrum antibiotic of *first* resort



Upjohn The Upjohn Company Kalamazoo, Michigan

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Fourth Estate

Continued from page 1913

are important in the origin and development of cancer."

Backed by funds from the American Cancer Society and the National Cancer Institute, scientists are hard at work attempting to unravel the many mysteries surrounding the tiny particles. Among the questions posed: Can one type of virus cause many kinds of cancer? Is there a limited number of virus families, each of which produces a wide variety of cancers? May there conceivably be only one sort of virus that, by mutation, produces the entire cancer spectrum?

"If the answers to any of these questions is yes," says Fortune, "the problem of devising anti-cancer drugs—including new anti-biotic-like substances—serums, and vaccines would be enormously simplified."

The biggest task facing virologists is to narrow the gap between knowledge of animal cancers and human cancers in order to demonstrate the role of viruses in humans as conclusively as they have done for animals. The steps taken will be the same as those taken to prove the virus origin of polio in humans, says Fortune, but the job is much more complicated because cancer is much more complicated.

"Viruses may be the one factor that must be present if cancer is to develop," concludes Fortune. "If so, they are the key link in the complex chain of malignancy, the link that must be broken before cancer is conquered."

It is an interesting theory, and the human race will benefit enormously if it proves to be a correct one.

—*Kokomo Tribune*
Sept. 29, 1959

Share the Road

The state-wide traffic safety emphasis for August is "Share the Road." Overwhelming evidence of the need for such concentrated effort is the 83,347 two-car crashes recorded in Indiana during 1958. Two types of actions, which violate the "share the road" principle, accounted for over 50 per cent of these tragic incidents. They were driving on the wrong side of the road and failure to yield the right-of-way at intersections.

Greater respect for center lines and lane markings and an increased willingness on the part of motorists to "give" the right-of-way rather than to "take" it would considerably reduce Indiana's rising traffic accident rate.

Another thing for motorists to remember is that parking lights are poor protection for driving. When visibility is reduced, always use headlights for greatest safety. During periods of low visibility parking lights are deceptive when used as driving lights. Most drivers judge safe passing distance by the size of oncoming headlights. Parking lights give a false impression of the distance of the oncoming car.

Following too closely set up nearly 25,000 traffic crashes in Indiana last year, accordinng to the Indiana Traffic Safety Foundation. Twenty-six per cent of the states traffic collisions were rear-end contacts. It is good to remember that the driver ahead may have better brakes than you, so observe safe following distances.

Then, of course, unreasonable speed is a major accident cause. The traffic safety foundation estimates that one-third of the fatal crashes in Indiana in 1958 were due to exceeding safe speed limits.

These are things to keep in mind any day you are on the road and particularly on holidays. Another Labor Day holiday isn't far away. One way to make it safer is to start now putting into practice the safety suggestions mentioned above.

Kokomo Tribune
Aug. 5, 1959

Drunken-Driver Menace Growing More Deadly

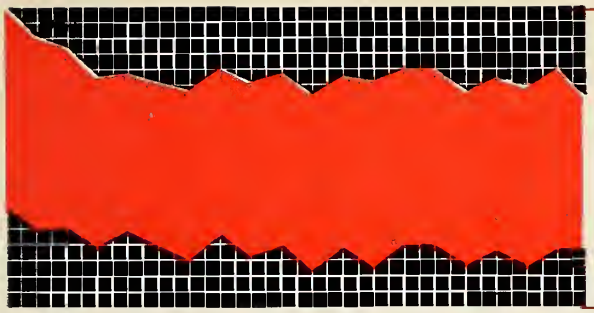
A special committee of the American Medical Association reported that 50 per cent of fatal automobile accidents in the U.S.A. in 1958 were caused by drunken driving.

This is higher than estimates by the National Safety Council.

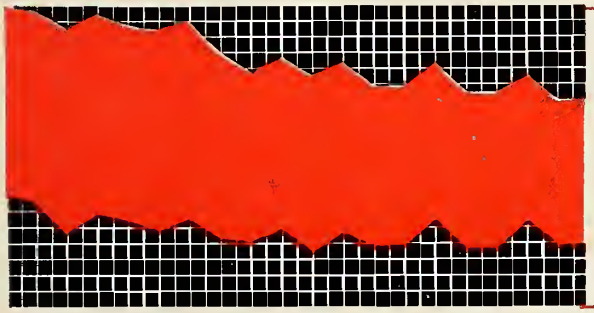
U.S. Senator Richard L. Neuberger (D.-Oregon) believes that the federal government and Congress will have to act to stop the slaughter. There were 86,000 convictions for drunk driving by State and Highway police last year. The number by cities and towns was not available.

The fact that most drunken drivers got off with a "slap on the wrist," as compared to the seriousness of the fatal accidents they caused, is

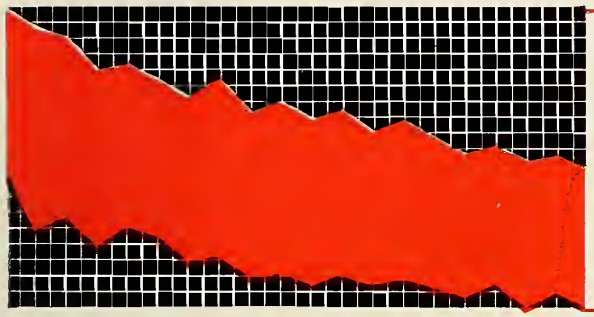
Continued on page 1920



HYDRODIURIL alone



RESERPINE alone



HYDROPRES
much more effective than either of its components alone

- Effective by itself in a majority of patients. Provides smooth, more trouble-free management of hypertension.
- Since HYDRODIURIL and reserpine potentiate each other, the required dosage of each is lower when given together as HYDROPRES than when either is given alone.
- HYDROPRES provides the needed and valuable tranquilizing effect of reserpine. Lower dosage may reduce such side effects of reserpine as excessive sedation and depression.
- Arrest or reversal of organic changes of hypertension may occur.
- Headache, dizziness, palpitations and tachycardia are usually promptly relieved. Anginal pain may be reduced in incidence and severity.
- With HYDROPRES, dietary salt may be liberalized.
- Convenient, controlled dosage.

HYDROPRES-25
25 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one to four times a day.

HYDROPRES-50
50 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one or two times a day.

If the patient is receiving ganglion blocking drugs or hydralazine, their dosage must be cut in half when HYDROPRES is added.

MSD **MERCK SHARP & DOHME,** DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

*HYDRODIURIL AND HYDROPRES ARE TRADEMARKS OF MERCK & CO., INC.

Fourth Estate

Continued from page 1916

of concern. Attitude of most judges and juries was, "Except by the Grace of God, there am I."

Indiana's legislature turned down an "implied consent" law to hit at the growing menace of drunken driving. The law holds that in accepting a driver's license a person is deemed as having given his consent to a chemical test.

Philip Johnson, of Mooresville, an orchardist, member of the State Legislature, has spent much of his adult life trying to make Indiana highways safer. He arranged extensive hearings on the implied consent law over the state. He was swept out of office by the landslide.

Nine states have "implied consent" laws operative. They are New York, Rhode Island, Vermont, North Dakota, South Dakota, Nebraska, Kansas, Idaho and Utah.

Such legislation is pending in Illinois, Michigan and Delaware. In California, drunken drivers became a terrific menace on the expressways, fastest civilian auto race track in the world. Many drank vodka that has no odor. Results were, California has tough drunk driver laws, with imprisonment up to five years.

It was Dr. Rollo N. Harger, of Indiana University Medical School, who invented a simple device to test the amount of alcohol in the blood stream.

Prior to that time, tests involving blood specimen were cumbersome. Dr. Harger's method, with some variations since, was the breath test. Samples of breath are obtained by the one suspected blowing up a toy rubber balloon.

Twenty-six states and 150 local police departments use the Harger method.

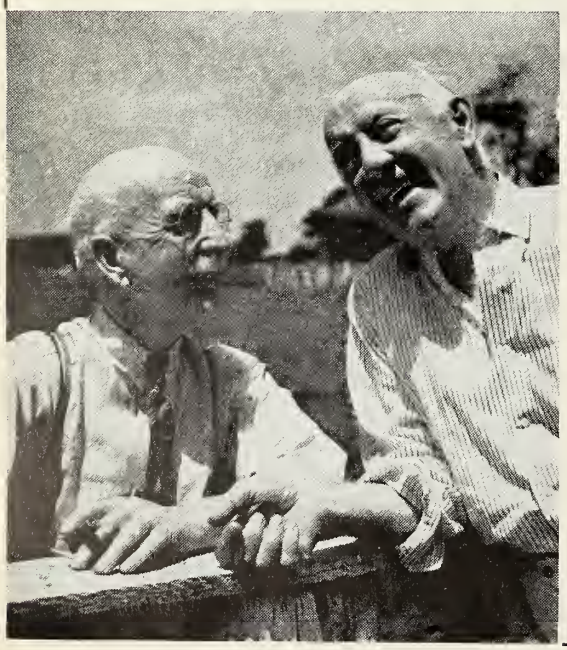
How many drinks does it take to make a drunken driver? The standards are higher in Sweden and some European countries, where the Harger method is used.

In Indiana, a person with 0.05 per cent or less of alcohol by weight in the blood stream is not considered under the influence. Between 0.05 per cent and 0.15 per cent of "blood alcohol" there is a question. It is almost always resolved in favor of the defendant. If the test shows over 0.15 per cent, it is accepted definitely that the defendant is under the influence of alcohol.

How much it takes ot make a drunk driver

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For Your Geriatric Patients



Metalex®

Pentylenetetrazol w/ Nicotinic Acid

METALEX is a vasodilator, a respiratory and central nervous system stimulant. It helps overcome the hypoxia frequently present in athero-arteriosclerosis of old age, its analeptic action increases nerve impulse transmission.

"TONIC" EFFECT—Ameliorates mood, paranoid delusions, loss of memory, confusion, depression, anxiety, apathy, vertigo, insomnia, headache and anorexia due to athero-arteriosclerosis.

IN TINNITUS—When cerebral function and oxygen supply can be improved, visual and auditory improvement is often noticeable.

SUPPLIED: Tablets—bottles of 100.
Elixir—pint bottles.

Composition: Each tablet and each 5 cc. elixir contains 100 mg. Pentylenetetrazol, and 50 mg. Nicotinic Acid.

Send for samples and literature.

STORCK **Pharmaceuticals,** 2326 Hampton Blvd., St. Louis 10, Mo.

depends on his weight, drinking habits, amount of food he has consumed before drinking the alcohol and other factors that are carefully computed.

Researchers say that an average 6 ounces of whiskey or six bottles of beer will produce 0.15 per cent alcohol in the blood stream, which is definitely a state of intoxication.

The studies show that a motorist does not have to be staggering drunk to be unfit to drive an automobile at present-day high speeds on our crowded highways.

New Albany Tribune
Aug 12, 1959

Auto Exhaust Fumes

What relation is there, if any, between fumes from automobile exhausts and lung cancer? General Motors Corp. is reported as planning to finance a study in an attempt to find out the answer to this question.

Some scientists suspect that burned gasoline fumes contribute to respiratory illnesses and eye afflictions as well as lung and skin cancer. It is this theory that the Sloan-Kettering Institute for Cancer Research will attempt to test by conducting experiments.

Not only the motoring public, but the public in general, will hail this experimentation with gratitude, for if exhaust fumes are found to be partly responsible for serious illness, the motor car industry will face a challenge to do more than it has to control them.

The Automobile Manufacturers Assn. has been studying a project for development of a new filter to cut all noxious exhaust fumes to a minimum. Research on such a project is reported to be going on at General Motors.

As yet, there is no proof that auto exhaust fumes are related in any way to lung cancer. But where there is such a possibility, it needs to be thoroughly investigated. If such an inquiry could result in discovering a way to spare the public from breathing the fumes, it will be duly noted with widespread satisfaction and gratitude.

Kokomo Tribune
Aug. 12, 1959

Safety experts and single girls agree that the best kind of beach to swim off of is one that's well manned. —Terry McCormick.

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ORAL therapy in diaper rash!



Convenient... simply open a capsule and add the contents to the baby's daily formula, or to fruit juice or water. No lotions... no rinses... no ointments... just oral therapy.

Send for samples and literature.

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Philadelphia 20, Pa.

Effective therapy! Thousands of pediatricians and general practitioners prescribe Pedameth for ammonia dermatitis—and they continue to prescribe it. Clinical tests have proved its effectiveness. Pedameth is safe because it contains only dl-methionine (0.2 Gm.) one of the essential amino acids. When Pedameth is administered, the pH of the urine is lowered and an as-yet-unknown antibacterial agent appears in the urine. Pedameth works . . . it's the safe, effective, convenient answer to ammoniacal diaper rash.

Prescribe

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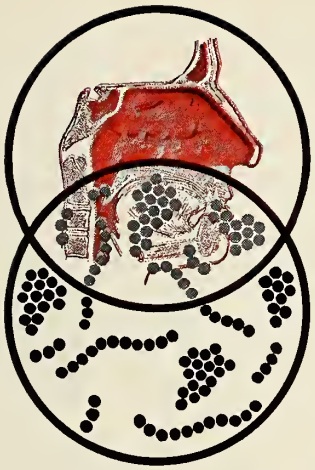
(dl-methionine DURST)

MORE
HIGHLY INDIVIDUALIZED
THERAPY
FOR THE
RHEUMATIC
"IN-BETWEEN"

when the
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disorder
is more
than salicylates
alone
can control...

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requires less
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intensive
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Aristo



when upper respiratory congestion is complicated by bacterial invaders

TRISULFAMINIC provides logical therapy

- for the patient ill with congestion and infection of the upper respiratory tract, as in purulent rhinitis, sinusitis, tonsillitis and otitis media, when caused by sulfa-susceptible bacteria;
- because secondary invasion by such bacteria so frequently follows the common cold.[1]

the reasons for combining Triaminic with triple sulfas

Triaminic and triple sulfas are not only pharmacologically *compatible*, they are a therapeutically *logical* combination for upper respiratory infections: Triaminic for effective decongestant relief from rhinitis, rhinorrhea and sinusitis;[2] triple sulfas for well-established antibacterial action.

The advantages of Trisulfaminic in upper respiratory infections include: proved effectiveness; safety; economy; ease of administration; less likelihood of sensitivity reactions;[3] compatibility with antibiotics and other antibacterial therapy. Provided also as Suspension for additional convenience.

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TRIAMINIC WITH TRIPLE SULFAS

Available as TABLETS and SUSPENSION

Each easy-to-swallow Trisulfaminic Tablet or 5 ml. teaspoonful of Suspension provides:

Triaminic® 25 mg.
(phenylpropanolamine HCl 12.5 mg.
pheniramine maleate 6.25 mg.
pyrilamine maleate 6.25 mg.)
Trisulfapyrimidines, U.S.P. 0.5 Gm.

Dosage:

Adults—2 to 4 tablets or tsp. initially, followed by 2 tablets or tsp. every 4 to 6 hours until the patient has been afebrile 3 days. *Children 8 to 12* — 2 tablets or tsp. initially, followed by 1 tablet or tsp. every 6 hours. *Children under 8*—dosage according to weight.

The palatability, convenience and effectiveness of the Suspension make it especially suitable for children and for those older patients who prefer liquid medication.

References: 1. Cecil, R. L., et al.: J.A.M.A. 124:8 (Jan. 1) 1944. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Beckman, H.: Drugs, Their Nature, Action & Use, Saunders, Philadelphia, 1958, p. 527.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

to the editor:

August 27, 1959

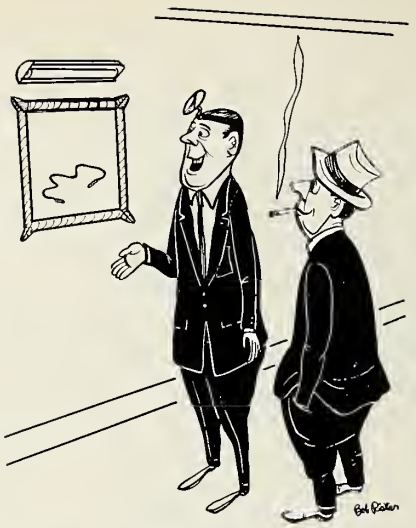
Dear Sir:

I wish to call your attention to an erroneous statement published in the August 1959 issue of the ISMA *Journal* on page 1260, paragraph 5, under a statement from the Vanderburgh County Medical Society regarding the checking of x-ray equipment.

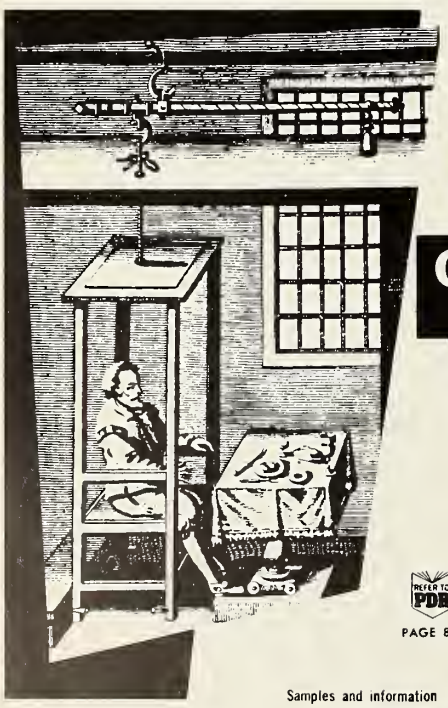
The statement is made that "Indiana has no registration law" regarding radiation equipment. I enclose a copy of the registration law which was passed by the Indiana State Legislature in January 1959 and which became effective on July 21, 1959. The registration of all radiation producing machines and radioactive sources will soon be carried out and should be completed by January 1960.

Yours very truly,
Jack A. Campbell, M.D.
Chairman
Department of Radiology
Indiana University

(Editor's Note: The work by the Vanderburgh County Medical Society in regard to safeguarding x-ray equipment was originated and partially completed prior to passage of the "Radiation Control Act of Indiana." Their report on the activity was written at about the time the new act was being passed. By virtue of the law the entire state will now benefit by the registration and control provisions of the new law.)



"That's a picture of our founder . . . this hospital was started on a shoestring."



Sanctorius on his steelyard chair in the act of weighing himself for a metabolism experiment

in obesity
bring the . . . MOOD UP
. . . WEIGHT DOWN
keep BLOOD PRESSURE LEVEL
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Quadamine GRANUCAPS® provide uniform and sustained therapeutic response. No excitation or sedation. Elevates the mood, protects against nutritional deficiencies, promotes activity and depresses the urge to eat.

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Dextro Amphetamine Sulfate	15 mg.	Vitamin C	30.0 mg.
Amobarbital	45 mg.	Ferrous Sulfate	20.0 mg.
Vitamin A	6,600 Units	Cobalt Sulfate	0.49 mg.
Vitamin D	400 Units	Copper Sulfate	2.8 mg.
Vitamin B-1	1.6 mg.	Sodium Molybdate	0.45 mg.
Vitamin B-2	2.5 mg.	Zinc Sulfate	3.9 mg.
Niacinamide	15.5 mg.	Potassium Iodide	0.13 mg.

REFER TO PDR
PAGE 826

Samples and information on request. Write or ask your TUTAG representative

TUTAG
S. J. TUTAG & COMPANY
DETROIT 34, MICHIGAN

■ Exhibits unusual analgesic properties, different from those of any other drug ■ Specific and superior in relief of SOMAtic pain ■ Modifies central perception of pain without abolishing natural defense reflexes ■ Relaxes abnormal tension of skeletal muscle

SOMA™

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■ More specific than salicylates ■ Less drastic than steroids

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SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with previously used analgesic, sedative or relaxant drugs.
SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

NOTABLY SAFE. Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy, particularly on high dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white coated 350 mg. tablets.
Literature and samples on request.

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A "Different" Way of Doing Business

This article is the ninth in a series prepared by Blue Cross — Blue Shield.

The effective administration of Blue Shield did not just happen. The methods and procedures used have been planned to produce the maximum advantages for members and doctors. Because of this planning, the contact you experience with Blue Shield whether through your patient, claims or service payments, has become a course of regularity. This matter-of-fact arrangement of working together is as it should be. Blue Shield methods of doing business offer procedural advantages not found in any commercial health care organization.

For example, the recognition and wide acceptance of the Blue Shield membership Identification Card is so commonplace that it is apt to be taken for granted. Yet, just as the growth of Blue Shield has been revolutionary in the field of health care, so has this Identification Card made its place in the concept of administering a health care financing program. It is a simple means of establishing credit for medical care once thought impossible to do.

Even the manner of processing a Blue Shield claim is a procedural advantage often overlooked. Confidential medical information is never furnished an employer. Because employers do not process claims as required by some commercial agencies, this information is never in their possession. A small point to many, but an important one to an employee when he is a patient.

The Blue Shield methods of operation dispute the advantages of major medical or deductible programs. The so-called "nuisance or small claims" are openly shunned by commercial companies through their deductible programs. They are considered too costly to administer. However, Blue Shield has the volume and procedural know-how geared to handle small claims at low cost, enabling even greater health protection to its members with first dollar coverage.

It would be impossible to set a fee for every medical procedure encountered. For this reason, in cases where the amount is not fixed or listed in the Blue Shield Schedule of Indemnities, a committee of doctors is called upon to establish a fair payment. On the other hand, commercial firms usually exercise the right of determining what insurance payments will be without regard to a general medical opinion. If a medical opinion is sought, it generally comes from the commercial firm's paid consultant.

Should there be a question about the Blue Shield payment made, a committee of physicians is called upon to discuss the case. This committee is appointed by the Blue Shield Board of Directors, a board that is elected through the Indiana State Medical Association. If an adjustment is warranted, it is made by Blue Shield. These committee members do not receive pay for their services. It is a contribution made in keeping with Blue Shield's philosophy of community responsibility.

Blue Shield was organized to provide a prepayment system for medical services. Speed of payment is important to the member and physician. For this reason, Blue Shield continuously strives to process claims in the shortest time possible. Through concentrated systems-procedure research, methods have been organized so that most claim payments are processed quite rapidly. With an average of 32,000 claims processed each month, this is no small task in itself.

The continuing development of new coverages or improvement in services is constantly sought by Blue Shield. It is a flexible organization, ready to meet changing conditions and always receptive to suggestions by medical groups.

Operating a health care financing program is not easy. Blue Shield believes its organization is equipped to do the job. Its "different" way of doing business is effective. Technical know-how, proven health protection programs, and genuine cooperation of physicians and hospitals enable it to do the job no commercial enterprise can match.

Sanford Schwartz
Public Relations Division

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 52 — November 1959 — Number 11

Vagotomy and Pyloroplasty
A Rational Procedure

JAMES Y. McCULLOUGH, M.D.

New Albany

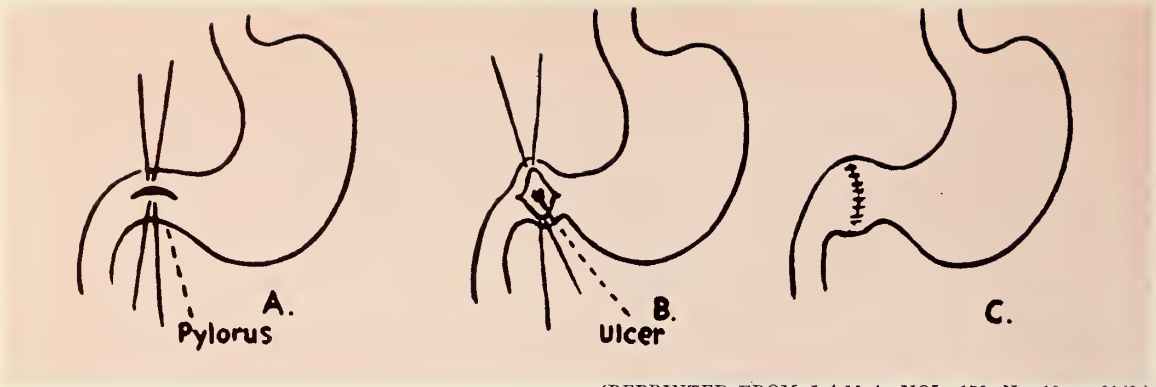
THE TREATMENT of the peptic ulcer in the absence of its complications remains a medical problem. The complications of duodenal ulcer, namely: perforation, hemorrhage, obstruction and intractable pain have, however, led to various surgical procedures and with varying degrees of success.

The operations which have been confined to procedures upon the stomach and small bowel have been directed toward excluding or removing the diseased portion and reducing the acid bearing area of the stomach.

The sub-total gastric resection operations have been followed by return of gastric acidity and gastric secretion in large volume in a disturbing percentage of cases and so recurrent symptoms and marginal ulcer have returned to plague the patient and the surgeon.

The operation designed to by-pass the diseased area or relieve a pyloric obstruction consisting of gastrojejunostomy has worked well in a peptic ulcer case with low acidity and a high degree of obstruction but has proven unsatisfactory in the case of high acidity and freely patent pylorus.

Reduction of gastric acidity by vagus section, introduced in 1943 by Drs. Dragstedt and Owens[1] after brilliant animal experiment and clinical experience, has proven the efficacy of this procedure in the reduction of acidity and the volume of secretion occurring in the stomach between meals. It is generally now accepted that duodenal ulcer is dependent upon the presence of increased acidity and that duodenal ulcer heals with diminished acidity and that such acidity is to a predominant degree controlled by a cephalic or neurogenic stimulation acting through the vagus nerve. Another element besides this nervous phase, is the hormone factor which regulates gastric secretion. This hormone, gastrin, is secreted by the stomach wall and the wall of the small intestine. Stimulation for the



(REPRINTED FROM *J.A.M.A.*, VOL. 170, No. 18, p. 2162.)

Figure 1

A. Gastroduodenostomy incision 6-8 cm. Placement of guy sutures.
B. Demonstration of posterior ulcer.
C. Transverse closure using one layer silk.

secretion of this hormone comes from the presence of food in the stomach or jejunum. Gastrin acts directly upon the acid secreting cells of the stomach. Antral stasis results in prolonged and excessive secretion of gastrin. Such hormonal hypersecretion as the cause of benign gastric ulcer is suggested.[2]

The factor which acts through the vagus nerve to stimulate gastric secretion no longer results in the outpouring of secretion in increased volume and the increase in acidity after a vagus section.

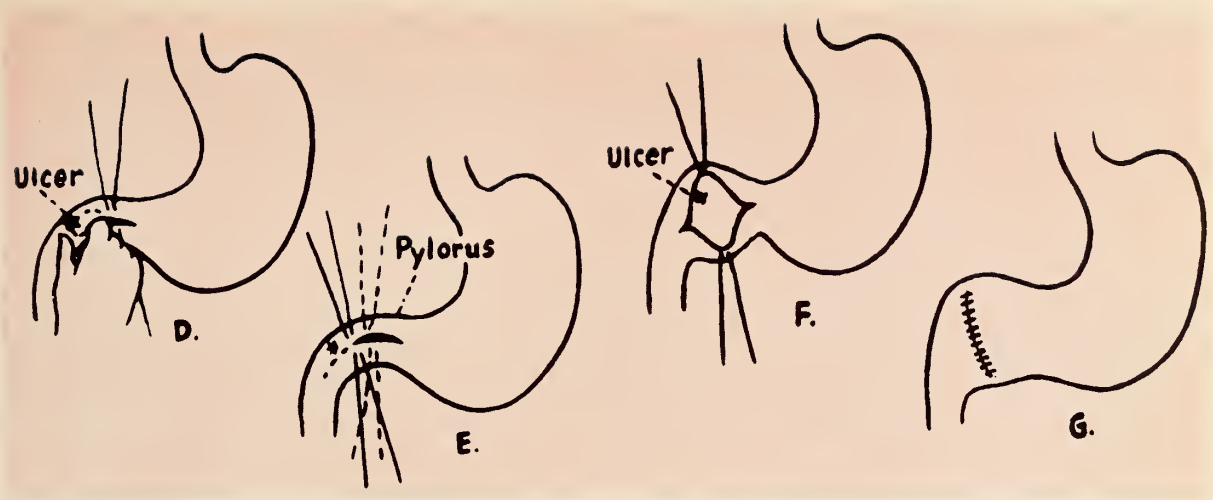
As in all new procedures the operators have been more or less on their own to discover errors and the operation of vagotomy has undergone modifications as a result of experience. Beginning in 1946 early results did not give the satisfaction which is commonplace with the operation done at the present time. Vagotomy alone, although successful in the healing of the ulcer, was accompanied by undesirable side effects. These side reactions were an aftermath of hypomotility and gastric retention and it resulted in re-operation in a significant percentage of cases. This brought about additional procedures to be done at the time of vagotomy which would insure or facilitate gastric emptying, and afford palpatation or inspection of the diseased area. Transthoracic vagotomy as a primary procedure gave way to an abdominal approach.

Gastrojejunostomy combined with vagotomy has proven effective as a drainage procedure to prevent antral stasis if placed in the most dependent portion of the stomach and parallel to the greater curvature.

There remained, however, the occasional problem of inadequate drainage due to improperly placed gastrojejunostomy, obstruction of the afferent or efferent limb of the jejunum and the dumping syndrome with which to contend.

In 1952 I began to use a pyloroplasty with increasing frequency as the drainage procedure and have found it eminently satisfactory.

Pyloroplasty offers the additional advantage of direct visualization of the disease area and palpation of the lumen of the distal duodenum where significant stricture may be found. Findings may cause reconsideration of the type of drainage procedure to be employed, i.e., duodenorrhaphy or gastrojejunostomy. In the case of the actively bleeding ulcer transfixation ligatures may be placed in the ulcer bed so hemorrhage may be quickly controlled. Bloating and anorexia when they occur after pyloroplasty are self-limited and post prandial pain has proven transitory. Pyloroplasty preserves the normal continuity of the gastrointestinal tract, obviates stasis in a redundant antrum, reduces surgical morbidity and in case recurrence of the ulcer dictates additional surgical attack, such subsequent surgical procedure can be accomplished with greater ease after prior pyloroplasty than after gastrojejunostomy. The pyloroplasty done by the Heineke-Mikulcz method of a longitudinal incision through the distal stomach and proximal duodenum and closed in a transverse direction is a simple procedure. It is modified by a one-layer closure of interrupted silk and has proven perfectly safe without one instance of trouble from leakage in 177 cases in which



(REPRINTED FROM *J.A.M.A.*, VOL. 170, No. 18, p. 2162.)

Figure 2

D. Gastroduodenostomy. Palpation of low lying ulcer with distal constriction.
E. Replacement of guy sutures. Indication for extension of the incision to 8-10 cm.
F. Demonstration of low lying ulcer.
G. Transverse closure using one layer of silk.

we have used this procedure since 1952. This closure adds to the efficiency of the pyloroplasty as a drainage procedure and avoids obstruction from subsequent cicatrization.[3]

Experience has taught us that the longitudinal incision should be a gastroduodenostomy one and about 6 to 8 centimeters in length and that in the presence of the low-lying ulcer, particularly with distal constriction, such gastroduodenostomy incision should extend for a length approaching 10 centimeters if need be to insure an adequate passage and avoidance of gastric stasis.

The failures in vagotomy are a result of incomplete vagotomy, antral stasis, inadequate immediate post operative care and the improper selection of cases for surgery. There is close correlation between symptomatic and objective improvement of the vagotomy as determined by the Hollander[4,5] insulin test. Incomplete vagus section is indicated by a rise in the volume of gastric secretion and increase in the acidity, by stimulation of the vagus by insulin induced hypoglycemia.

Vagotomy effectively reduces the volume of gastric secretion and the acidity and preserves the storage function of the stomach. Vagotomy and pyloroplasty as a drainage procedure has controlled the undesirable side effects of gastric retention, antral stasis and its stimulation of gastrin formation, jejunitis and regurgitation of jejunal contents into the stomach and also diminishes surgical morbidity. I have not observed the dumping syndrome after pyloroplasty.

Adequate post operative management demands the use of the naso-gastric tube for four or five days after surgery or establishment of a tube gastrostomy at the close of the operation. Gastrostomy, though prolonging the procedure a few minutes, offers the advantage of additional freedom of motion and obviates the nasopharyngeal irritation with its problem of increased secretion of phlegm. The secretion necessitates repeated efforts to keep the Levin tube open and this in itself may foster over-zealous efforts on the part of the nursing staff and adds to the annoyance of an already nervous patient. The excessive mucous may occasionally be sufficient to give rise to bronchiolar plugging and concern over-atelectasis. The gastrostomy tube may be clamped off after four or five days and re-opened occasionally as indicated after that time. The tube is removed on the seventh day and prompt closure of the tract in 24 hours is the rule.

Other post operative attention toward avoidance of hypokalemia is to be borne in mind. Ordinarily hypokalemia is not a factor unless gastric drainage by means of a tube has been necessary for a time before surgery or is for some reason prolonged following surgery. Electrolyte imbalance is somewhat less likely with

the use of a gastrostomy tube and gravity drainage than it is with the gastric tube applying constant suction, repeated lavage through irrigation and attempts on the part of the nursing staff to maintain an empty and dry stomach.

Following ingestion of food it is advisable to adhere to the principle of too little rather than too much and in case of fullness or tightness to skip a meal. Urecholine to decrease gastric emptying time is seldom needed but is a useful adjunct.

Ulcer-like symptoms, arising out of abnormal physiology in the emotionally unstable constitute a problem in diagnosis and care is necessary in selection of cases for surgery. Best results are obtained in the patient presenting definite objective signs of duodenal ulcer (x-ray confirmation, increase in volume of secretion and acidity in the daytime and in the 12-hour overnight collection). The poorest results of surgery are in the patient with the maximum in complaints but little in objective evidence.

After experience these past 12 years in 340 operated cases[6] I believe vagotomy combined with pyloroplasty as a drainage procedure is a rational, safe, conservative and effective method of surgical control of duodenal ulcer.

700 East Spring Street
New Albany, Indiana

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THE SEARCH FOR HIDDEN DIABETES

The American Diabetes Association, Inc., will again sponsor its annual Detection and Education Program the week of November 15th. Each ISMA member is urged to offer free tests of the urine during Diabetes Week in an effort to detect diabetes as early as possible in the people for whom he is medically responsible.

To improve the statistics on incidence it is suggested that a report to the Committee on Diabetes of your county medical society or of the state association be made showing the number of patients tested during Diabetes Week, the number showing glycosuria, and the number of these determined to have true diabetes.

The Committee on Diabetes of your county society needs volunteers to give talks about the Diabetes Detection program—to business men, Parent-Teacher Associations, women's organizations and other groups whose cooperation is essential if our unknown diabetics are to be guided to medical care.

A successful screening campaign during Diabetes Week—which is always the week immediately preceding Thanksgiving in November—requires no elaborate equipment or public fund-raising. Rather, it depends for its effectiveness on organizational effort volunteered by the physicians of a community with the cooperation of other professional and lay groups.

Rupture of the Uterus

RICHARD W. STANDER, M.D.

*Indianapolis**

FEW OBSTETRIC emergencies approach rupture of the gravid uterus in respect to maternal mortality and fetal loss. Certainly none is more dramatic. Although this complication occurs less frequently than other less lethal complications of obstetric practice, the dire consequences of this accident prompt occasional review of this condition with respect to frequency, cause, diagnosis and treatment.

The material for this current review is drawn from the Obstetric Service of the Indiana University Medical Center from Jan. 1, 1945, through April of 1959, as well as from the Obstetric Service of Marion County General Hospital from Jan. 1, 1950, through April of 1959. Twenty-one cases of rupture of the uterus have been treated during this time. During the same period, there have been 53,796 deliveries, or an occurrence of rupture of the gravid uterus once in each 2,557 deliveries. Figure 1 illustrates the incidence of rupture of the uterus in this current series compared to other series covering a similar span of time (Part B), as well as to the incidence reported from 1900 through 1945 (Part A). As noted, the incidence of uterine rupture on the two services studied is slightly lower than the current reports of Maisel and Voogd, but that the combined statistics of the most recent reports indicate that rupture occurs about as frequently as it did 30 years ago.[5,6] For purposes of discussion and presentation, ruptures of the uterus may be categorized as to whether they are *spontaneous* or *due to obstetric trauma*. Uterine ruptures may be further qualified as to *whether or not a scar was present in the uterus prior to rupture* (due to previous cesarean section, myomectomy, *et cetera*). A final classification necessary for accurate interpretation of data is that of whether the rupture is *complete* or *incomplete*. Complete rupture of the uterus is present when abdominal and uterine cavities communicate. Rupture may be classified as incomplete when the serosa of the uterus remains intact over a defect in the myometrium and endometrium. Such classification of the varieties of ruptured uterus is necessary because fetal and maternal outcome vary decidedly from one group to another, as do signs and symptoms. Figure 2 indicates the distribution of these 21 cases of uterine rupture in the current report with respect to classification. Further classification as to whether rupture is silent or overt, as recommended by some authors, was not deemed necessary in this small group of cases.

Maternal and Fetal Mortality

In the 21 cases of rupture of the uterus, there were two maternal deaths. This mortality rate of approximately 10% represents a substantial reduction in maternal mortality from the 47.1%, 52% and 61.9% reported respectively by Delfs, Dugger and Lynch.[2, 3, 4] It is also in accord with the maternal mortality contained in the current reports of Maisel and Voogd. This decrease in maternal mortality can undoubtedly be attributed in part to expansion of facilities for blood replacement, the advent of antibiotic therapy, advances in anesthetic technics, as well as general improvement in obstetric practice.

However, another reason may be postulated for this improvement in maternal mortality during recent years. In the early reports, a large proportion of the ruptures of the uterus was due to obstetric trauma, whereas in the current reports rupture through previous cesarean section scars constitutes one of the largest categories of uterine rupture. Maternal mortality in the latter instance is generally below that which is found when uterine rupture is due to other causes. The better outcome for the mother when rupture occurs through a scarred area in the uterus may be attributed to: 1) the fact that the scarred area

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is relatively avascular and maternal blood loss subsequent to rupture is decreased; 2) the alertness of the physician to the possibility of uterine rupture and the alacrity with which the diagnosis is made in the patient who has had a previous cesarean section; 3) the absence of several hours of labor prior to rupture which often enhances the possibility of peritonitis following rupture.

Maternal Deaths

One maternal death occurred in a 26-year-old, white, para 0, gravida 2. The patient was admitted to the Indiana University Medical Center from another hospital 60 hours after the onset of labor. Upon admittance, the occiput was found to be presenting 1 cm. below the ischial spines and the cervix was completely dilated. Blood pressure was 190/110 and a 3 plus albuminuria was present. The patient's oral temperature was 104°, there was clinical evidence of endometritis and no fetal heart tones could be heard. A mid forceps delivery of a stillborn, 3940 gram, male infant was accomplished with difficulty. Profuse vaginal bleeding followed delivery and manual exploration of the uterus revealed a complete rupture of the lower segment anteriorly. At laparotomy, the rupture appeared to be of recent origin; subtotal hysterectomy was accomplished. During the procedure, the patient became hypotensive and remained so until her demise two hours later. She received 2 units of whole blood. Autopsy was denied. In final analysis, it would seem that death was due to shock and that blood replacement had been inadequate. Severe preeclampsia and sepsis were complicating factors.

The second maternal death occured in a white, 34-year-old, para 3, gravida 4 admitted to the Marion County General Hospital at 34 weeks' gestation. Labor had begun 4 hours prior to admittance. The patient was a known chronic alcoholic and was intoxicated when admitted. An hour after entering the hospital, the patient complained of severe abdominal pain and slight vaginal bleeding was noted. The fetal heart tones, present upon admittance, were no longer heard. Laparotomy revealed a dead, female fetus of 1630 grams lying in the abdominal cavity. Complete rupture of the left side of the uterus was found and subtotal hysterectomy was carried out. Despite infusion of 8 units of whole blood, the patient's blood pressure gradually fell and she expired 4 hours after operation. Autopsy indicated severe degenerative changes secondary to malnutrition and it was felt that poor general physical condition may have been a contributing factor in this patient's death.

INCIDENCE OF RUPTURE OF THE UTERUS

A. PRIOR TO 1945

AUTHOR	DATE	NO. CASES	DELIVERIES	INCIDENCE
DUGGER	1931 - 1941	105	318,103	1:3029
DELFS	1900 - 1944	53	53,574	1:1010
LYNCH	1920 - 1945	44	41,706	1:1118
	TOTAL	202	413,383	1:2465

B. SINCE 1943

AUTHOR	DATE	NO. CASES	DELIVERIES	INCIDENCE
VOOGD	1943 - 1955	12	17,181	1:1432
MAISEL	1945 - 1955	11	21,209	1:1929
STANDER	1945 - 1959	21	53,796	1:2557
	TOTAL	44	92,186	1:2093

Figure 1

In the 19 patients who survived rupture of the uterus, postoperative morbidity was noted in 8 (42%). Morbidity was observed only in those in whom labor had been established prior to rupture and was presumably due to spread of infection from the uterine cavity to peritoneal surfaces of the pelvis.

Fetal Loss

Comparison of current reports with reports prior to 1945 indicates that reduction in maternal mortality has not been accompanied by a concomitant decrease in fetal loss. Fetal loss prior to 1945 has been quoted by Dugger as being 62%, Delfs 80% and Lynch 89%. In the present review, the fetus was lost in 15 cases (71%). Fetal loss is generally the highest in the category of complete spontaneous rupture of the uterus occurring before the onset of labor or during the first stage of labor. In such instances, the infant has usually expired by the time laparotmy can be accomplished. In 11 such instances in this series, no infant survived. On the other hand, when rupture is due to obstetric trauma, such trauma usually occurs during the act of delivery, thus fetal survival depends more upon the degree of trauma to the fetus rather than rupture of the maternal uterus *per se*. In seven such cases in this series, three infants survived. In addition, incomplete ruptures of the uterus are often silent and discovered after delivery or at the

time of repeat cesarean section in an asymptomatic patient and fetal survival should be better in this particular group. In the three cases in which incomplete rupture of the uterus occurred, all infants survived.

Etiologic Factors in Uterine Rupture

In 6 instances (29%), rupture of the uterus took place at the site of previous cesarean section scar. Four of these cases represented complete spontaneous ruptures through cesarean section scars in the upper portion of the uterus prior to the onset of labor. It is of interest to note that in two instances in which rupture of the uterus occurred in patients who previously had had both "classic" and lower segment cesarean section subsequent complete rupture occurred in the upper scar. One case of incomplete rupture of a previous lower segment incision was noted in an asymptomatic patient at the time of repeat cesarean section during the 39th week of pregnancy. The second instance of incomplete rupture at the site of previous cesarean section also followed a previous lower segment operation. Repeat cesarean section was performed in this patient at 35 weeks' gestation because of progressive lower abdominal discomfort and tenderness of one week's duration.

This meager data should not be interpreted as qualifying the now popular lower segment operation incapable of complete spontaneous rupture. However, current opinion holds that rupture during subsequent pregnancy occurs less frequently following the lower segment operation than following "classic" cesarean section. No cases of rupture of the uterus during labor in patients with previous cesarean sections are recorded in this series since it is the general policy of both services to perform repeat cesarean section prior to the onset of labor once maturity of the fetus is assured. At this time, there is no active program designed to select certain patients to deliver vaginally after cesarean section. It is often pointed out that postoperative infection may lead to faulty healing of the uterus following cesarean section, predisposing to rupture during subsequent pregnancy. However, in the four complete and two incomplete ruptures following previous cesarean section, there was no evidence of postoperative morbidity following previous cesarean section. The average age of these six patients was 27. Two patients had had one cesarean section prior to rupture, three patients had had two previous cesarean sections and the remaining patient had had three cesarean sections preceding rupture of the uterus. The earliest rupture with respect to length of gestation occurred at 32 weeks, while the latest occurred at 40 weeks. The average duration of gestation at which uterine rupture due to previous cesarean section occurred was 34.5 weeks. No maternal deaths occurred in these patients and this encouraging note is sounded by other authors. As noted before, maternal mortality should be low even when complete spontaneous rupture through the site of previous cesarean section scar occurs prior to the onset of labor. The patient with a previous cesarean section should be observed closely throughout the last trimester of pregnancy for persistent abdominal discomfort and tenderness. The appearance of these symptoms may signify incomplete rupture of the uterus.

Spontaneous rupture of the unscarred uterus occurred eight times (38%) in the present series. It occurred in two patients prior to the onset of labor. In one of the latter, rupture of the uterus associated with abruptio placentae occurred at 33 weeks' gestation. In the other patient who was not in labor, rupture occurred at 16 weeks of pregnancy through an underdeveloped horn of a bicornuate uterus, the site of placentation. Surprisingly enough, prolonged labor was not a striking feature in the six patients in whom rupture occurred during labor. Prolonged labor was recorded in only one instance (29 hours). The average duration of labor was

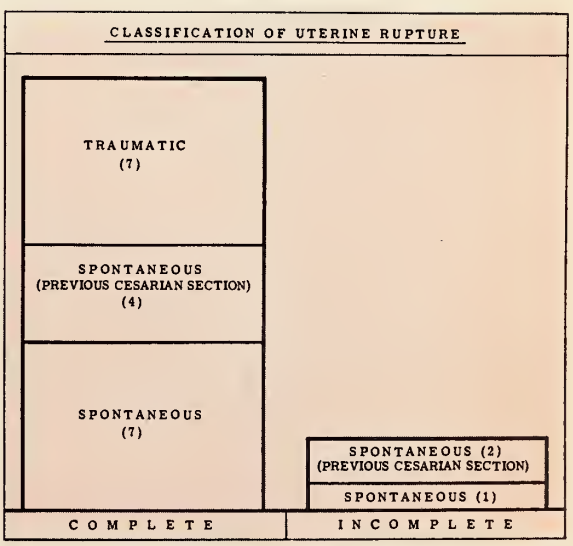


Figure 2

RUPTURE OF THE UTERUS DUE TO OBSTETRIC TRAUMA					
OBSTETRIC TRAUMA	AGE	PARITY	FETAL WEIGHT (Grams)	MATERNAL OUTCOME	FETAL OUTCOME
MIDFORCEPS	26	0	3940	DIED	STILLBORN
MIDFORCEPS	40	4	5450	LIVED	LIVED
FAILED MIDFORCEPS (CESARIAN SECTION)	19	1	3860	LIVED	LIVED
SHOULDER DYSTOCIA (INTRAUTERINE MANIPULATION)	31	4	5522	LIVED	STILLBORN
BREECH EXTRACTION	30	3	2951	LIVED	LIVED
LOW FORCEPS (INCOMPLETELY DILATED CERVIX)	24	2	3080	LIVED	NEONATAL DEATH
INTERNAL VERSION and EXTRACTION	31	3	2690	LIVED	STILLBORN

Figure 3

15 hours and in three cases labor had been in progress 12 hours or less when spontaneous rupture of the uterus occurred. In only one patient was there a history of previous intrauterine manipulation or infection and this was a criminal abortion followed by endometritis in the pregnancy preceding the one during which rupture occurred.

The factors of age and parity of patients in whom spontaneous rupture occurred during labor are of interest. The average age was 33, while the average parity was four. Fetal weights in this group averaged 3855 grams and two infants weighed more than 4530 grams. Thus, spontaneous rupture of the uterus without previous scar would seem more likely to occur in the patient in the fourth decade with a relatively high degree of parity. Fetal oversize commonly occurs and, in a review of these records, it would seem that unrecognized cephalopelvic disproportion was an important factor in spontaneous rupture of the uterus in four patients. Such rupture was not necessarily the consequence of prolonged labor. Thus, the parous individual who has successfully delivered infants of normal size must be evaluated carefully during labor when abdominal palpation suggests the presence of an infant appreciably larger than the previous ones. Too often there is a tendency to accept the parous individual with complacency and optimism, often unjustified, based solely on past performance. In no instance was the use of oxytocics incriminated in spontaneous rupture of the uterus in this series. Although such agents are employed on both services in cases of uterine inertia as well as for the medical induction of labor when the latter is indicated for maternal or fetal cause, it is felt that their cautious use in indicated cases in controllable, dilute intravenous infusion is safe after careful evaluation of the patient as to presentation, position and adequacy of the pelvis in respect to the particular fetus involved. This degree of safety does not exist when evaluation of the patient is inadequate or the preparations are used in the intramuscular form.

The third major category consists of iatrogenic uterine rupture. Rupture due to obstetric trauma occurred seven times in this collected series of patients (33%). Figure 3 outlines the various types of obstetric trauma encountered in these patients, as well as maternal age, parity, fetal weight and maternal and fetal outcome. All ruptures in this category were complete. It is noteworthy that internal podalic version and extraction accounted for only one rupture in the entire series of 21 patients (approximately 5%), whereas, in earlier reports covering the period from 1900 through 1945, version and extraction accounted for 21%, 31% and 45% of all ruptures of the uterus.[2,3,4] It is to be commended that current obstetric practice has restricted the use of this procedure almost completely to its occasional employment in delivery of the second twin in case of fetal distress or premature separation of the placenta. Most of the instances in which internal version and extraction were formerly practiced are now best treated by timely cesarean section. It will be noted from Figure 3 that again in this category large fetal size was a common finding in these patients in whom rupture occurred due to obstetric trauma. In four cases of rupture of the uterus due to obstetric trauma, unrecognized feto-pelvic disproportion was present. This includes the three instances of rupture during attempt at mid forceps delivery, as well as the case of rupture of the uterus that occurred in an attempt to overcome shoulder dystocia. In four of the seven cases, rupture was discovered promptly following vaginal delivery because of persistent bleeding. In another instance, the rupture was discovered at cesarean section following an unsuccessful attempt at mid forceps delivery. In the case of rupture of the uterus that occurred during internal podalic version, the accident was not discovered until five hours after delivery, at which time the patient went into shock following profuse vaginal bleeding. In one case, rupture was discovered at the time of examination and curettage for abdominal

pain and bleeding persisting for two weeks after delivery. Manual exploration of the uterus should be accomplished under the following circumstances:

1. Difficult forceps delivery.
2. Breech extraction.
3. Laceration of the cervix.
4. Vaginal delivery following previous cesarean section.
5. Excessive postpartum bleeding.
6. Vaginal delivery of large infants.

Signs and Symptoms of Complete Uterine Rupture

Figure 4 indicates the signs and symptoms occurring in the 11 cases of complete spontaneous rupture of the uterus. As mentioned, vaginal bleeding was a consistent sign in instances of uterine rupture due to obstetric trauma. However, since all of the latter patients were anesthetized at the time of rupture, there were no subjective findings to evaluate. In the 11 cases of spontaneous complete rupture analyzed in Figure 4, rupture occurred either prior to the onset of labor or during the first stage of labor and thus enabled analysis of subjective complaints as well as objective findings. Abdominal pain was the most consistent finding of all. Usually, it was severe and sudden in onset. Although vaginal bleeding was recorded in five instances, it was invariably described as slight or mild in nature. No instance of vaginal bleeding was recorded when complete rupture occurred through cesarean section scar prior to the onset of labor. Shock following the onset of pain was the most consistent sign in these patients. Although cessation of uterine contractions was recorded only four times after complete spontaneous rupture of the uterus, this is significant in that it represents the total number of patients in whom labor had been established when this catastrophe occurred. In one case in which rupture of the uterus occurred during labor, recession of the presenting part by vaginal palpation was noted. In only three of the 11 cases did abdominal examination reveal readily palpable fetal parts suggestive of extrusion of the fetus into the abdominal cavity.

Management

Successful management of the patient with the ruptured uterus depends upon: 1) early diagnosis; 2) prompt and sufficient blood replacement; 3) ancillary measures to combat shock; 4) the appropriate surgical procedure necessary to produce hemostasis in the individual case; and 5) the prevention of sepsis. In the 21 patients under study, blood replacement averaged 4.1 units per patient during the immediate preoperative, operative and postoperative periods, yet blood value determinations during convalescence in six patients indicated inadequate blood replacement and additional transfusions were carried out prior to discharge in these patients. This indicates a common tendency to underestimate blood loss in the patient with rupture of the gravid uterus.

Although the technic of intra-arterial infusion of whole blood as described by Collins was utilized in none of these patients, such a procedure may prove valuable in an occasional patient with marked blood loss. Collins has described the successful treatment of shock in obstetric and gynecologic patients by direct intra-arterial infusion with an 18-gage needle placed in one of the pelvic arteries and directed toward the heart. His experience indicates that circulatory equilibrium is quickly established and it is then possible to maintain the patient by the usual intravenous infusion route.[1] When the diagnosis of uterine rupture is suspected or established, two routes of intravenous infusion should be established by venapuncture. If venous collapse has already occurred, a venous cut-down should be quickly performed. Clotting defects due to hypofibrinogenemia may be associated with uterine rupture and this possible complication must be borne in mind.

The surgical management of the patient may vary from simple closure of a small rent in the

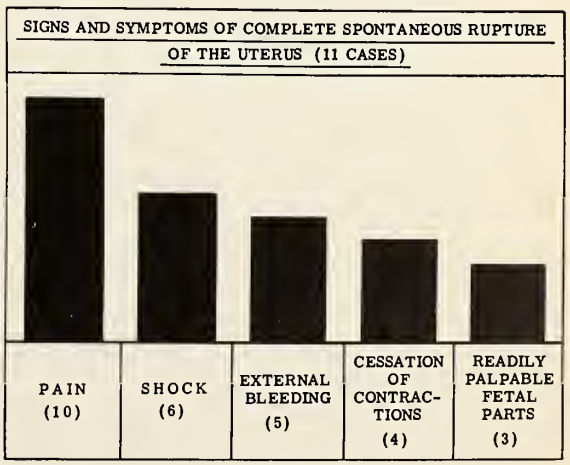


Figure 4

uterus to total abdominal hysterectomy. The former was carried out in the two patients in whom incomplete rupture was found at the time of repeat cesarean section. In both cases, the edges of the site of rupture were freshened and reapproximated following cesarean section. One of these patients has had a subsequent successful pregnancy also terminated by cesarean section with no evidence of a second dehiscence. In the other, tubal ligation was carried out at the time of uterine repair. In 18 cases, subtotal hysterectomy was carried out, while total hysterectomy was utilized once. The age, parity, site and extent of rupture, as well as the patient's condition, will determine the extent of surgical management in the individual case. In many cases of uterine rupture, shock will have preceded laparotomy and the surgical procedure indicated will be that which will produce adequate hemostasis with the shortest operating time. Usually this will be subtotal hysterectomy. However, if the patient's condition is good, total hysterectomy may be utilized. The total operation may be advantageous in certain instances of lacerations of the cervix accompanying or continuous with uterine rupture.

Occasionally when the diagnosis of ruptured uterus is made at delivery and laparotomy is performed, the surgeon is dismayed to observe continued vaginal bleeding after removal of the uterus. Such bleeding may arise from vaginal lacerations previously overlooked.

Antibiotics should be employed in instances in which rupture is incurred during labor or at the time of delivery since bacteria are usually present in the uterus under these circumstances and peritonitis may follow rupture.

Summary

Twenty-one cases of rupture of the gravid uterus have been discussed. The incidence of this complication in these two hospitals is one case per 2,557 deliveries. The maternal mortality is approximately 10%; fetal loss is 71%. The most common single cause for uterine rupture in these institutions is previous cesarean section. Spontaneous rupture of the unscarred uterus is often associated with the patient in her fourth decade, a high degree of parity, a large infant, and often with unrecognized disproportion. Traumatic rupture of the uterus still occurs to a large extent with unrecognized disproportion in multigravidae with large infants. The signs and symptoms and the treatment of uterine rupture have also been discussed.

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MYCOBACTERIAL AND MYCOTIC DISEASES CONFERENCE

A one-and-a-half-day Conference on Mycobacterial and Mycotic Diseases with Special Reference to Childhood will be presented in New Orleans at the L. S. U. Medical School on December 10 and 11, 1959. The Conference is sponsored by the Tuberculosis Association of Greater New Orleans, the medical school, Tulane School of Medicine and the Orleans Parish Medical Society. Members of the ISMA are invited to attend. Further details may be obtained by addressing W. Findley Raymond, 1240 Camp St., New Orleans 13.

Habitual Abortion—Its Causes and Treatment

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IN RECENT years the practicing physician has been exposed to and inundated with innumerable conflicting reports on the treatment of habitual abortion. There are almost as many therapeutic regimens as there are writers on the subject. Reports of high success rates are attributed to such divergent methods as bed rest, antiluetic treatment, a variety of hormonal agents, psychotherapy, or specific vitamin medication (Table I). It is necessary, therefore, to analyze this problem more critically and to place the various therapeutic agents in their proper perspective.

Definition

Habitual abortion may be defined as the occurrence of three or more consecutive spontaneous abortions. The abortions must be consecutive and not interposed with viable pregnancies, in order to place the patient in the category of an habitual aborter. Lack of strict adherence to this definition has prevented a proper statistical analysis of the results gained from the proffered regimens of treatment.

Etiology

The basic pathologic processes leading to habitual abortion are multiple and must be considered individually in any therapeutic attack. Failure to recognize this variability of causes has created much confusion and led to false impressions by many writers and clinicians. Each patient should be studied as completely as possible and her treatment individualized according to the underlying pathology, insofar as is practical.

The basic pathology in habitual abortion may be divided into nine groups as shown in Table II. It is apparent that there is some overlapping in these groups and that a given patient's difficulties may be based on more than one of the factors listed here. The relative frequency of each factor as a cause leading to repeated miscarriages is not accurately known.

Anomalies and Tumors of the Uterus

Under this heading are included those anomalies and growths which tend to encroach on or distort the endometrial cavity. The most common anomalies are those resulting from varying degrees of incomplete fusion of the Mullerian duct system to give a bicornuate, septate or arcuate uterus (Figure 1). The most common tumor is a submucous myoma (Figure 2). Pure chance seems to play a part in the outcome of a pregnancy under these circumstances, since many women with these abnormalities will be able to produce viable infants if the ovum implants itself in such a location as to allow adequate room for growth of the placenta. Implantation on the septum or around a myoma does not favor adequate placental growth and may well eventuate in abortion. The diagnosis of these conditions may be suspected by history and pelvic examination and confirmed by hysterosalpingography or instrumental exploration of the uterus after dilatation of the cervix. Treatment is purely surgical, in the form of various unification procedures[21] and myomectomies.

Incompetent Cervical os

In 1948, Palmer and Lacomme first described the incompetent os of the cervix as a cause of late abortion or premature labor and devised a successful operative procedure for its correction.[15] Since that time, much has been written about the diagnosis and treatment of this anat-

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omic defect. Commonly, the patient with an incompetent internal os of the cervix gives a history of middle trimester labor and delivery with subsequent pregnancies being terminated progressively earlier. The patient may have had a previous term delivery with severe lacerations of the cervix, or the defect may be congenital in origin. On the other hand, the incompetency may be on a functional basis without a demonstrable defect. History will reveal that previous pregnancies have progressed normally to a certain stage when the membranes painlessly extruded through the cervix and ruptured to be followed by a miniature labor with expulsion of the products of conception. The diagnosis of this condition is made on the basis of history and the x-ray findings of a wide open gaping internal cervical os. Easy insertion of a sound, cannula, or other instrument suggests the diagnosis, and Palmer claims that ability to insert an 8 mm. Hegar dilator through the internal os is diagnostic.[16] The purely surgical treatment is aimed at restoring the internal os to its normal anatomy and physiology by removing a wedge of the cervix as in the Lash procedure,[12] or preferably by tightening the cervical os with a strip of fascia lata, as pioneered by Shirodkar[19] and since modified by many gynecologists who have employed a synthetic plastic material or a dacron ribbon for tightening the os. Although this corrective procedure is done preferably in the non-pregnant state, it may be performed on the pregnant cervix if the incompetency is discovered before rupture of the membranes. Barter[1] prefers to perform the procedure between the 8th to 12th week of pregnancy.

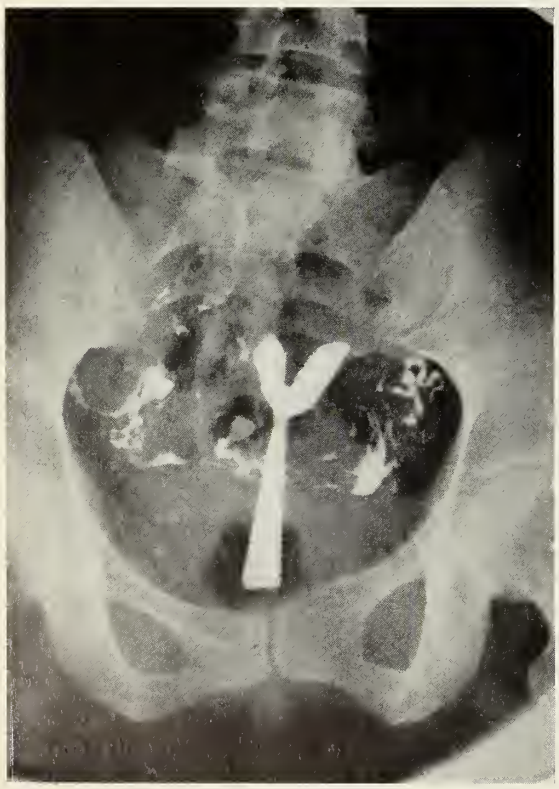


Fig. 1. Hysterosalpingogram of bicornuate uterus.

Pathologic Conceptus

Under this category are included those abortions in which there is an abnormality of the ovum, fetus or cord. Although the belief in the "blighted ovum" as a cause of abortion is widespread, abnormalities of the ovofetus were found in only 27% of Javert's cases[9] and in 36% of the series reported by Wall and Hertig.[22] On the other hand, Hertig and Sheldon report finding pathologic ova in 52% of all abortions.[8] It must be emphasized that the pathologic conceptus may result from other causes than poor protoplasm, a fact which may decrease the importance of this cause of abortion. Little may be done therapeutically in these instances except to attempt to correct any defects which may be found in the husband's semen.

Improper Placentation

Abnormal implantation of the normal ovum, with resulting poor placental function, is frequently noted in a single abortion but is a rare cause of repeated miscarriages. Here chance plays a part, and other than in those cases in which distortion by anomalies or tumors directs improper implantation, little may be offered therapeutically.

Vascular Disorders

In a large majority of abortions, decidual hemorrhage will be seen on histopathologic examination. Whether this be the primary cause of the abortion is frequently difficult to discern; however, other causes may not be evident, leading to the conclusion that this may be a common origin for the abortive process. One of the mechanisms of decidual hemorrhage is a defect in the clotting mechanism of the patient. The role of the various vitamin preparations in the clotting process has long been known and vitamins have been used therapeutically by many investigators. A deficiency of vitamin C has been



Fig. 2. Hysterogram (lateral view) showing large filling defect representing a submucous nyoma later proved at operation.

definitely correlated with decidual hemorrhage and an increased incidence of abortion.[10] With the observation that easy bruisability was often seen in habitual aborters, Greenblatt began to test capillary fragility in these patients and found evidence of increased fragility in many of them as shown by a positive petechial test.[5a] The isolation of the anti-hemorrhagic factor, hesperidin, among the citrus bioflavonoids led to its use in these patients. With the use of hesperidin and vitamin C*, a positive petechial test may frequently be converted to negative, and it is our impression that such therapy will decrease the incidence of abortion in this group (Table III). Vitamin K may also be of some benefit. The mechanism of action in the prevention of abortion is not known, but it probably acts to lessen the chance of decidual hemorrhage by decreasing capillary fragility.[5a]

Relative Thyroid Deficiency

Increased thyroid activity has long been noted to be a normal reaction to pregnancy. This is seen clinically in the form of diffuse enlargement of the gland, heat intolerance and tachycardia. In the laboratory one finds elevation of the basal metabolic rate and protein bound iodine. The BMR normally begins to rise about the fourth month of gestation and progressively increases until the time of delivery.[4] The PBI often rises to hyperthyroid levels by the 5th to 8th week and remains at this same level throughout pregnancy.[7] This rise has recently been shown to be due to increased binding of thyroid hormone by thyroxine binding protein.[18] It has been shown though not confirmed by other workers[20] that an absence of this rise is associated with an increased incidence of abortion, several observers stating that as many as two-thirds of all patients who aborted failed to show this increase in PBI.[7, 17] One case of an inevitable abortion, saved by intravenous and later oral thyroxine, without other therapy, offers an idea of the importance of adequate thyroid activity for the successful continuation of pregnancy.[7] It must be pointed out that the absolute level of the PBI is not as important as evidence of an increase over the non-gravid state. Obviously, thyroid hormone in any form will correct this

* Hesper-C (hesperidin with vitamin C) was used in our studies, and acknowledgement of generous supplies is made to Mr. Steven Horoschak of National Drug Company.

Table I

HABITUAL ABORTION

AUTHOR	AGENT	SALVAGE	CRITERION (No. of Abortions)
Davis and Fugo	Stilbestrol	45%	2 or more
	Progesterone	66%	" " "
Sw er and Daley	Control	75%	" " "
	Progesterone	80%	" " "
Smiths	Stilbestrol	73%	3 or more
Bishop	Progesterone	72%	" " "
Javert	Psychotherapy, C, K, P	91%	" " "

Table I. Illustration of excellent fetal salvage obtained in habitual abortion by investigators using various therapeutic regimens.

defect in the endocrinologic reaction to pregnancy.

Abnormal Gonadotropin, Progesterone, and Estrogen Metabolism

Abnormalities of gonadotropin, estrogen and progesterone metabolism may be reduced to simple discussion of the action of progesterone and its relationship with estrogen. Gonadotropins seem of little import if the patient has adequate progesterone in proper ratio to estrogen. It may be assumed that any pregnant patient having a urinary pregnanediol excretion of less than 5 mg. per 24 hours is deficient in progesterone and should be treated promptly and adequately.[2] In certain animals, removal of the corpus luteum at any stage of pregnancy is followed by abortion, which can be prevented by the administration of progesterone. In certain other animals, including the human, the corpus luteum is essential only for a specified time after which its removal will not influence the gestation. Estrogens act synergistically with progesterone in the maintenance of pregnancy and the ratio of progesterone to estrogen appears to be the important factor. Kelly showed that the administration of large doses of estrogen to the pregnant dog caused abortion[11] and similar findings have been demonstrated in other animals. Normally the ratio of progesterone to estrogen in the pregnant woman is 2500:1, or perhaps as low as 1000:1.[14] Although a decrease in this ratio results in abortion in the rabbit, it does not in the human, which is probably related to the rapid deactivation of estrogens in man. It is significant, however, that recent experience here indicates that the newer progestational agents which possess a great deal of estrogenic activity (such as 17-a-ethinyl-19-nor-testosterone and norethynodrel with 3 methyl ether of ethinyl estradiol) are not as effective in maintaining pregnancy in habitual aborters as pure progesterone has been. Experiments here and elsewhere have shown near-total failure of these compounds to maintain gestation in pregnant rabbits ovariectomized on the 8th day.[6] This would seem to bear out the need for caution in administering these substances to habitual aborters. We share the experiences of Davis and his co-workers,[3] that injections of long-acting preparations such as 17-alpha-hydroxyprogesterone caproate (Delalutin)* and estradiol val-

* The Delalutin and Delestrogen used in our studies were generously supplied through the courtesy of Dr. E. C. Reifenstein Jr. of E. R. Squibb and Sons.

Table II

ETIOLOGIC FACTORS IN HABITUAL ABORTION

1. ANOMALIES AND TUMORS OF THE UTERUS
2. CERVICAL INCOMPETENCE
3. PATHOLOGIC CONCEPTUS
4. VASCULAR DISORDERS
5. IMPROPER PLACENTATION
6. RELATIVE THYROID DEFICIENCY
7. ABNORMAL GONADOTROPIN, ESTROGEN AND PROGESTERONE METABOLISM.
8. PSYCHOGENIC FACTORS
9. MISCELLANEOUS FACTORS

Table II. Self-explanatory.

erate (Delestrogen)* have been more effective in preventing abortion in these hormonally deficient women. An excellent practical method of following such therapy or determining the need for it is examination of the cervical mucus for ferning. The presence of ferning during pregnancy indicates that estrogen is overriding the progesterone effect and more progesterone is needed.[5b]

Psychogenic Factors

The similarity of results obtained with widely differing modes of therapy has led many observers to emphasize the influence of the psyche in habitual abortion and to suggest that the major benefit of the various treatment programs lies in their psychotherapeutic value. This has been emphasized by several investigators and exhaustive studies of the psychodynamics of habitual abortion have been undertaken. That this may well be a factor has been evidenced in a statistically significant percentage of aborters who may be carried through subsequent pregnancies with no medication other than sedatives and conversation.[13] It would seem impossible for the average practicing physician to make a positive diagnosis of this as an etiologic basis for habitual abortion, so it must be made in a negative sense by ruling out other causes for repeated miscarriages. Certainly, all of these patients should receive a certain amount of simple psychotherapy but its place in the over-all treatment of the problem remains conjectural.

Miscellaneous Factors

Under this heading are included such conditions as syphilis, nutritional deficiencies of various kinds and chronic diseases. These are probably not common causes of habitual abortion and rarely will repeated miscarriage be the major complaint of the patients.

Treatment

The treatment of habitual abortion must be divided into two phases. The first phase consists of procedures that should be carried out to determine if possible the etiologic basis of the repeated abortions in the patient who presents herself before conception. A careful history and physical examination will frequently reveal certain points which tend to suggest one or more of the listed causes. Special procedures which should be done are the petechial test which may be performed as in Figure 3, serum protein bound iodine and cholesterol, hysterosalpingography, endometrial biopsy, and examination of the husband's semen. Abnormalities found are corrected whenever possible.

The second phase of therapy is employed after conception takes place. It is apparent that most practitioners have neither the fortitude nor the facilities to attempt to discern the exact mechanism operating in the patient who faces him with a greater than 80% chance of losing her pregnancy before viability is reached; consequently, all-inclusive therapy to cover every pos-

sibility is usually employed. Although empiric in most respects, such "shot-gun" therapy is frequently the only course to follow. Procedures which may be carried out consist of drawing blood for a PBI and cholesterol, examination of the cervical mucus, and a gentle, careful pelvic examination to detect any abnormalities, notably retroversion, which can be corrected without endangering the gestation. The regimen of medical therapy used with greatest success here has been constituted as follows:

1. Supplementary thyroid in a dosage equivalent to one-half to one and one-half grains of desiccated thyroid per day, or 25 to 100 mcgm. of triiodothyronine.*

2. Hesperidin with vitamin C in doses of 500 mg. of each per day.

3. Vitamin K in doses of 10 mg. a day.

4. Multi-vitamin preparations in recommended doses.

5. Weekly to semi-weekly injections of 250 mg. of 17-alpha-hydroxyprogesterone caproate and 5 mg. of estradiol valerate through the 28th week.

6. Psychotherapy in the form of reassurance, interest, careful attention to all questions and certain tranquilizers or sedatives.

This regimen has given a satisfactory salvage rate in habitual abortion and its efficacy in threatened abortion is even greater. The major difference in the treatment of the two groups has been the institution of therapy as soon as pregnancy is confirmed in the former and with the first sign of bleeding or cramps in the latter.

* Supplies of triiodothyronine used in this study were provided as "Cytomel" by Smith, Kline and French Laboratories.

Conclusions

1. Much confusion exists as to the best mode of therapy in habitual abortion because of poor selection of patients and lack of understanding of basic processes involved in this condition.

2. There are nine different basic etiologic factors involved in repeated miscarriages, and each must be considered in every patient.

3. All-inclusive therapy to cover all of these possibilities offers the best fetal salvage rate.

4. Caution must be exercised in the use of some of the newer 19 norprogestational agents in the treatment of habitual abortion. Although successes have been encountered with their use it is our experience that better results have been obtained with long-acting estrogen-progesterone therapy administered at weekly or bi-weekly intervals.

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Table III

HABITUAL ABORTION: SUCCESSFUL TREATMENT AND EXPECTED PREGNANCY

No. patients	*No. abortions each pt.*	*Success*	*Failure*	*Results (%)*	*Estimated results (%)*
Group 1: 7	3 to 8	4	3	57.1	16.4
Group 2: 13	2	11	2	84.6	63.1
TOTAL 20					

Table III. Results of treatment in habitual abortion using hesperidin with vitamin C in conjunction with hormonal therapy. (From Greenblatt, R. B., Habitual Abortion, *Obstetrics and Gynecology* 2:530. 1953).

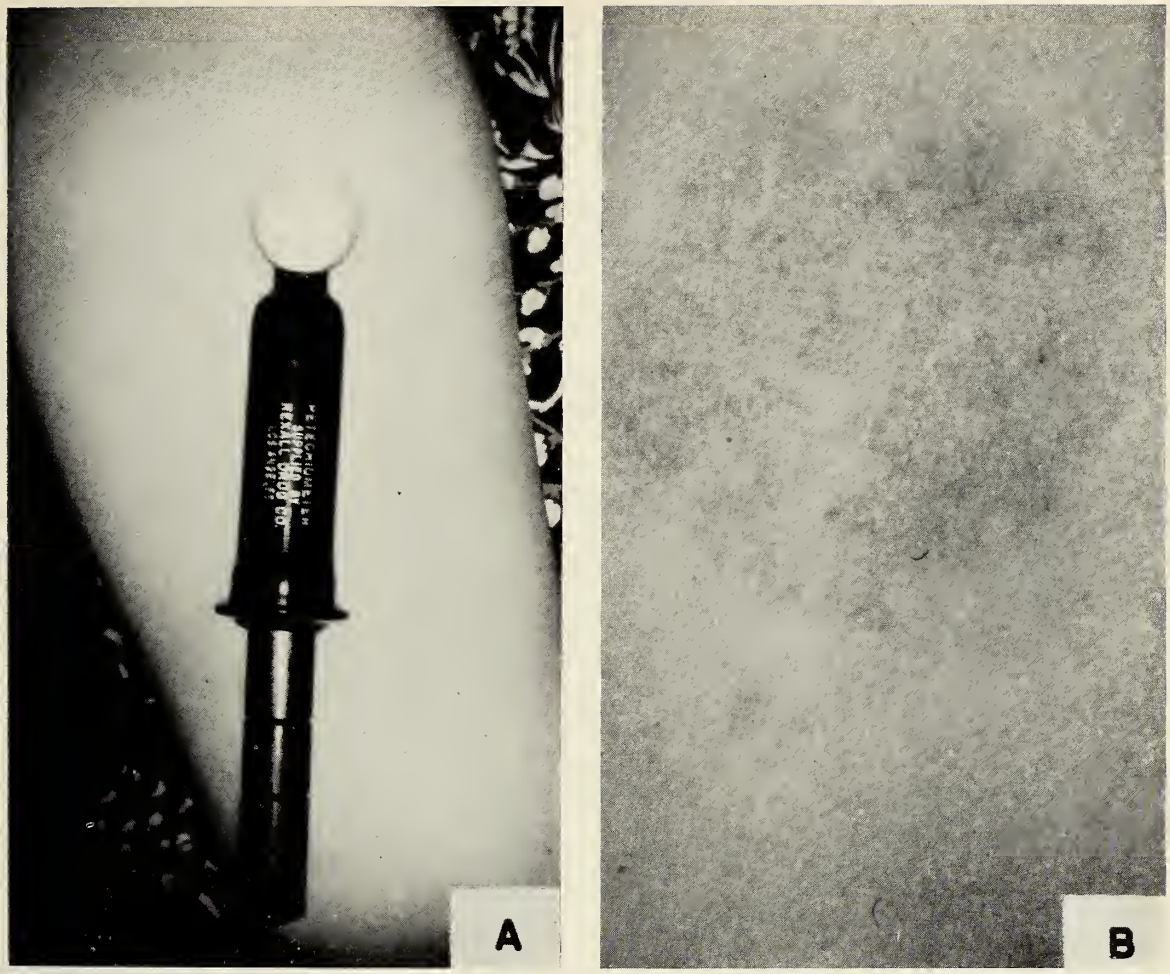


Fig. 3. A convenient method for testing capillary fragility. (A) Petechiometer in place. (B) Positive test for increased capillary fragility showing numerous petechial hemorrhages. (From "Habitual Abortion," by Robert B. Greenblatt, M.D., *Obstetrics and Gynecology*, 2:530, 1953.)

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Systemic Lupus Erythematosus:

Report of a Case With a Remission From a Very Severe Renal Involvement

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GREAT PROGRESS has been made in the treatment of systemic lupus erythematosus. The response of the disease to corticotropin and the corticosteroids is often dramatic. However, these hormones do not always help the severe renal damage. Nitrogen mustard seems to help the edematous patient with the nephrotic syndrome of lupus erythematosus.

In 1950 Dubois[1] and his co-workers studied 79 patients with systemic lupus erythematosus, 45 of whom were treated with ACTH and/or cortisone and 34 who were on other therapy. In the latter group only 7 developed clinical remissions and these patients all died within a period of 15 years. However, in the ACTH and cortisone treated group all had remissions and only two, who developed severe renal damage, died. In 1953 Cohen and Cadman[2] reported that 17 patients who were treated with cortisone and corticotropin responded satisfactorily. More recently Haserick[3] reported on 12 patients with severe systemic lupus erythematosus who lived six or more years after acute episodes. Of these 12 patients, steroid therapy was gradually discontinued and its resumption was not necessary. Two patients, after being off steroid therapy for two years, relapsed and required further hormone therapy. The most striking therapeutic response was noted in two patients who were given combined treatment with steroids and nitrogen mustard.

In evaluating the various forms of therapy in systemic lupus erythematosus the consensus of opinion is that salicylates, bed rest and antimalarial drugs should be used in the mild forms of this disease. Atabrine, chloroquine phosphate and amodiaquin hydrochloride are almost specific for the cutaneous lesions of the disease and greatly help the arthritis. Steroid therapy is the mainstay of treatment in the acutely ill patient. Nitrogen mustard has a pronounced effect in the edematous nephrotic patient with renal involvement. However, it should be administered to the patient only after the condition has been ameliorated as much as possible by the steroids, since these hormones will help early renal damage in lupus.

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Report of Case

H. S., a white female, age 27, was first seen Sept. 25, 1952, with a history of three small red spots which appeared on her right cheek about three or four months before. The rash gradually spread to the left cheek. She saw a dermatologist who prescribed a protective ointment and atabrine orally. In spite of this treatment the rash spread to the forehead, ears, elbows and dorsum of both hands. She then began to have malaise, easy fatigability, joint pains and fever. I first saw the patient at this time. She had the typical erythematosus rash of lupus erythematosus, a temperature of 99.8°F; arthralgia, weight loss and a toxic appearance. She was hospitalized where examination revealed a blood pressure of 150/99 mm. of mercury, temperature 100.6°F, pulse 90, rash as previously described, and palpable cervical and epitrocheal lymph nodes. The liver and spleen were not palpable. The heart and lungs were normal.

Laboratory studies on admission revealed a red blood cell count of 3,830,000 per cu. mm., a hemoglobin of 10 gm. per 100 ml., a white blood cell count of 3,550 per cu. mm., sedimentation

rate of 48 mm/hr by the Westergren method. The total serum protein was 6.6 gm.%, albumin 2.4 gm.%, and globulin 4.2 gm.% with an A/G ratio of 1 to 2. The lupus erythematosus cell preparation was positive. Urinalysis revealed a three plus protein, 3 plus white blood cells and three plus red blood cells, many hyaline casts and occasional granular and leucocytic casts. The electrocardiogram and an x-ray of the chest were negative.

The patient was started on treatment as follows: 25 mg. of ACTH I.M. every six hours, a salt free diet, potassium chloride 0.66 gm. three times daily, ascorbic acid 100 mg. three times daily, and crude liver extract 1 c.c. I.M. every other day. After six days, the ACTH was reduced to 20 mg. four times daily. On the twelfth day, ACTH was reduced to 5 mg. twice daily. On the 19th hospital day, ACTH was stopped and the patient was placed on cortisone 25 mg. four times daily. On the 21st day, the patient was discharged from the hospital, feeling much improved, the temperature was normal and the rash had completely disappeared.

Laboratory tests upon discharge revealed a red blood cell count of 4,260,000 per cu. mm., a white cell count of 11,000 per cu. mm., and sedimentation rate of 38 mm/hr. The total serum protein was 8.70 gm.% with 4.4 gm. globulin and 4.3 gm. albumin. Urinalysis showed no protein, no sugar, many white blood cells, but no casts or RBC.

The patient continued to improve and gradually the steroids were decreased, and while on 2½ mg. of meticorten daily all tests became normal. However, in August 1956, while in a remission and having been off steroids for many months, shortly after a severe upper respiratory infection the patient developed abdominal pain, enlarged liver, hypertension (210/120 mm of mercury), 2 plus edema of the face, and 4 plus protein in the urine. The optic discs showed about 2 diopters of papilledema, total protein was 4.6 gm.%, albumin was 1.6 gm.% with the globulin 3.1 gm.%.

The patient was hospitalized on Sept. 17, 1956, and an examination revealed a pale skin, no rash and marked edema of face and extremities. The liver was felt 2 fingers below the costal margin. The blood pressure was 190/130 mm. of mercury. The red blood cell count was 3,300,000 per cu. mm., the hemoglobin 10.4 gm. per 100 ml, the hematocrit was 30%, reticulocytes 3,990, the sedimentation rate 20 mm/hr and the platelet count 123,000 per cu. mm. Three lupus erythematosus cell preparations were negative. The blood urea clearance was 27% of normal. Total proteins were 4.0 gm.%, with albumin 2 gm. The serum cholestrol was 890 mg. per 100 ml. The C-reactive protein was negative. The serum complement was 30 units (normal 40-50). Urinalysis showed 4 plus protein; the Addis count revealed 1,900,000 hyaline casts, 5,000,000 red blood cells and 48,000,000 white blood cells. X-rays of the chest and the gastro-intestinal tract were normal. The electrocardiogram was normal. She was given meticorten 10 mg. four times daily and a low salt diet. On Sept. 21, 1956, she was given 20 mg. of nitrogen mustard I.V. Diuresis began within 24 hours and within one week she was almost edema free. However, her hypertension and proteinuria (3 to 15 gm. daily) continued unchanged. The anemia increased and despite a transfusion the hemoglobin decreased to 8 gm.%, the white blood cells decreased to 2750 per cu. mm. and the platelets to 48,000 per cu. mm. The urinary sediment, however, improved markedly. On Oct. 1, 1956, the serum complement was 33 units. She was discharged from the hospital on Oct. 6, 1954, with a well developed moon face (Cushing's State). At this time her treatment consisted of meticorten 20 mg. daily, 100 mg. of ascorbic acid three times daily, potassium chloride 0.33 gm. three times daily and antacid tablets after each meal.

Subsequent Observations

Oct. 24, 1956: Patient felt well and was doing her usual housework. Her blood pressure was 178/78 mm. of mercury, no edema present and a grade 2 systolic murmur was heard over her percordium. Urinalysis revealed protein 4.7 gm., red blood cells 46,000,000 and urinary casts 579,000. The blood urea nitrogen was 23 mg.%, hemoglobin 11.8 gm., white blood cells 14,700 and platelets 433,000. The C-reactive protein was negative.

January 22, 1957: Patient felt fine, but still had a moderate "moon face." The blood pressure was 156/105 mm. of mercury and no cardiac murmurs were heard. The urinalysis showed 5.6 gm. of protein in a 24-hour period. The urinary sediment contained many red blood cells, white cells and casts of all types. The serum complement had returned to normal (41 units).

April 16, 1957: Felt fine. The steroids were stopped on March 12, 1957, after gradual reduction in dose. Her moon face had practically subsided. The blood pressure was 130/86 mm. of mercury. The red blood cell count was 3,820,000 per cu. mm. and the white cell count was 7,200 per cu. mm. The hemoglobin was 12 gm. per 100 c.c. The sedimentation rate was 22 mm/hr. The urinalysis revealed no sugar and a two plus protein.

July 28, 1958: Patient felt fine, and her "moon face" had completely subsided. She did all her housework without tiring. The laboratory examination revealed red blood cells 4,930,000 per cu. mm., white blood cells 6,850 per cu. mm. and the sedimentation rate was 7 mm/hr. The urinary findings were: sugar negative, protein negative, no red blood cells and 0-2 white blood cells per high power field, and no casts were seen. The blood pressure was 120/84 mm. of mercury.

March 9, 1959: Patient completely well. There were no abnormal laboratory findings and the blood pressure was 118/78 mm. of mercury.

Comment

The remarkable feature in this patient was the complete subsidence of hypertension and evidence of severe renal disease, and a return to normal of the blood chemistry.

The rationale for using nitrogen mustard is based on the assumption that human glomerulonephritis is the result of tissue alterations in the kidneys induced by antigen-antibody complex. Nitrogen mustard is known to inhibit antibody production. Dubois[5] gave nitrogen mustard to 15 lupus erythematosus edematous patients with the nephrotic type of nephropathy and 12 of these were helped. Two patients without edema were not helped. Schwab,[6] *et al,* have reported that experimental nephritis produced in rabbits by administration of bovine gamma globulin can be prevented by nitrogen mustard, and Dammin[7] and Bukantz showed that nitrogen mustard inhibits antibody production, the Arthus reaction and vascular lesions in rabbits produced by horse serum antigen.

In discussing the underlying mechanism of systemic lupus, Mellors[8] disclosed that wire loop kidney lesions contain a large accumulation of gamma globulin and that fluorescent antibody studies of the glomerulus tissue sections revealed that glomeruli showing fibrinoid change have a much higher concentration of gamma globulin than other proteins. Holman[9] stated that the localization of gamma globulin in kidney lesions bolsters evidence that the disease involves an abnormal immunologic response.

In 1945 the author[4] presented a patient with systemic lupus erythematosus whose onset was precipitated by sulfonamide therapy. At that time it was suggested that hypersensitivity may play an important role in the etiology of systemic lupus erythematosus as well as in several of the other collagen diseases.

Summary and Conclusion

The dramatic life-saving effect of the steroids on severe cases of systemic lupus erythematosus has been well established. It is important to give adequate doses of the steroids to institute an early remission. It is felt that the usual cause of failure for patients with systemic lupus erythematosus to respond to these hormones is inadequate dosage. As the symptoms subside the dosage is gradually reduced and the intervals between doses is lengthened. The steroids are completely stopped shortly after a remission of the disease. The patient's symptoms are used as a guide as to when to reduce the amount and frequency of the steroids. The increased sedimentation rate may persist for a long time, and may be slightly increased for some time after a remission.

The early mild nephropathies clear with the use of the steroids. Nitrogen mustard is helpful in the severe nephrotic syndrome which is frequently a part of this disease.

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In the JOURNAL Next Month:

Minutes from the

HOUSE OF DELEGATES

Meeting

Held in October, 1959

at the

ANNUAL CONVENTION

A Case Report:

The Marfan's Syndrome

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MARFAN'S SYNDROME is a heritable disorder affecting tissues of mesoblastic origin, creating disturbances in the ocular, skeletal and cordiovascular systems of the body. Since Marfan's description in 1896 of a condition in a 5-year-old girl he called "dolichostenomelia" (long, thin extremities), the various clinical manifestations of this disorder, which in composite forms a well recognized clinical picture, have been reported in the literature. Among the stigmata of Marfan's Syndrome are dolichocephaly, ectopia lentis, high arched palate, arachnodactaly, hyperextensibility of the joints, kyphoscoliosis, pigeon breast, pectus excavatum and cardiovascular abnormalities as aortic and pulmonary artery dilation and dissecting aneurysm of the aorta. The atypical case of forme fruste presents a much more diagnostic problem.[14]

Case Report

The patient is a 57-year-old negro female who was first admitted to the hospital on Feb. 12, 1958 for exertional dyspnea, precordial chest pain radiating to the right side of the neck and paroxsymal nocturnal dyspnea. About three weeks prior to this admission she noted a pulsating mass at the right base of her neck. During this admission, she was placed on digitalis, diuretics and a low sodium diet and responded well to this regimen and was discharged after two months. She was readmitted on Sept. 25, 1958 for the same symptoms as her first admission and was placed on similar therapy as her first admission with poor response. She was given a course of 25 millicuries of radioactive iodine in the hope of producing hypothyroidism to relieve some of the cardiac decompensation. The patient did improve and was discharged on Nov. 18, 1958. Her last admission was on Feb. 4, 1959 with symptoms of marked cardiac decompensation and angina.

Past Medical History: There is no history of rheumatic fever or syphilis. The patient gradually developed kyphoscholiosis at the age of 24.

Family History: The patient's father was in this hospital being treated for heart trouble. No history of the manifestations of Marfan's Syndrome could be elicited in any of the patient's parents, siblings or children. However a granddaughter has long, thin fingers.

Physical Examination: The patient was a thin, chronically ill appearing negro female with long, thin face and bilateral arachnodactaly. Blood pressure was 180/50 in the right arm and 185/60 in the left arm. Pupils were equal but reacted poorly to light. The palate was high and arched. A pulsatile mass was palpated in the suprasternal notch area and a bruit was heard in this region. There was marked kyphoscoliosis of the thoracic spine and inspiratory rales in both bases. The heart was very enlarged with a loud, rough systolic murmur heard in the aortic area with transmission to the neck. A loud diastolic murmur was heard along the left sternal border in the third intercostal space. The neck veins were very distended in the semi-reclined position.

Laboratory Studies: Complete blood count and uranalysis were normal. The serum electrolytes revealed a moderate hyponatremia. The serology was negative. Blood urea nitrogen rose from 46 to 69. The electrocardiogram revealed left ventricular hypertrophy with strain.

X-Rays: A P-A film of the chest revealed marked left ventricular hypertrophy with congestion of the lung bases. Cardiac fluoroscopy

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Fig. 1. Microscopic picture of the dissected channel and of medial necrosis. (Hematoxylin and eosin stain.)

verified the left ventricular hypertrophy. The ascending aorta was dilated and suggested an aneurysm.

Hospital Course: The patient was placed on digitalis, diuretics and low sodium diet but responded poorly to this regimen. Her course was downhill and she finally succumbed on Feb. 20, 1959. Final clinical diagnosis was aortic insufficiency and Marfan's Syndrome.

Autopsy: The body weighed 70 pounds and was 56 inches in length. Hair distribution was normal. Pupils were equal and regular. There was a lack of subcutaneous tissue. Both hands manifested arachnodactaly. There was marked kyphoscoliosis of the thoracic spine and a high arched palate. The heart weighed 510 grams. The coronary arteries were noted to be affected with moderate arteriosclerosis. There was no gross evidence of infarction of the myocardium. The aorta, just distal to the heart was noted to be tortuous and dilated and it was suggestive of an aneurysm. There was a dissecting aneurysm beginning 1 centimeter above the aortic valve leaflets, continuing up the ascending aorta, into the innominate artery, down the aorta, breaking into the main channel at the left external iliac artery. The coronary arteries were not involved.

Microscopic Examination: The myocardium revealed individual muscle hypertrophy and interstitial fibrosis. No areas of infarction were noted. Numerous sections of the aorta were examined and showed the presence of medial necrosis. There were the presence of linear defects in the media, usually in the outer portions. There was no cellular response to this defect. The aorta was split in the area between the inner two-thirds and outer one-third of the media. The dissected channel was lined with endothelium, producing a double lumen aorta. There was moderate changes of atherosclerosis, but at no point did this disease appear significant. Lungs were congested and occasional phagocytic cells were present in the alveoli containing hemosiderin pigment. There was also a moderate degree of emphysema. The liver showed a slight degree of chronic passive congestion. The central portions of the lobules showed almost complete destruction of liver cells with replacement by fibrous tissue in some areas. There were areas containing cells with hemosiderin pigment. It was not felt that definite cardiac cirrhosis was



Fig. 2. Double lumen aorta. The dissected channel was endothelialized.

present. Spleen showed a marked degree of congestion. Pancreas showed slight fat necrosis in the peri-pancreatic fat. Adrenals showed lipoid degeneration of the cortical cells.

Final Anatomic Diagnosis: Arachnodactaly, kyphoscoliosis of thoracic spine; old dissecting aneurysm of the aorta, left common iliac and innominate artery; cardiac decompensation; chronic passive congestion of the liver; idiopathic medionecrosis of the aorta; moderate pulmonary emphysema.

Discussion

According to McKusick,[9] 15% of cases of Marfan's Syndrome may be due to *de novo* mutation. He also stated that 80% of the cases have ectopia lentis but that virtually 100% of cases would demonstrate at least minor redundancy of the suspensory ligament if examined carefully with the slit lamp.

There are at least 350 cases of Marfan's Syndrome reported in the literature.[7] About 73 of these cases have had autopsy findings.[13] Of these 73, at least 28 cases[3, 6, 7, 8, 11, 12] of dissecting aneurysms of the aorta have been reported with three of these[7, 11, 12] having extra-aortic dissections as did our case. It is interesting to note that in our case the dissected channel was lined with endothelium and that although the time of initial dissection is not known, it probably had occurred at the time of the patient's first admission, about one year before her death.

Gore[4] feels that the "degeneration" of the elastic lamella in the primary event which coupled with arterial stress, leads to dilation of dissection of the aorta, a theory McKusick[9] also feels plausible. The pathogenesis of Marfan's Syndrome is still unknown however. Ponseti and Baird[5] reproduced dissecting aneurysms of the aorta and kyphoscoliosis in rats by feeding them Lathyrus odoratus, the toxic agent thought to be beta-amino proprionitrile. Because of the degeneration of elastic fibers in the aorta found in autopsied cases of Marfan's Syndrome with cardiovascular abnormalities, some authors feel that the basic defect of this disorder is in the elastic tissue. Roark[13] attempted to find other areas where the elastic tissue disorder may play a role in the morphologic abnormalities other than the cardiovascular system by use of special stains on sections of skin, trachea, lung, anterior spinous ligaments, lamina fibrosa and intervertebral disk but failed to demonstrate microscopic changes, although undeniable phenic manifestations were present. He felt that this failure may have been due to the crudeness of the methods used, sparsity of elastic fibers in the structures examined and differences in the types and degrees of stress to which the structures were subjected. He concluded that the defect is probably not limited to elastic tissues but more likely to some substance common to elastic tissues and supporting substance outside the cardiovascular system.

Summary

A case of Marfan's Syndrome with postmortem findings has been described. There are at least 73 cases of Marfan's Syndrome with autopsy reports in the literature and of these 28 have had dissecting aneurysms of the aorta. The basic defect of this disorder probably lies in a substance common to elastic tissues and supporting substance outside the cardiovascular system.

ACKNOWLEDGEMENTS

To Dr. Paul Evans and staff of the Pathology Department of Marion County General Hospital for their assistance in the autopsy material.

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Fig. 3. The point of initial dissection, about 1 cm above the aortic leaflets.

We doctors, while we still retain that measure of control over our practices allowed us by the inspired popular clamor of patients to be dosed, must make the decision whether to give up all along the line and merely hand out the pills, or not. No individual can *dictate* that decision, but I shall here attempt to *influence* it by saying this much: All drugs—even the very best and least noxious of them—are, psychologically or physically, potentially toxic agents; and none of them should be used unless such use cannot reasonably be avoided.—Harry Beckman: Must All the Drugs Be Used? *Wisconsin Medical Journal,* March 1959.

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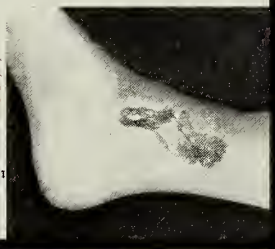
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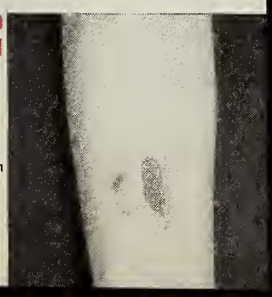
VARICOSE
ULCER
15 years duration
. . . resolved with
VARIDASE[1]



INFLAMMATORY
DERMATOSIS
rapidly spreading
rhus dermatitis
healed within
a week[1]



INFECTED
LACERATION
marked reversal
in 3 days . . .
returned
to school . . .
closure advanced[1]





THROMBOPHLEBITIS
back on his feet
in a week after
recurrent episode[1]





REFRACTORY
CELLULITIS
normal routine
resumed after 4 days
of VARIDASE[1]



Surgical Treatment of Sudden Hemiplegia Due to Complete Occlusion Of the Internal Carotid Artery

HAROLD KING, M.D.
JOHN RUSSELL, M.D.
HUNTER SOPER, M.D.

Indianapolis

OCCLUSIVE DISEASE involving the large arteries which supply the brain is a surprisingly frequent occurence. Fields, Crawford, and DeBakey[1] studied patients with stroke syndromes. The lesion causing cerebral arterial insufficiency was located outside the skull in about 25% of patients. Lofstrom, Webster and Gurdjian[2] found internal carotid occlusion or severe stenosis in 29% of patients with hemiplegia or hemiparesis. With increasing experience in this field, it has become clear that patients with a history of intermittent episodes of neurological deficit caused by a *partial* occlusion of the carotid artery can often be benefited by operation. If the arterial occlusion is *complete,* surgery has less chance of effecting recovery from a severe neurological deficit. Unfortunately, the diagnosis of complete occlusion is often established weeks or months after it occurred. Under these circumstances the thrombus has usually extended and become well organized into the intracranial portion of the vessel. Present surgical technics do not permit the re-establishment of blood flow under these circumstances. If, however, the patient can be treated shortly after the complete occlusion occurs, there is a chance of successful restoration of blood flow and ultimate complete recovery.

The following is a case report of a patient who was experiencing transient mild episodes of cerebral ischemia. He was referred to the hospital for evaluation. While there, he had the onset of a rapidly developing severe hemiplegia. It was possible to quickly establish the diagnosis of complete occlusion of the internal carotid artery and to carry out emergency surgical treatment. This was followed by almost complete recovery.

From the Departments of Surgery and Medicine, Indiana University School of Medicine, Indianapolis. Aided by grants obtained from a contract between the Office of Naval Research of the United States Navy and Indiana University.

Case Summary

The patient was a 46-year-old white male who was admitted to the Robert Long Hospital July 22, 1958. In January, 1958, he had the sudden onset of a "dizzy, faint feeling." He did not lose consciousness at that time but he was not able to speak clearly and both arms felt weak for a few minutes. After this episode, the patient went back to his usual routine. However, he felt tired most of the time. He noticed that he occasionally seemed to drag his left heel. He had trouble with his golf game and shot in the eighties instead of the seventies as usual. On July 21, 1958, the day before admission to the hospital, he once again had the sudden onset of a feeling of faintness. Later, he was told that the left side of his face appeared weak. A few hours later he noted clumsiness of the left hand and some difficulty in speaking. Because of these progressive cerebral symptoms he was referred to the hospital for neurological evaluation.

Examination disclosed a blood pressure of 130/88. Mild dysarthria was present which was consistent with weakness of the left face and tongue. There was profound hypalgesia of the entire left side of the face, the left shoulder and arm. There was moderate left facial weakness. The tongue protruded to the left of the midline. There was definite weakness of grip in the left hand and the left biceps was slightly weak. His

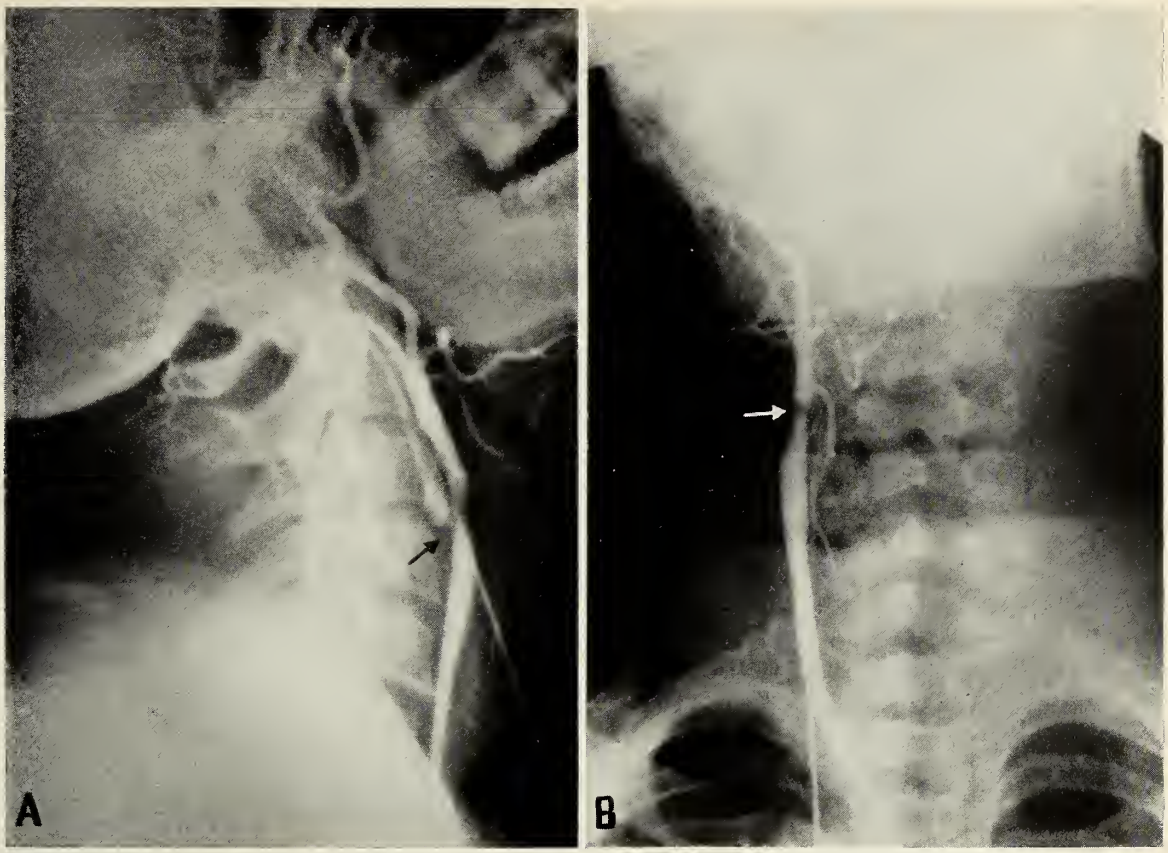


Figure 1. Photographs of lateral and anterior-posterior carotid arteriograms showing complete occlusion of the internal carotid artery. The external carotid and its branches are well visualized in both views. In the lateral roentgenogram a small streak of radiopaque dye is seen to have extravasated into the tissues along the course of the internal carotid. Arrow points to the common carotid bifurcation.

gait was normal except for the loss of associated movements of the left arm.

The blood serology was negative. Urinalysis, complete blood count, platelet count, total serum cholesterol, and spinal fluid examination were normal. X-ray films of the skull and chest appeared normal.

During the first 24 hours of hospitalization the patient demonstrated progressive weakness of the left arm. In the second 24 hours of hospitalization, the left face and leg also became involved and by the afternoon of July 24th he had almost complete left hemiplegia with profound paralysis of the left arm and marked paresis of the left leg. A few hours later a right carotid arteriogram was performed. This showed complete occlusion of the internal carotid artery. (Figure 1) It was our impression that the patient's early symptoms were due to a high grade but partial obstruction of the mouth of the internal carotid artery and that the hemiplegia which had occurred during hospitalization followed the complete occlusion of the vessel.

The patient was given intravenous heparin immediately after the arteriogram in an attempt to prevent propagation of the thrombus. One hour after the arteriogram was done he underwent emergency operation. The right internal, external and common carotid arteries were dissected free and isolated. Palpation revealed the common and external carotid arteries to be pulsating well. However, the internal carotid had no pulsation. An obstucting mass was felt at the bifurcation. An incision was made into the common carotid artery at its bifurcation and a large amount of atherosclerotic material was dissected free and removed. A thrombus extended up the internal carotid artery for a distance of two to three centimeters which was also removed. Following this, brisk retrograde flow of blood through the internal carotid artery occurred. The artery was then closed. The patient was continued on anticoagulant therapy.

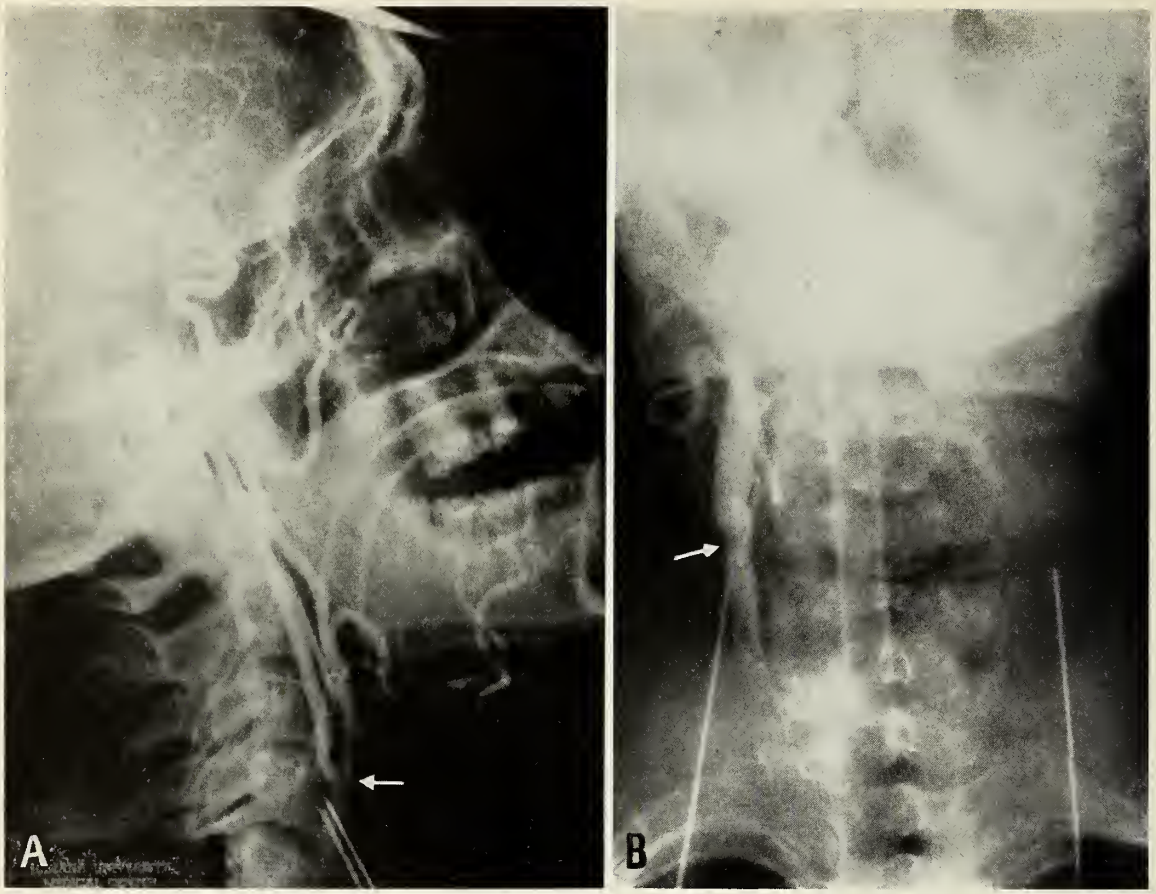


Figure 2. Photographs of lateral and anterior-posterior carotid arteriograms performed about two months after the operation showing the internal carotid to be patent and functioning. The arrow points to the carotid bifurcation.

During the first 24 hours following the operation, the patient had marked improvement in the strength of the left arm, leg and face. He was able to walk on the second postoperative day. He continued to make improvement during the remainder of his hospitalization and also after he went home.

He returned to his employment and was able to play golf again, though he complained of having difficulty in breaking eighty. Except for slightly hyperactive reflexes in the left extremities, the patient's neurological examination became normal. In September, 1958, bilateral carotid arteriograms were carried out. These disclosed a normal appearing arterial pathway both on the operated and the nonoperated sides. (Figure 2) The patient has continued to do well.

Discussion

Diagnosis of occlusive disease of the carotid or vertebral arteries is difficult to make by history and physical examination. A single symptom complex characteristic of the underlying disease does not exist. Furthermore, it is almost impossible to discretely palpate the internal carotid artery and definitely determine whether pulsation does or does not exist in that artery. In order to salvage those patients with potentially remedial arterial disease, a high degree of suspicion should be maintained for the possible occurrence of this disease. Any patient who exhibits sudden or episodic motor or sensory disturbances, convulsions, hemianopia or amblyopia, mental disturbances or bruits of the upper neck or cranium which are not well explained on other grounds should be considered as possibly having occlusive disease of the large arteries in the neck.

The diagnosis can be established only by arteriography, a procedure which carries very little risk in this location and frequently can be done

under local anesthesia. If a partial arterial obstruction is found, operative removal of the atherosclerotic plaque should be strongly considered. At the present time, this procedure can be carried out with a relatively low risk and with a good possibility of elimination of the patient's symptoms and prevention of the more serious difficulties which would likely follow complete occlusion of the artery. If the patient is seen early after the development of hemiplegia, emergency arteriography should be carried out. If a diagnosis of carotid occlusion is established, operation for removal of the obstructing atherosclerotic deposit and thrombus should be carried out as soon as possible. Prompt operation may result in the almost complete reversal of severe neurological symptoms.

Summary

A case of hemiplegia due to complete occlusion of the internal carotid artery is reported. Almost complete recovery followed emergency thromboendarterectomy. The diagnosis and management of occlusive disease of the carotid arteries is discussed.

(We wish to express our appreciation to Dr. Robert F. Harris who helped in the management of this patient.)

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PREPARATION FOR SURVIVAL

With our modern weapons of unprecedented destructive power which give offense the predominant role, we must realize that in unlimited thermonuclear war decisive blows will be struck at the very outset. Within a few moments of this occurrence the medical profession will be called into action. If we are unprepared, our accomplishments will be dispersed, uncoordinated, and too often futile. If we are prepared with good programs, good planning, and good organization, much may be accomplished even in the areas of devastating destruction, and our means to protect human resources and rehabilitate our population will be greatly enhanced. The surviving population is the most valuable asset in any economically developed country.—Frank B. Berry: Mass Casualty Planning and Management, *North Carolina Medical Journal*, October 1958.

A good conscience is to the soul what health is to the body; it preserves a constant ease and serenity within us, and more than countervails all the calamities and afflictions that can possibly befall us.—Joseph Addison

Diverticulosis and Diverticulitis of the Colon

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WE HAVE made a review of diverticular diseases of the colon as recorded in the literature and in the case records of patients with such disorders seen at the Mayo Clinic during 1956. This presentation of the various aspects of diverticulosis and diverticulitis includes remarks on what we have learned from supervision of the diagnostic aspects of the disorder as well as the medical treatment.

General Aspects and Review of Literature

Diverticula of the colon occur in susceptible persons. Not a great deal of credence should be given to the origin of diverticula as the result of sedentary habits, constipation, increased intraluminal pressure, lack of peritoneal support of the colon and rectum, fatty changes in the colonic musculature or neuromuscular defects. Diverticula of the colon occur in close relationship to the blood vessels as the vessels pass through the muscular coat, and they may appear on the lateral and the antimesenteric aspects of the intestine. Whether this weakness of the colonic wall is of congenital or acquired origin is not known. The process of diverticularization begins most commonly around the age of 40 years, and the condition is about equally distributed between men and women. The bowel habits prior to the presence of diverticula or the somatic types of body conformation are not informative; however, many persons who have diverticular disease are obese. The number and size of diverticula increase with the passage of time. The sigmoid segment of the colon is affected most commonly, but no segment is exempt; in some instances, the process is disseminated throughout the colon. Commonly, the number of diverticula decreases as the more proximal segments of the colon are reached. Diverticula of the cecum are rare as compared with those in the rest of the colon, although exceptions to this general statement occur; on rare occasions, the cecum and ascending colon will be beset with diverticula, whereas only a few will be sparsely spread in the distal segments of the colon.

Pathologists, internists and surgeons long have been interested in the occurrence of diverticula of the colon and the ensuing diseases that the diverticula can produce. According to Patterson,[1] Cruveilhier recognized colonic diverticula but did not intimate that they might cause disease. The same historian stated that Habershon, 45 years later, suggested that colonic diverticula might be clinically significant; he also noted that Klebs, in 1869, discussed the presence of diverticula in relationship to the passage of blood vessels through the colonic wall and observed that the wall of the diverticulum lacked a muscular coat. Beer,[2] in 1904, thought that such a lack indicated some type of muscular deficiency.

W. J. Mayo and associates,[3] in 1907, reported five cases of diverticulitis with sigmoidal resection, which was the first demonstration of the pathologic changes in diverticulitis during life. In 1917, W. J. Mayo[4] classified diverticular disease of the colon as follows: (1) self-limiting diverticulitis and peridiverticulitis, (2) diverticulitis and peridiverticulitis with abscess and fistula, (3) obstructive diverticulitis and (4) carcinoma developing in a diverticulum. It is now known that the presence of carcinoma in the midst of diverticula is coincidental. However, as revealed by this report concerning 42 cases of diverticulitis, with coexisting carcinoma in 13, one should not overlook the possible coexistence of these two diseases.

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Diverticula of the colon may be classified as true or false. True diverticula contain all of the intestinal layers, are usually of congenital origin, and are more commonly found in the cecal segment. False diverticula contain only the mucosal and serosal layers of the intestine. For the most part, the wall of the false diverticulum does not contain the muscular coats of the intestine. True diverticula do not tend to enlarge with the passage of time, whereas the false ones do enlarge. True diverticula do not tend to increase in number, whereas it is the rule to observe increases in numbers of false diverticula with time.

Diverticulosis

Diverticulosis of the colon was present in 3 to 10% of all patients of all ages studied at the clinic and was evident in 7% of all colonic roentgenograms.[5] The incidence increases with age. The sex ratio was 1.25:1, with the higher incidence in men. Saint's triad of diverticulosis, diaphragmatic hernia and gallstones is rare and of little clinical significance. Diverticulosis was present in 75% of patients more than 50 years of age seen at the Cleveland Clinic, and 65% of these patients were obese.[6] In 90% of the Cleveland Clinic series, the diverticula were in the sigmoid. Fagin[7] observed evidence of diverticulosis in 19% of 1780 colonic roentgenograms; 97% of these patients were more than 40 years of age.

In the absence of infection in or around the diverticula, diverticulosis of the colon produces no symptoms. A patient who has diverticulosis accompanied by an irritable-colon syndrome presents a difficult diagnostic and therapeutic problem. The manifestations of the irritable-colon syndrome arise from disturbance of the autonomic nervous system mediated through the diencephalon. This neuromuscular disturbance is expressed most commonly by the presence of constipation or diarrhea and the feeling of pressure or pain in the abdomen. Some patients with the irritable-colon syndrome may have alternating or accompanying irritability of the duodenum that simulates the symptoms of duodenal ulcer, or the patient may exhibit less characteristic manifestations of disturbances of the intestinal neuromuscular mechanism. Because of the foregoing reasons, it is well not to attribute abdominal symptoms to the presence of colonic diverticula in a patient who is psychically tense, who has fears, anxiety and fatigue, and in whom no objective evidence can be demonstrated that is indicative of diverticulitis. If a neurotic patient is told that the abdominal symptoms are referable to colonic diverticula, the treatment of the irritable-colon syndrome becomes most difficult.

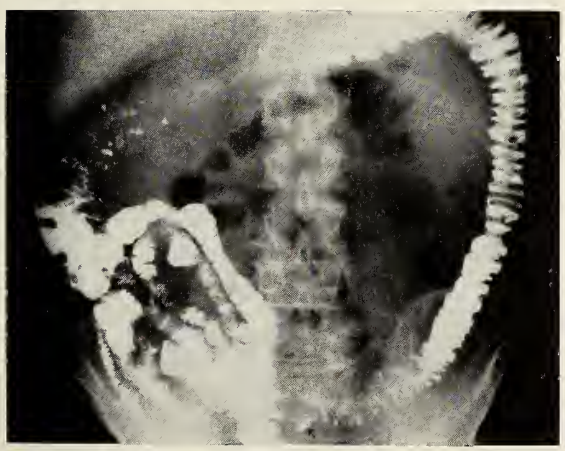


Fig. 1. Diverticulitis with a small fistula.



Fig. 2. Diverticula and a polyp in the sigmoid.

Diverticulitis

It appears reasonable to assume that diverticulitis ensues when for some reason or other the outlet of the diverticular sac becomes occluded and the free passage of intestinal dejecta into and out of the sac is prevented. Diverticulitis of the colon may be classified as (1) acute, (2) recurring or (3) chronic. The acute and the recurring forms are characterized by complete restoration of colonic function in the interim be-



Fig. 3. Carcinoma of the sigmoid with diverticulosis.

tween attacks. Chronic diverticulitis is present when recurring diverticulitis deforms the lumen of the colon to a sufficient degree to cause interference with colonic function, such as varying degrees of colonic obstruction. Ochsner and Bargen[8] presented an extensive outline of the varieties of diverticulitis of the colon as well as the complications. In practice, however, it will suffice to consider that diverticulitis occurs as simple, recurring or chronic diverticulitis or as diverticulitis with complications.

Complications of Colonic Diverticulitis

The complications of diverticulitis of the colon are relatively infrequent and by definition do not occur in simple diverticulitis. However, reports based on hospital records in cases of this disease reveal that complications often are manifested on the patient's first visit to the hospital. No conflict arises in these statements, because those who have simple diverticulitis often are not hospitalized. Reid and Workman[9] observed complications manifested as obstruction in 23% of cases. Perforation of diverticula was present in 8% of their series; free perforation into the peritoneal cavity occurred in four patients. In a series of 111 patients, Morton[10] observed that 85 had complications, including 39 with perforation, 22 with fistulas and 34 with obstruction. C. W. Mayo[11, 12] stated that diverticulitis rarely occurs in the distal 12 cm. of the colon, namely the rectum. He noted that obstruction, fistulas and abscesses are the most common complications and that free perforation into the peritoneal cavity occurs most frequently from cecal diverticula. In his series of 202 cases, the urinary bladder was involved by perforation or adhesions in 46 instances, and the skin was involved in 27 cases. In the aforementioned report by Beer[2] in 1904, he reviewed the then reported 18 cases of diverticulitis; he included a discussion of the complications, among them being stenosis of the intestine, perforation with abscess formation, and fistulas, including vesical fistulas. He questioned the relationship of diverticulitis to malignant tumors.

At the University of Wisconsin, obstruction was the commonest indication for surgical treatment.[13] In 1939, Brown[14] emphasized that the most serious complication of diverticulitis was perforation with abscess, and he reported that 15% of 191 patients with diverticulitis had vesical fistulas; almost all of these patients were men. Pemberton and associates[15] reviewed the records in 144 surgically treated patients in 1947 and found that 36% had an abdominal mass, 42% had fistulas and 30% had obstruction. They noted that it was impossible to rule out the presence of malignancy in 25% of the cases, even grossly at operation. In 46 instances of vesical fistulas, C. W. Mayo and Blunt[16] noted that all of them communicated with the sigmoid; 40 of these patients had pneumaturia and 21 passed feces in the urine. In general, pain and fever were not observed until after pneumaturia had become established. In the experience of Counseller,[17] vesical fistulas never heal spontaneously and, therefore, all of them should be treated surgically.

It is not possible to enumerate statistically the order of frequency of occurrence of the complications of diverticular disease. Recurring diverticulitis should not be considered as a complication. The commonest complication probably is obstruction of the colon resulting from repeated attacks of diverticulitis that deform or narrow the lumen of the intestine; it is not unusual for such obstruction to have its inception at the time of a recurring acute episode of diverticulitis. The next commonest complication is chronic perforation with localized peritonitis with or without abscess formation. Fistulas have

their origin in such abscesses. Acute perforation into the peritoneal cavity is rare. Although less common, peridiverticular diverticulitis and peridiverticular abscesses may occur and be difficult to diagnose because of the absence of roentgenologic findings. Fistulas may form from these abscesses.

The localized and the general symptoms indicative of complications of colonic diverticulitis are varied, ranging from none at all to severe septicemia and acute peritonitis.

Manifestations of Colonic Diverticulitis

Diverticulitis of the colon causes symptoms and signs indicative of (1) enterospasm, (2) infiltration of the colonic wall or (3) perforation of a diverticulum. Evidence for all of these conditions may be present simultaneously. Enterospasm causes pain, which is likely to be more severe if inflammatory infiltration of the intestine adjacent to the diverticulum also is present. However, in an occasional instance of diverticular disease, such infiltration does not extend to the colonic wall; if this situation prevails, the condition is designated as "pericolonic" diverticulitis. In any of the foregoing situations, the disorder may subside within a short time, from 3 or 4 days to 2 weeks, after which the patient may continue to enjoy good health. Instances in which recovery is quick are designated as "simple" diverticulitis.

Fallis and Marshall[18] observed that acute diverticulitis occurred 38 times less frequently than did appendicitis; 20% of their patients gave histories of previous attacks of diverticulitis. Of 434 patients reported on by Patterson,[19] 50% had abdominal pain and 26% had nausea and vomiting; only 16% had fever, urinary symptoms or constipation.

Diverticulitis in the right side of the colon represents only 2% of the total incidence of the disease, according to Mears and associates.[20] When diverticulitis affects the right portion of the colon, it often is noted that only one true diverticulum is present, and it is situated in the cecum. Patients who have cecal diverticulitis are younger than those who commonly have diverticular disease.

Mayo Clinic Series: 1956

During 1956, a total of 221 patients who had diverticulosis or diverticulitis or who had had acute diverticulitis were examined at the clinic. Aside from the general manifestations of diverticulosis and diverticulitis, we were particularly interested in (1) whether or not the use of antibiotics in the acute phase of the disease decreased the incidence of complications, (2) the incidence of rectal bleeding during the course of diverticulitis and (3) the relationship of diverticulitis, carcinoma and rectal bleeding.

General Manifestations

Of these 221 patients, 83 (37%) had surgical treatment, and all of these patients had at least one of the complications already mentioned. The percentage of men and women operated on was essentially the same. The entire group included 105 men and 116 women (Table 1). The women tended to contract the disease at a later age, as indicated by the fact that 47 women were more than 65 years of age, as opposed to only 25 men more than 65. On the other hand, seven men and only one woman were less than 40 years of age.

The commonest symptom was abdominal pain, which was usually present in the left lower portion of the abdomen. The pain was cramping, dull and intermittent in character (Table 2); it was present in 203 patients (92%). Fever was present at some time during the course of the

TABLE 1

Ages of 221 Patients with Diverticulitis

Age, yr.	Men	Women	Total	Age, yr.	Men	Women	Total
<36	4	0	4	61-65	15	21	36
36-40	3	1	4	66-70	17	23	40
41-45	6	7	13	71-75	4	11	15
46-50	11	4	15	76-80	3	5	8
51-55	15	14	29	>80	1	8	9
56-60	26	22	48				



Fig. 4. Short constricting lesion in the sigmoid and numerous diverticula in remaining colon. Lesion was diverticulitis.

illness in 88 (40%) of the patients. The bowel habits were variable and difficult to evaluate. A significant number of patients (49, or 22%) had no change from the usual bowel habits; 94 (42%) complained of constipation, whereas 71 (32%) had diarrhea. The diarrhea was not severe, generally being manifested by two to five loose bowel motions daily. The remaining seven patients had alternating constipation and diarrhea.

A previous history of one or more episodes of diverticulitis was obtained in 90 patients (41%); this included 50% of the men and 34% of the women. A history of having had a previous roentgenologic diagnosis of diverticulosis was recorded in 40 patients (18%). A total of 91 patients (41%) presented no evidence of previous episodes of diverticulitis.

Roentgenologic Studies

Roentgenologic findings often did not correlate with the clinical data. Some patients presented evidence of having had severe clinical symptoms; however, roentgenologic examination revealed only the presence of diverticulosis. In contrast, others had extensive roentgenologic evidence of diverticulitis without a history of severe clinical disease. A total of 85 patients (38%) had roentgenologic findings and clinical data indicative of acute diverticulitis. Diverticulosis without signs of active diverticulitis at the time of examination was observed in 101 patients (46%); this group represents those who had had acute diverticulitis that had subsided completely prior to examination at the clinic. Roentgenologic examination of the colon gave normal results in 23 patients. Perhaps some sex differences are significant in this respect; 48% of the men had roentgenologic findings of an acute process against an incidence of 30% for the women.

Complications

Complications of diverticulitis were present in 81 patients (37%), being almost equally divided between the sexes (Table 3). Among men, local perforation with abscess formation was found 28 times; another patient had free perforation of a diverticulum, with signs of acute generalized peritonitis. Six men had varying degrees of colonic obstruction, and nine had sigmoidovesical fistulas. One man had sigmoid carcinoma with extravesical fistulas. Frequent recurrence of simple diverticulitis had occurred in four men; to prevent future recurrence, segmental resection of the colon was done.

Of the 44 women who had complications, 33 had local perforation with abscesses and pelvic masses. Six women had colonic obstruction, and seven were surgically treated for recurrent lesions. Two women had sigmoidovaginal fistulas, one had a vesical fistula and one had a fistula leading to the abdominal wall. One woman had active chronic ulcerative colitis, and six women had carcinoma of the rectosigmoid in the midst of the diverticulitis.

Antibiotic Therapy for Acute Diverticulitis

Only 31 patients (14%) were treated solely with antibiotics, and the sex difference was in-

TABLE 2

Symptoms of 221 Patients with Diverticulitis

Symptoms	Men	Women	Total
Abdominal pain without fever	56	62	118
Abdominal pain with fever	44	41	85
Fever without pain	1	2	3
No pain or fever	4	11	15
Constipation	45	49	94
Diarrhea	32	39	71
Alternating constipation and diarrhea	4	3	7
No change in bowel habits	24	25	49

significant. The antibiotics used were generally penicillin and streptomycin or one of the broad-spectrum antibiotics. No specific therapy was given in 107 patients (48%); these patients came to the clinic after their acute symptoms had abated.

We cannot state how many complications of diverticulitis can be prevented by the administration of antibiotics. However, we were impressed by the rapid improvement observed after such therapy.

Rectal Bleeding and Diverticulitis

Comments on rectal bleeding as a complication of diverticulitis or diverticulosis are placed in this separate section for the sake of emphasis. The question of whether or not colonic diverticula bleed and, if so, how frequently, has been asked since diverticular disease of the colon has been known to exist. In the early literature, Beer[2] and Telling and Gruner[21] did not mention rectal bleeding, and Giffin[22] mentioned it only to emphasize that its absence was a strong point in favor of the diagnosis of diverticulitis rather than carcinoma. However, in 1948, Turnbull[23] reported 12 cases of massive hemorrhage from diverticula of the colon. He emphasized that bleeding occurred more frequently in elderly patients; he noted massive hemorrhage in 6% of 151 patients in 5 years. Only one of his aforementioned 12 patients had carcinoma, and five required blood transfusions. Hoar and Bernhard[24] found bleeding from the rectum in 42 of 111 cases of diverticulitis in the absence of carcinoma, and they also observed this in elderly patients with hypertension. Four of these patients had massive colonic bleeding. They also found rectal bleeding in 16% of 236 cases of diverticulosis during the same period.

TABLE 3

Complications in 221 Patients with Diverticulitis

Complications	Men	Women	Total
Local perforation with abscess	28	33	61
Free perforation	1	0	1
Obstruction	6	6	12
Vesical fistulas	9	1	10
Vaginal fistulas	-	2	2
Abdominal fistulas	0	1	1
Recurrent episodes	4	7	11
Acute ulcerative colitis	0	1	1
Colonic carcinoma	1	6	7



Fig. 5. Diverticulitis with perisigmoidal abscess.

Mobley and associates[25] reported from the clinic that 7% of 1970 patients with diverticulitis seen during a 15-year period had blood in the stool without apparent other cause. All these patients passed gross blood, often intermittently; this was the first symptom in 22% of this group and the only symptom in 19%. Of 32 surgical specimens studied histologically, three displayed ulceration of the colonic mucosa, 19 had discolored zones in the mucosa and one had an inverted ulcerated diverticulum. They stated that rectal bleeding was five times more common in carcinoma than it was in diverticulitis.

De Cosse and Amendola[26] also pointed out the intermittent character of the rectal bleeding and emphasized that other causes for bleeding should be ruled out before it was attributed to diverticulitis. They studied 13 patients who had bleeding with diverticulitis and found that six had polyps, one had hemorrhoids, one had a duodenal ulcer and three had localized perforation. They concluded that diverticulitis "seldom but not never" causes rectal bleeding and that, if present, it is usually associated with a far-advanced process. They advised that all such patients who had rectal bleeding should be surgically treated.

Noer[27] stated that rectal bleeding could be



Fig. 6. Extensive diverticulosis.

"associated with diverticulitis but not with just diverticulosis"; he found the site of bleeding in only one of six patients at the time of surgical operation. Stanton[28] reviewed 37 instances of gross bleeding and 14 of "massive hemorrhage" (transfusions of 1 to 5 pints of blood required) occurring in 131 cases of diverticulitis. The ages of the patients ranged from 64 to 83, and he postulated that arteriosclerosis in the gastrointestinal tract may be a factor. Young and Howorth[29] suggested that bleeding may be caused by inversion of a diverticulum, so that it bleeds like a polyp.

Rushford[30] reviewed the literature in 1956 and found that 90 reports recording 6000 cases of diverticulitis indicated that 17% of the patients had rectal bleeding. Bell[31] emphasized that surgical treatment should be carried out if a cause for the bleeding could not be found; he discussed carcinoma or polyps coexisting with diverticulitis as a frequent cause of hemorrhage. Cate[32] reported a case of massive melena caused by diverticulosis; he quoted Ochsner and Bargen as stating that the incidence of rectal bleeding in diverticulosis was 5%, and he quoted Willard and Bockus as recording this incidence to be 18%.

In a symposium in 1956,[33] it was stated that massive hemorrhage is more common in diverticulitis than it is in carcinoma; gross and occult rectal bleeding was observed in 35% of patients with diverticulitis at the Peter Bent Brigham Hospital. Reid and Workman[9] said that 29% of their patients had blood in the stool and quoted Nesselrod as stating that massive bleeding is more frequent with diverticulitis than it is with carcinoma. Zinninger[34] reported on 10 patients who had diverticulitis and massive rectal hemorrhage and reiterated the frequency of this complication in elderly men who had hypertension. He recommended conservative treatment. C. O. Patterson[19] observed 65 patients who had gross blood in the stools among 434 patients with diverticular disease. In this series, 13 patients had carcinoma and 52 had necrotizing infections involving the mesenteric vessel. Fallis and Marshall,[18] on the other hand, said gross blood is rare but found that 41% of 94 patients with diverticulitis had occult rectal bleeding. H. A. Patterson,[35] in a discussion of the complications of diverticulitis, stated that the site of bleeding generally is not found; he discussed erosion, infection, inversion of diverticula and fecal concretions in diverticula as possible causes. He again emphasized that other causes should be looked for before bleeding is attributed to diverticulosis or diverticulitis. Similarly, Ransom[36] found carcinoma in seven of nine cases of rectal bleeding with diverticulitis.

Bleeding in Mayo Clinic Series (1956)

In any instance of rectal bleeding, all possible causes must be considered. Rectal bleeding was present to some degree in 44 of our 221 patients (20%), being about equally divided between the sexes. In any discussion of diverticulitis and

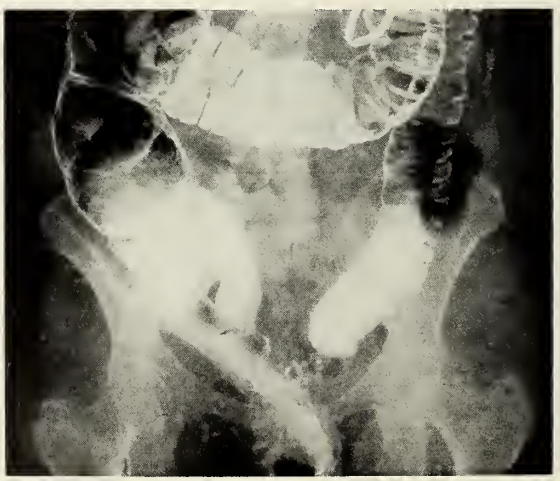


Fig. 7. Diverticulitis obstructing the sigmoid colon.

TABLE 4

Ages of 48 Patients with Diverticulosis and Colonic Carcinoma

Age, yr.	Men	Women	Total	Age, yr.	Men	Women	Total
41-45	1	0	1	66-70	6	6	12
46-50	2	0	2	71-75	3	6	9
51-55	3	1	4	76-80	2	1	3
56-60	3	2	5	81-85	0	2	2
61-65	5	4	9	>85	0	1	1

rectal bleeding, one must first consider the more common causes or any that might be readily apparent and yet not related directly to the diverticulitis. If an obvious explanation is not apparent, then the diagnosis must be made by exclusion on the basis of the most likely cause. The causes of bleeding in these 44 patients were as follows: hemorrhoids, 18; polyps, with or without hemorrhoids, 10; carcinoma, with or without hemorrhoids or polyps, five; diverticulitis and coexisting ulcerative colitis, one; diverticulitis with abscess formation, two; bleeding from diverticulitis (?), eight. Thus, it is apparent that, although bleeding occurred in 44 of these 221 patients who had diverticulitis, the bleeding apparently was caused by diverticulitis alone in only 11 (5%) of the entire group. The bleeding in diverticulitis possibly comes from a segment of colon that is chronically involved by an inflamed mucous membrane, such as occurs in this disease.

Diverticula of the Colon and Carcinoma

It is no longer held that any causal relationship exists between diverticulitis and carcinoma. Shaiken[37] stated that the simultaneous occurrence of carcinoma and diverticulitis must be considered relatively rare, but he also pointed out that diverticulitis does not "protect" against the development of carcinoma. Rankin and Brown[38] found only four cases of colonic carcinoma in 227 patients with diverticulitis, and only four cases of diverticulitis in 679 patients who had colonic carcinoma. Morhous[39] stated that 1% of 274 patients with diverticulosis had colonic carcinoma. The Thompsons[40] concluded that diverticulitis was complicated by carcinoma in 1.7 to 8% of cases. Martin and Adsit[41] found carcinoma in 8% of 201 cases. Brown and Marcley[42] compared the incidence of carcinoma in diverticulitis and in diverticulosis and noted five cases in 326 instances of diverticulitis, as against 15 cases in 192 instances of diverticulosis.

Colcock and Sass[43] contrasted the symptoms and findings in 50 cases of diverticulitis and 50 cases of colonic carcinoma. They pointed out that the inability to differentiate between these two diseases is an important surgical indication. They noted that pain was far more common with diverticulitis (74%) than with colonic carcinoma (26%); on the other hand, rectal bleeding was seen more often with malignant neoplasms (64%) than with diverticulitis (22%). The duration of symptoms averaged 40 months for diverticulitis and 8.5 months for neoplasm. Fever and tenderness were more frequent with diverticulitis, although not pronouncedly so in their experience. In 16% of their patients, the differentiation between diverticulitis and neoplasm could not be made roentgenologically.

Carcinoma in Mayo Clinic Series (1956)

During the year 1956, a total of 48 patients were seen at the clinic who had diverticulosis and colonic carcinoma occurring together. These patients are not included in the series of 221 previously considered. The records in these patients were studied in an effort to compare the findings with those in diverticulitis. This group included 25 men and 23 women; the patients were generally older than those who had diverticulitis (Table 4). The symptoms were not so specific as those in patients who had diverticulitis; 21 had abdominal pain, usually rather vague, and in only two was an abdominal mass palpable. A surprisingly large number of patients (21) had no change in bowel habits; of those who had a change, 14 had diarrhea and 13 complained of constipation. Rectal bleeding was present in 29 patients (60%). Roentgenologic examination of the colon showed only diverticulosis in 14 cases, only the carcinoma in five, and

both lesions in 16; the findings were normal in five patients, and such studies were not done in the remaining eight patients. Rectal carcinoma was found on proctoscopic examination in all 48 patients. All these patients were explored surgically, and the lesions were proved histologically.

Summary and Conclusions

The records of 221 patients seen at the Mayo Clinic in 1956 who had diverticulitis or diverticulosis were reviewed. The results of antibiotic therapy were not conclusive from the data available. It appears reasonable to assume that many such patients successfully treated by antibiotics have no reason to come to the clinic. Only 31 of these 221 patients were treated with antibiotics alone, and they responded well to treatment.

The main interest in this study was the presence of rectal bleeding in diverticulitis of the colon. This was caused directly by the diverticulitis in only 11 of the 221 patients (5%). In these 11 patients, the bleeding point was not actually seen but it was presumed to be due to bleeding from a chronically inflamed mucosa. Another 33 patients with diverticulitis also had bleeding caused by hemorrhoids, polyps or carcinoma.

The percentage of rectal bleeding actually caused by diverticulitis has been overemphasized but its significance has not. If causes for bleeding other than diverticulitis are looked for, more will be found, including many lesions, such as polyps, that are of considerable significance. When the cause of rectal bleeding is not apparent after thorough investigation, such patients probably should be explored surgically.

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ACCEPT NEW DRUGS—SLOWLY

Be slow to accept any new agent. In dealing with new drugs it is particularly important to remember the principle—"First, do no harm." Very few new drugs represent major advances in therapy, and those which do will quickly show their real value. You will do your patients little harm by delaying the acceptance of new agents, and you may save them from dangerous side effects, from unjustified reliance on new drug therapy to the exclusion of more reliable, if less spectacular measures and, if nothing else, from the unnecessary expenditure of considerable sums of money. New drugs are never cheap.—Mark Nickerson and John P. Gemmell: Doctors, Drugs and Drug Promotion, *Canadian Medical Association Journal,* April 1, 1959.

Condensed Cardiology



Presented as a regular feature of The JOURNAL, Condensed Cardiology is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Clinical Evaluation of Heart Sounds

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IN SPITE of the recent advances of electronic equipment and refinement of preexisting technics in electrocardiography, the use of the stethoscope remains an integral part in the evaluation of the heart. The interpretation of auscultatory phenomena as perceived by the stethoscope has been illuminated by correlation with the oscilloscope and EKG. Many phenomena previously neglected, or poorly understood, have in light of the new facts assumed an extremely useful and important role in the bedside diagnosis of the anatomical and physiological status of the heart.

Mechanics of the Stethoscope

It is beyond the scope of this paper to go into the details of physics that gave rise to the development of an adequate stethoscope. Nevertheless, it is important that some criteria should be considered as tantamount to a satisfactory stethoscope.

The earpieces should, whenever possible, suit the individual. Earpieces can be obtained in a sufficient variety to satisfy the idiosyncracies of the average ear. Suffice it to say, they should fit the canal snugly without undue pressure or distress to the ear of the listener. Even a small "leak" of air around the ear piece will permit the reduction of sound transmitted from the chest.

The next point of consideration is the length and diameter of the tubing. The variations that are available in length range from those so short as to bring the physician into uncomfortably intimate contact with the patient to one so long as to be suitable for examining the most infectious persons. The proper length of tubing is about 10 inches. An internal diameter of 1/8 inch with 3/8 inch external diameter is considered the most efficient.

The chest piece in all cases should consist of a bell and a diaphragm. Whether these are incorporated into a single unit or are used individually is entirely up to the preference of the individual. The bell is designed to transmit the low pitched sounds more efficiently. These would include the diastolic rumble of mitral stenosis, the ventricular filling sound, gallops and other cardiac sounds that are low pitched.

When auscultating with the bell only very light pressure is applied to the chest piece. This is of utmost importance, since more than minimal pressure will stretch the skin under the bell converting the chest piece into a diaphragm. To illustrate this, Figure 1 shows a phonocardiogram taken at the apex of the heart. Section A is with the bell held very lightly. Note the magnitude of the first sound. Section B is taken in the same area, on the same patient with slightly more pressure applied to the bell. Note the marked reduction in the magnitude of the first sound. From this example it becomes clear that by simply increasing the pressure, while using the bell, one could obliterate a faint low-pitched sound or murmur, and thus defeat the purpose of the bell.

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The diaphragm chest piece is for the transmission of high pitched cardiac sounds. The diameter of the chest piece should be 1½ inches. The thickness of the plastic diaphragm, itself, has relevance to the quality of sound that is transmitted. The optimum thickness for the diaphragm is .015 inches. Generally speaking, the stiffer and the larger the diaphragm, the higher the frequency transmitted. The ribs of the patient should not interfere with the firm contact of the diaphragm with the chest wall. In some patients, it may be necessary to use a smaller diaphragm or the bell with pressure.

Even though stethoscopes of the same manufacturer are quite similar, the clinician will become more adept at the art of auscultation by using the same stethoscope continuously. The use of any available stethoscope at hand is to be abhored.

Technic of Cardiac Auscultation

It is reasonable to assume that prior to auscultating the physician has obtained a good history, has inspected, palpated and percussed the areas in question. These procedures facilitate auscultation by giving the physician some idea as to what he might hear. For example, after having felt a diastolic thrill at the apex, the examiner will make every effort to hear a diastolic, apical rumble.

One of the most important adjuncts to successful auscultation is a quiet environment. This is not always possible, but reduction in the din and clatter will reward the physician with more efficient auscultation. The patient should be in a warm environment to prevent muscular twitching. It is advisable to have the patient in a comfortable position. The individual should be undressed since auscultation through clothing is misleading. The comfort of the physician is no small matter. Reduction of external stimuli; auditory, visual or muscular, is conducive to more effective auscultation. He should stand or sit in comfortable proximity to the patient.

There are certain primary areas that must be auscultated during a cardiac examination. The aortic area lies to the right of the sternum in the second intercostal space. The pulmonic area is the left sternal border at the second intercostal space. The lower left sternal border at the fourth intercostal space is approximately the area of the tricuspid valve. The apical area, or the fifth intercostal space at the left mid-clavicular line in the absence of an apical beat, is the area generally assigned to the mitral valve.

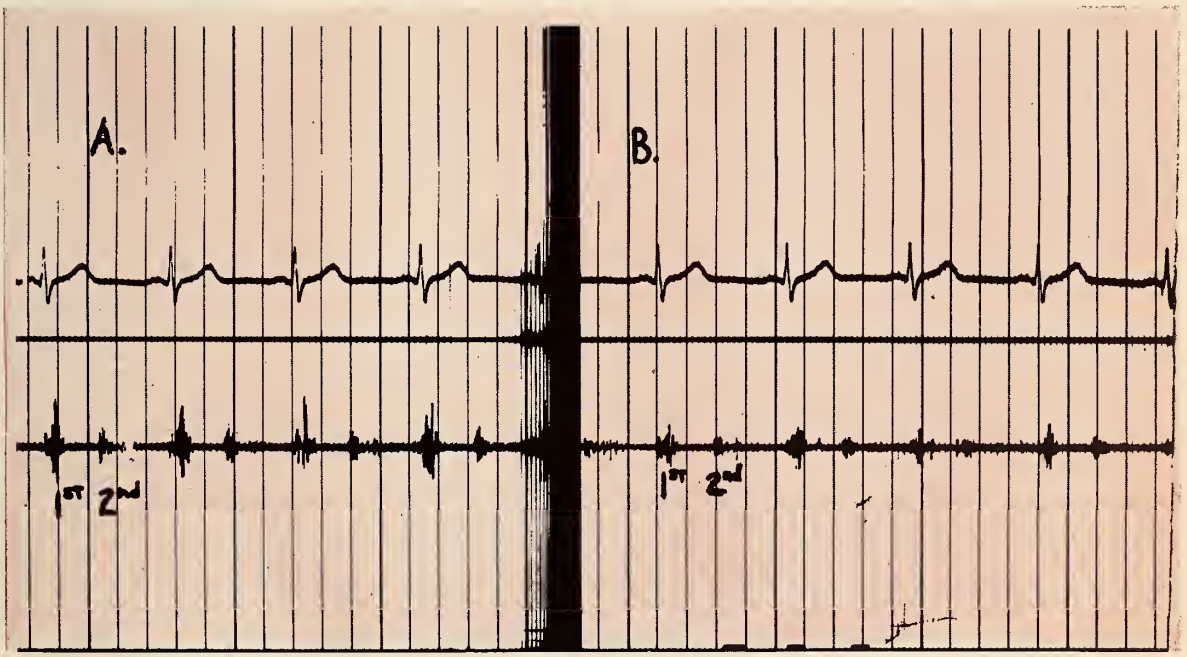


FIGURE 1 showing effect of pressure on the stethoscope in relation to the intensity of heart sounds. In A, the bell is held lightly against the patient's chest and the sounds are of considerable magnitude. In B, minimal pressure was exerted on the bell of the stethoscope and the amplitude of the sounds is greatly diminished. With further pressure the sounds were eliminated entirely (not shown on this photograph).

Posteriorly the intra-scupular region should be explored since certain murmurs are transmitted to the back.

These areas should be auscultated with the patient lying supine, in left lateral, sitting up and also leaning forward. One should use both the diaphragm and the bell while exploring for sounds and murmurs. When mitral valve disease is suspected, the patient is turned into the left lateral position and the apical area is auscultated.

The patient may breath quietly with very little effect on the accuracy of auscultation. If any question arises as to interpretation of certain sounds, the patient may suspend breathing for a few moments.

One of the more basic questions of auscultation, and one that is often most elusive, is what represents systole and what represents diastole. Palpation of the carotid pulse will sometimes aid in deciding this matter. The radial pulse is too far removed from the cardiac activity and can be confusing. The most satisfactory method is to listen at the base of the heart where the accentuation of the second sounds permits a lucid analysis of systole and diastole. By inching the chest piece gradually down to the apex one can retain the identity of systole and diastole. Whenever there is any question, it is well worth the time to concretely identify these phases of the cardiac cycle. It is possible, with a little practice, to selectively listen to just systole or diastole. One can concentrate on each phase and virtually obliterate any other portion of the cardiac cycle. When finesse has been developed with this technic, then the timing of murmurs, triple rhythms, etc., becomes much less difficult.

The physician should accustom himself to listening in a given area for a short period of time. Cardiac activity can be assessed more accurately by listening briefly several times than by concentrating on one area for a prolonged time.

We have tried to discuss, briefly, some of the mechanics of adequate auscultation. No attempt has been made to delineate heart sounds or murmurs. The more detailed discussion of the auscultatory phenomena associated with anatomic and physiologic changes of circulation will be discussed in a subsequent paper. ◄

THE POWER OF WORDS

Good writing about medicine really does not differ very much from good writing about anything else. Good writing is said to have conversational quality but it has something more than that, even in medicine. It appeals not only to the intellect but it touches the emotions as well and can moisten the cheek or lift the lips in smile, or bring friendly glow of understanding to the heart.—Art of Writing. (editorial) *Northwest Medicine,* March 1959.

Children's Mental Health Facilities— A Local Responsibility

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PARENTS WITH problem children, schools with poor learners, courts with delinquents, physicians with referral headaches and psychiatrists with inadequate treatment facilities all echo, "They ought to provide more—" This raises some interesting and significant questions. Who ought to provide what, where and with whose money? Whose responsibility is it to inform the "providers" of what is needed? Should the mental health facilities be planned, administered, and/or financed at a national, state or local level?

Let us look for some of the answers by following the usual sequence of events.

Who first discovers these unmet needs? Usually it is the person who finds he has a child with a problem and that, apparently, none of the existing facilities or programs offer the help which seems needed. What he does next can have a small but significant bearing on whether future improvements and expansions occur. Eventually the "fact" which he has discovered must get into the hands of those with the authority, means and sophistication to critically evaluate the current programs and plans for future improvements.

After some inquiry, this "fact finder" usually discovers that there are other children in his area with similar problems and other adults who are aware of the need for additional facilities. To become effective these "fact finders" must become the nucleus for the organization of a pressure group. As this group begins to educate itself, it may find that there are other groups already working on related problems. At this point a pooling of effort to consider the overall problem of children's mental health will usually increase the effectiveness of the groups.

A group usually continues to educate itself and to pass its information along to others. Professionals from the field of mental health can frequently help with this educational process, but expert professional advice only becomes imperative when the group has activated sufficient interest and potential support to be ready for action. The professional can then help by discovering additional "facts," pointing out overlooked opportunities, and asking realistic professional and financial questions about the plans already under consideration.

The most valuable assistance comes from the professional who makes an effort to understand the local situation, and then works with the local lay and professional groups on the plans they have proposed. A program merely duplicating the successful program of another community may create more problems than it solves. The final program must always be a compromise between professional ideals and lay dreams on the one hand and what a local area can actually accomplish on the other.

Since the demands for service originate through very personal and specific needs of individuals and groups in the given community, these must be the cornerstone of an effective mental health program for that community.

A useful mental health program must be an accepted part of the community. Its facilities function well only when there is frequent and adequate communication with the schools, courts, churches, civic organizations and other health and welfare facilities. A psychiatric facility, serving the local area upon which it is economically dependent, must live with and explain its failures, while depending upon its successes to

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bring continued support and any needed expansion. As a community changes, its mental health facility needs also change, and it is the people who use these facilities that are most alert to the expansion needs.

The maladjusted child and his home community have mutual responsibilities to each other. A mental health staff which is a part of that community is not so likely to overlook this. The members of a staff who live as well as work in a local community, better understand the social patterns and values of that community. With this understanding goes an increasing interest in helping the maladjusted individual fit into his home community rather than encouraging him to make a "therapeutic" move. A staff responsible for complete definitive care cannot glibly recommend a specialized, but unavailable, institution or school in lieu of treating a difficult problem themselves. When one cannot "pass the buck," one is frequently surprised by his increasing ability to work with "untreatable" cases.

Any child, sent away from home, faces problems when returning to his family and home community. When the treatment facility is sufficiently remote and different, the therapy itself, inadvertently, may make it unlikely that the child will ever again be able to fit into his home community. If the child has developed a new set of values which makes him seem different, he is doubted, feared or shunned when he returns. When the child lives at home while he is changing, both he and his community can learn about each other. A community that understands what is happening and what it can do is more willing to help. The inexperienced community and its leaders are frequently suspicious of the cost and results of treatment in a distant facility.

When the child is away and the pressure on his home and community is reduced, plans for the time he will return are frequently neglected. Because of this neglect some children are detained in an inpatient psychiatric facility far beyond the therapeutically correct time for discharge. The expense of the child's remaining must be borne by funds (tax or charitable) which are needed elsewhere. The expensive therapy the child has received can suffer a setback because he must wait. Another child waiting for the scarce space which the treated child is now occupying may become sicker. In a program coordinated at a local level or using facilities with overlapping staffs, this costly error is less likely to occur.

When a child must travel long distances for each treatment appointment, the alleged superior skill of the well-known, but distant, specialist may not balance the problems created by the travel. Parents, who must miss a day of work, and local departments of public welfare, who must transport patients, are well aware that distance can double the cost of therapy. When the travel time also causes a poor student to miss a day of school, or a shy, withdrawn child to miss routine available social activities, a therapeutic paradox may result. Therapy will take longer and the result may be poorer.

Broken appointments increase when long distances, poor transportation and bad weather can be used as excuses. The psychiatrist who has already arranged to see his patient at the minimal effective frequency, may find that a few cancellations so dilute his therapy that it is ineffectual. The more realistic the cancellation excuses, the more difficult and expensive they are to handle. Broken scheduled appointments and patients dropping out before their treatment is completed wastes scarce and expensive staff time. The use of distant treatment facilities is neither good medicine nor economical.

The terms "great distance" and "local" should be more clearly defined. For this discussion a "great distance" is one of more than 50 miles and/or a traveling time greater than one and a half hours between the child's home and the therapist's office. Using this yardstick, "local" would be defined as anything within a radius of 50 miles or one and a half hours traveling time. This might be a single town, a single city, a single county or a group of counties, but "local" is more appropriately defined as the smallest unit which can be expediently programmed. This would not necessarily correspond to the area which would be considered the ideal unit from a medical viewpoint.

To become established and maintained, a "local" facility must be able to attract the essentials of: 1) money, 2) personnel, 3) community interest. Roads, travel flow, shopping preferences, population, per capita income, existing facilities and charitable individuals or organizations may be the significant determining factors which ultimately define "local."

Wherever possible the existing facilities, such

as state hospitals, general hospitals, outpatient clinics, welfare agencies, child care agencies, private practitioners, etc., should be used as nuclei. Expansion and alterations of existing services are frequently less costly than the experimentation of a new community bringing in a new staff to offer new (and at times overlapping) services. Experienced trained personnel is expensive and scarce. The community and its facilities can rarely afford to use it extravagantly.

Before the reader begins to feel that I am implying each community should isolate itself, I wish to remind him that *mental health or illness is contagious*. Neighboring communities do have significant good and bad influences. A county line is a political, not a physical boundary. People constantly cross back and forth for good and bad interpersonal relationships with those on the other side. At times in self-defense a community may be obliged to offer help, which it feels it cannot spare, to its neighboring communities. This "missionary" activity may be expressed through mental health education, demonstration services, service for a fee, or even financial subsidy.

Any "local" area must recognize that some aspects of a complete mental health program will always be too elaborate or expensive (of money and/or personnel) to be undertaken by a single local community. In such cases several communities or a small section of the state might wisely decide to operate such projects jointly. Still other projects are so expensive and the local demand for that specific service so small, that they can be operated economically only at a state level. One must remember, however, that whoever contributes the greatest financial support will have the greatest say about the policy and program of the facility.

Our state mental health program is needed to assist and compliment the local programs. Facilities which are too specialized or expensive for local areas must be planned, financed and administered at a state level. Few local facilities will have staff or budget for major research projects. However, the results of research in state facilities can provide valuable information to the local service-oriented facilities. State personnel training programs are already in existence and could be expanded as the local facilities' requests increase. State staff members can be of great assistance as consultants about establishing, operating or expanding local programs. These consultants may be able to offer in-service training to local staffs with a subminimal training. A state staffed temporary demonstration clinic may be used to crystallize plans of the local community to operate its own clinic. We must not forget that many local communities will need financial assistance through matching funds from state and/or federal moneys.

In no way wishing to minimize the tremendous value of the state program, I feel the best children's mental health programs will be developed in those local communities recognizing their own needs and accepting the responsibilty of operating most of their own facilities. ◄

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DIABETES DETECTION

EACH YEAR the month of November is set aside as Diabetes Month, and the week preceding the week of Thanksgiving is designated Diabetes Week. This week is devoted to detection of early and nonsymptomatic diabetes by the nation-wide performance of simple screening tests for as many people as possible.

Diabetes Week in 1959 is from November 15 to 21. It is conducted by the American Diabetes Association and its 42 affiliate units in cooperation with the county and state medical societies of the American Medical Association.

It is estimated that there are about as many unknown diabetic individuals in the United States as there are known diabetic patients. There are approximately one million in each group. Finding the unknowns is the purpose of the detection drive.

There is a tremendous advantage in making the diagnosis of diabetes early in the course of the disease. When diabetes is known early and carefully treated throughout the life of the patient, the complications such as arteriosclerosis, heart disease, retinitis and coma are much less serious or entirely avoided.

While early detection is important for all age groups it is especially valuable for children and elderly persons. School children should be included in the drive. One of the days of Diabetes Week may be designated as School Day. Industrial groups may be the object of mass screening tests. Every effort should be made to include as many people as possible in the program.

The screening test for glycosuria may be made simply by moistening a specially prepared strip of paper, known as the Dreypak, with urine and observing the color reaction at any time later. One doctor and several volunteers will be able to test as many as 500 individuals per hour. It is possible to screen the entire population with a minimum of time and expense.

Besides the detection drive, Diabetes Week will be utilized to educate the public on the symptoms of diabetes and the importance of early diagnosis and prompt treatment.

SURGERY IS SAFER

IT IS common knowledge that the risk of surgical operations is less today than ever before. However, the extent to which the statement is true is not appreciated until the actual statistics are examined.

A recent statistical summary* quotes the mortality rates for various surgical procedures as published by several large hospitals, medical centers and clinics in the United States.

In one large general hospital 37,940 operative and anesthetic procedures, excluding neurosurgical work, between 1925 and 1934, carried a surgical mortality of 0.14%. In the same hospital between 1945 and 1954, 103,777 comparable procedures were done with a mortality of 0.08%.

A clinic which experienced a fatality rate of 0.7% for cholecystectomy between 1942 and 1944, recently reported a mortality of only 0.2% for the operation in the years 1955 and 1956.

Abdominoperineal resection of the rectum was performed at a university center from 1947 to 1951 with a rate of 9.6%. From 1952 to 1956 their mortality rate has been 3%.

Plastic operations on stenosed mitral valves were first performed in 1949 with a mortality rate of 14%, a low rate for a formidable operation. From 1953 to 1956, in a group of four hospitals in one large city, the same operation was carried out in 375 patients with a loss of only 0.8%.

Another operation which has been performed successfully only in recent years is that of resection of aneurysm of the abdominal aorta. A group of hospitals in which this procedure was pioneered reported a surgical mortality of 25% in 1952 and 1953. Today the same group accomplishes aortic resection with a mortality rate of 1.8%.

Many factors are cited as the basis for such striking improvements in the surgical art. The truth is that surgical results have improved because everything that contributes to success has been improved. Preoperative preparation, accurate diagnosis, better anesthesia, improved instruments, more knowledge of physiologic and pathologic processes and more effective postoperative care—all of these essentials must be given credit.

Two considerations make this progress even more remarkable. One is that the record has not been achieved by selecting all good risks. In fact, mortality rates have improved while more and more poor risk patients have been afforded the advantages of surgical treatment, and have survived it due to improved care.

The other is that there is no indication that the improvement, excellent though it is, will not be further enhanced in the future.

* Statistical Bulletin, Metropolitan Life Insurance Company, August, 1959.

A "good" patient is one who has an interesting ailment capable of cure and at the same time continues to look pleasant, understands directions, asks very few questions and never complains. A "bad" patient begins by telling a poor story, full not of fact but of the alleged opinions of many physicians, is not easy of diagnosis and contrives to irritate and bewilder the attendants. Such a patient complains continually, asks questions innumerable and whether things go well or ill, never gives the attendants the satisfaction of seeing her made happy. There are of course degrees of "badness." Some patients are "terrible" while others are just difficult. The truth is that they are all "sick."

JOHN HOMANS

(Reprinted from
Connecticut Medicine
Vol. 23, No. 10)

President's Page

One cannot assume the responsibility of leadership of this organization without mixed feelings—one of pride in the organization, with its history and aims for the future—one with deep humility for one's individual ability in relation to the task ahead.

Today, Medicine finds itself in a changing social scene. Medicine cannot remain static because Medicine is living and living things change. The profession cannot remain reactionary while everything about it changes—nor can the profession accept, blindly, all new concepts which are proposed.

To anticipate and insure the future of Medicine is the task before us now. This is not easy, and will require the utmost of every practitioner. There is no physician who can longer neglect this prerogative and expect the changes to be all that are desired. Only clear and fearless thinking will lead the profession through the next years.

When our organization was young, Medicine was on the offensive and worthwhile progress was accomplished; recently, the profession has been on the defensive, and this has gone on too long. It is now time for our voices to be raised again for the proper consideration of our views, and for us to reassume the responsibilities which we are expected by all to assume.

In the past, other dangerous and trying days have been successfully handled. The profession's problems are great, but perhaps no more so than those our predecessors have met in worthy manner, and successfully.

With all the resources available in our membership, the problems can be met and the proper course charted.

I am certain that our course being right and with the participation by all of our members, we can give an account of ourselves which will testify to our sincerity of purpose.

Earle W Arnold M.D.

The Woman's Auxiliary

REPORTS TO I.S.M.A.

September, 1959

Dear Doctor:

I want to thank you for the recognition the medical society has given the auxiliary for their work on legislation. We are happy to help in the letter writing, telephoning and telegraphing that is so necessary.

There is a new project on deck at the present time. This I will call "Talking to Congressmen Back Home." The program has been given to each county, and with the doctors' approval, I hope some of the counties can report that they have successfully reached their Congressmen.



Mrs. Bowen

In meeting with the counties this year I am going to stress that auxiliary members talk federal legislation every time the opportunity arises, especially outside of medical circles. Most people are poorly informed on facts concerning legislation in general and specifically on legislation that affects medicine and their health. Since we have the facts we must share them with everyone possible by every honorable method. I feel that "Working for Freedom needs no apology."

Sincerely,
Mrs. Otis R. Bowen, Bremen
Legislative Chairman

Remember—52% of the voters in the nation are women. This *does* make a difference to the politicians. Please let your auxiliary members help you with your work on legislation. Thank you.

Sincerely,

Mary Annette Black

Mary Black, President

Maternal Mortality in Indiana

The Maternal Mortality Study Committee of the Indiana State Medical Association was formed in 1956 to study maternal deaths reported in the State. The aim in establishing the Committee was to gather material which could be used for educational purposes to improve maternity care and reduce preventable maternal deaths. This is a summary of findings for 1956 and 1957.

For the years 1956 and 1957, there were 81 maternal deaths reported in Indiana, and 229,177 live births, which gave a maternal death rate of 3.6 deaths per 10,000 live births for the two years combined.

These 81 deaths were reviewed by the committee, plus an additional 19 other deaths in which pregnancy was associated in some way. A total of 100 cases were reviewed for the two-year period. Of the 100 cases reviewed, 81 deaths were considered to be due to obstetric causes, 17 were considered to be non-obstetric deaths, and a determination could not be made in two cases.

As to the actual causes of death, hemorrhage was first with 36 deaths or 44.4% of the obstetric deaths. Infection was the cause of death in 14 cases or 17.2%, toxemia in 11 cases or 13.6%, pulmonary embolus in 6 cases or 7.4%, anesthetic in 4 cases or 5%, and the other deaths were from various causes. Table I shows the causes of the obstetric deaths.

An oxytocic was used in three cases for induction of labor in which death was due to a ruptured uterus and in the case in which death was due to amniotic fluid emboli.

Prevention in a number of instances of hemorrhage would have been dependent upon early recognition of the blood loss with adequate treatment including replacement of blood loss. In other cases there was failure of the patient to seek prenatal care. Several of the deaths from infection were the result of self-induced abortions.

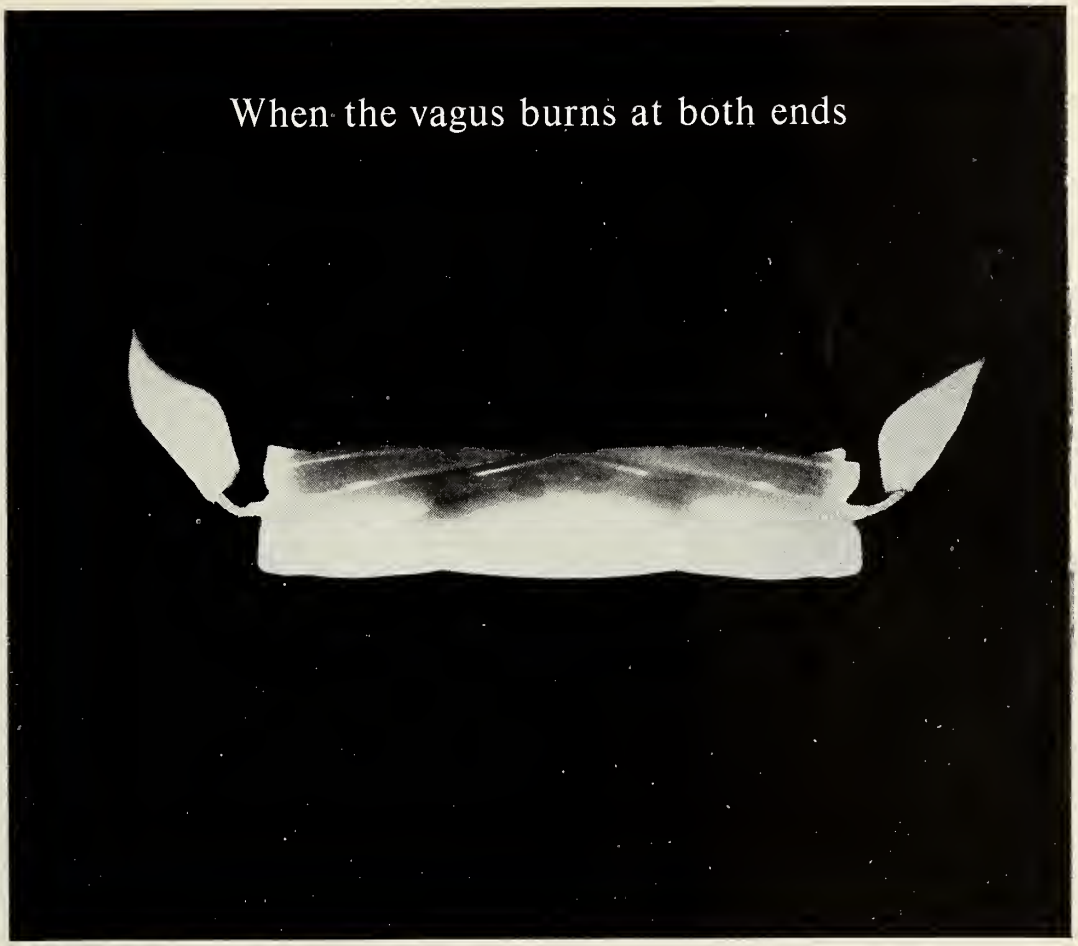
The maternal deaths were analyzed from the standpoint of age of the mother and, also, according to parity.

Table II and Table III illustrate these items.

Forty-eight deaths occurred in mothers age

TABLE I

		No. of Cases	*Percent*
1.	Hemorrhage	36	44.5
	Ruptured uterus 16		
	Ectopic pregnancy 6		
	Post partum hemorrhage 5		
	Placenta previa 3		
	Abruptio placenta 3		
	Vaginal laceration 1		
	Fibrinogenopenia 2		
2.	Infection	14	17.2
3.	Toxemia	11	13.6
4.	Pulmonary embolus	6	7.4
5.	Anesthetic	4	5.0
6.	Cerebral vascular accident	2	12.3
7.	Pneumonia with cardiac disease	2	
8.	Transfusion reaction	1	
9.	Subacute bacteria endocarditis	1	
10.	Congenital heart disease	1	
11.	Serum hepatitis	1	
12.	Amniotic fluid emboli	1	
13.	Undetermined	1	
		81	100.0%



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MATERNAL MORTALITY RATES
INDIANA, 1915-57

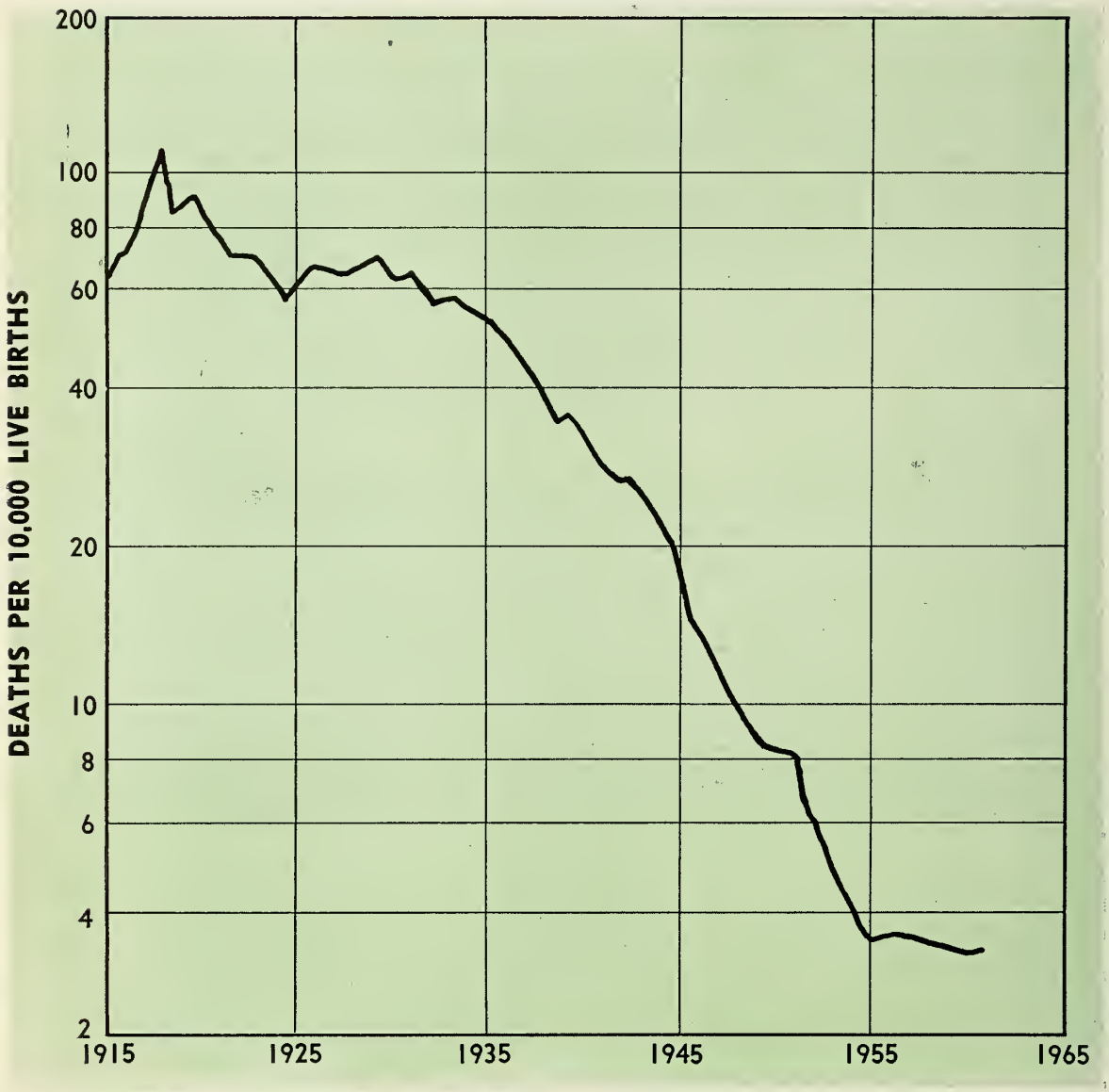


TABLE II

Age of Mother	*No. of Deaths*
Under 20	3
20-24	12
25-29	18
30-34	20
35-39	19
40 or over	9

TABLE III

No. of Pregnancies	*No. of Deaths*
3 or less	34
4 or more	46
Undetermined	1

30 or over, which gives a considerably higher death rate than for mothers under 30. The percentage from previous years of total births to mothers over 30 were applied to the births for 1956 and 1957. By doing this, the approximate maternal death rate for mothers 30 or over was 8.2 deaths per 10,000 live births as compared to a rate of approximately 1.9 deaths for mothers age 29 or under. The difference in the rates between the two age groups is statistically highly significant.

There were 46 deaths in women having 4 or more pregnancies as compared to 34 deaths in

TABLE IV

	Married	*Unmarried*	*Divorced*
White	67	1	1
Non-white	10	0	2

women having 3 or less pregnancies. There was a considerably higher number of deaths in women of greater parity in proportion to the number of births by women of this parity than of women of lesser parity.

Table IV shows the maternal deaths by race and marital status.

There were 31 babies who survived more than one week born to the 81 mothers.

Autopsies were performed in 48 cases.

There has been a marked reduction in maternal deaths in Indiana over the past 40 years. Chart number 1 shows this graphically. Further improvement in the maternal mortality picture will depend mainly on the following factors: (1) continual alertness on the part of physicians for complications, especially early recognition of hemorrhage and prompt institution of measures to combat it, (2) blood available for every obstetric patient, (3) more frequent use of consultation when complications arise, (4) careful use of oxytoxics, (5) education courses on obstetrical care in the various medical societies or districts, and (6) continued education of the public — especially prospective mothers—of the importance of early and regular prenatal care. ◄



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Colloidal Isotopes and Leukemia—Joseph M. Hill, Dallas—Lecture

Treatment of Diabetes—Randall G. Sprague, Rochester, Minn.—Panel Moderator

Infectious Diseases in Children—Harris D. Riley, Jr., Oklahoma City—Panel Moderator

Tranquilizers in Medical Practice—Stewart Wolf, Oklahoma City—Lecture

Surgical Approaches to Parkinson's Disease—William W. McKinney, Fort Worth—Lecture

Congestive Heart Failure—James V. Warren, Galveston—Panel Moderator

Peptic Ulcer in Rheumatoid Arthritis—Lloyd G. Bartholomew, Rochester, Minn.—Lecture

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An Analysis of 1957 Indiana Births by Time of Day and Day of Week

*ROBERT A. CALHOUN, P.E.D.**
*VERNE K. HARVEY, JR., M.D.***
*J. E. HOLWAGER****
Indianapolis

FOR EACH birth occurring in Indiana in 1957, the State Board of Health tabulated the hour of birth and the day of the week. It was, of course, relatively simple to calculate the day of the week from the specific date of birth, while a definite time of day was given on approximately 108,000 of the 116,000 recorded births.

These data were analyzed in three principal ways:

1. Births by Time of Day
2. Births by Day of Week
3. Births by Time of Day and Day of Week

These analyses could have been made considerably more detailed by adding another important factor for which information was readily available: *Month of Birth.* However, it was felt that any additional precision that might have been gained in this manner would be more than offset by the resulting complication of data.

1. *Births by Time of Day*

The five hours of the day with the largest number of Indiana 1957 births are given in Table 1. The 8 to 9 a.m. hour stood far above any other, but it will be noted that all the five highest birth hours fell between 4 and 10 in the morning.

In Table 1a are given the five hours with the fewest births. While the 3-4 p.m. hour ranked lowest, it can readily be seen that the five hours starting with 2 in the afternoon marked the low point of the day for births.

In Table 1b the day is broken into quarters and number of births analyzed in this manner. While the first two quarters (midnight to noon) are virtually equal, and the last two are also very close, there is a striking contrast between the morning and the "p.m." hours. Actually there were almost 20% more births before noon than after. There is almost no possibility that these differences could have occurred purely by chance.

TABLE 1*.

Five Hours of Day with Largest Number of Births, Indiana, 1957

Hour	No. Births
8— 9 a.m.	5,475
7— 8 a.m.	5,033
4— 5 a.m.	5,016
6— 7 a.m.	5,003
9—10 a.m.	4,999

TABLE 1a*.

Five Hours of Day with Fewest Births, Indiana, 1957

Hour	No. Births
3—4 p.m.	3,936
2—3 p.m.	3,998
5—6 p.m.	4,009
4—5 p.m.	4,011
6—7 p.m.	4,030

TABLE 1b*.

Births by Time of Day, Indiana, 1957

Period	No. Births
Midnight to 6 a.m.	29,119
6 a.m. to Noon	29,751
Noon to 6 p.m.	24,282
6 p.m. to Midnight	24,964

*Excludes births for which no time of day given.

*Director, Division of Public Health Statistics, Indiana State Board of Health.
**Director, Bureau of Special Health Services, Indiana State Board of Health.
***Director, Division of Vital Records, Indiana State Board of Health.

BIRTHS BY HOUR OF DAY, INDIANA, 1957*

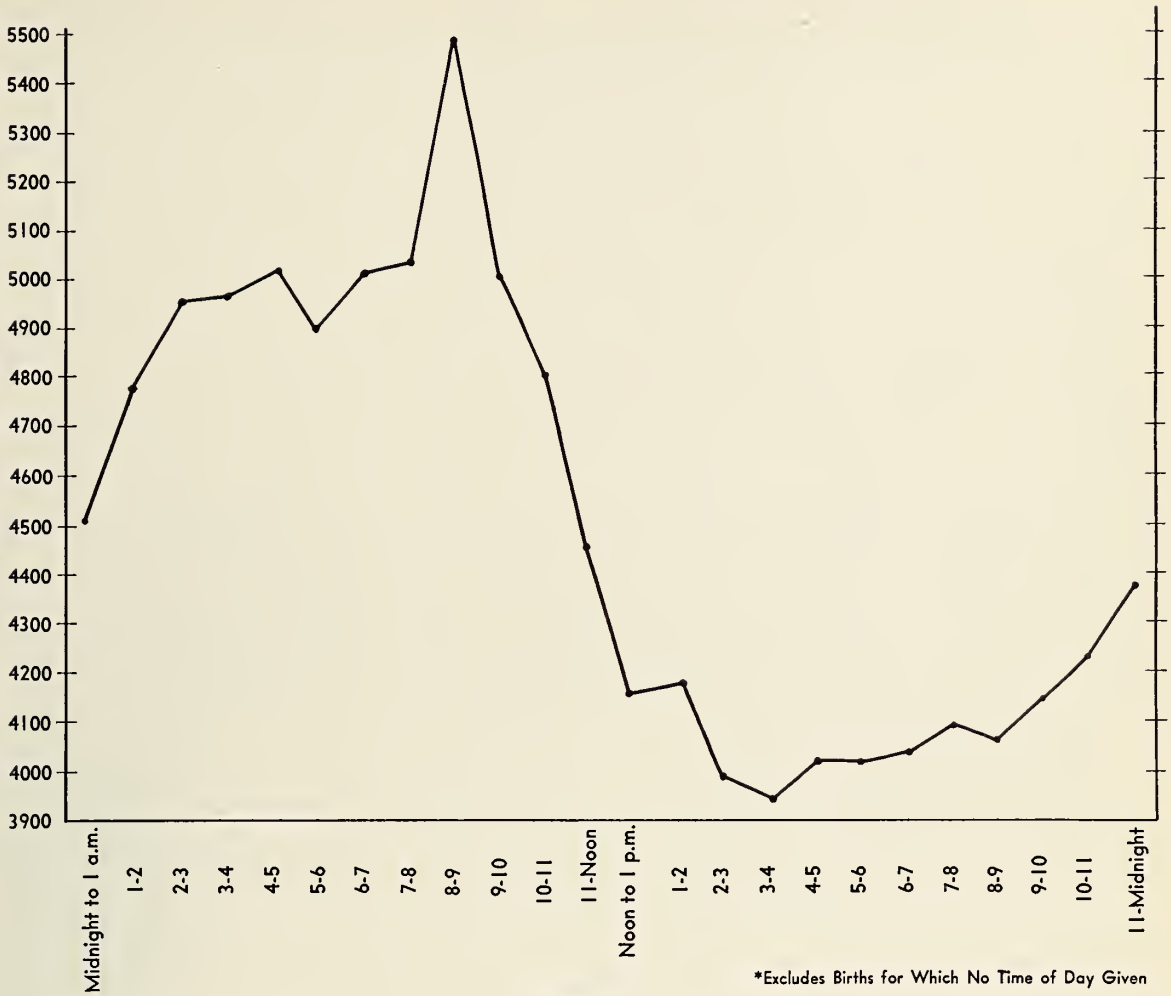


Figure 1

Births are plotted by individual hour in Figure 1. While occasional minor fluctuations are present in the graph, an increase in births from midnight to a peak between 8 and 9 a.m. is indicated. This period is followed by a rapid drop in the next four hours, and a leveling off until the 8 to 9 p.m. period. At this time, the rise indicated on the left side of the figure actually starts.

The 7,834 births for which no definite time of day was given were not included in the above analyses.

2. *Births by Day of Week*

In Table 2, the days of the week are given in order of number of births. It is apparent from these data that, aside from Sunday and Tuesday, there is little to choose between the days in regard to number of births. When all seven days were considered, however, and the data analyzed by means of a chi square test, a result significant at the 1% level was obtained.

TABLE 2.

Days of Week in Order of Number of Births, Indiana, 1957

Day of Week	No. Births
Tuesday	17,375*
Friday	16,602
Wednesday	16,577
Saturday	16,547
Thursday	16,529
Monday	16,490
Sunday	15,830

*There were 53 Tuesdays in 1957. Adjusting for this factor, this figure is reduced to 17,047.

Thus it can be stated that, even allowing for the fact that there were 53 Tuesdays in the year, more 1957 Indiana births occurred on Tuesday than could reasonably be expected on the basis

Indiana Births

Continued

of chance alone. Similarly, fewer babies were born on Sunday than would have been anticipated in the normal course of events.

3. *Births by Time of Day and Day of Week*

In Table 3, a complete breakdown of 1957 Indiana births by hour of day and day of week is given.

The 10 hours of the week in which most 1957 Indiana births occurred are given in Table 3a. This table is adjusted to compensate for the fact that there was an extra Tuesday that year. As might be expected from the previous analyses, 8 to 9 a.m. was the most frequent hour of day (only on Sunday was this hour not represented in the top 10) and Tuesday the most frequent day of the week. Adjusted totals varied from 760 to 832, and all times listed were morning hours.

The 10 hours of the week with the fewest births are given in Table 3b. Sunday was the day most frequently represented and 3-4 p.m. the most common hour. These results are in line with findings mentioned earlier. All hours were afternoon and births ranged from 514 to 554.

A comparison of Tables 3a and 3b reveals that the average number of births in the highest hours ran approximately 50% above the average in the lowest. The highest figure (832) was over 60% above the lowest. A chi square analysis of these data gave a highly significant result, indicating there was little likelihood such differences occurred by chance alone.

TABLE 3a*.

Ten Hours of Week with Largest Number of Births
Indiana, 1957

Hour of Week		No. Births
Monday	8 - 9 a.m.	832
Friday	8 - 9 a.m.	814
Thursday	8 - 9 a.m.	791
Tuesday	8 - 9 a.m.	790*
Monday	9 - 10 a.m.	767
Tuesday	2 - 3 a.m.	766*
Tuesday	4 - 5 a.m.	763*
Wednesday	8 - 9 a.m.	762
Tuesday	5 - 6 a.m.	760*
Saturday	8 - 9 a.m.	760

*Adjusted To Compensate for the Fact There Were 53 Tuesdays in 1957.

TABLE 3.—1957 Indiana Births by Hour of Day and Day of Week

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total
12 m - 1 a.m.	577	602	730	633	641	652	671	4,506
1 a.m. - 2 a.m.	645	654	728	705	689	671	695	4,787
2 a.m. - 3 a.m.	681	665	781	676	737	705	702	4,947
3 a.m. - 4 a.m.	675	682	748	758	742	677	682	4,964
4 a.m. - 5 a.m.	747	725	778	714	699	691	662	5,016
5 a.m. - 6 a.m.	649	662	775	672	725	648	768	4,899
6 a.m. - 7 a.m.	718	699	764	726	742	687	667	5,003
7 a.m. - 8 a.m.	612	733	728	752	747	749	712	5,033
8 a.m. - 9 a.m.	711	832	805	762	791	814	760	5,475
9 a.m. - 10 a.m.	675	767	750	711	695	679	722	4,999
10 a.m. - 11 a.m.	749	672	677	690	641	693	683	4,805
11 a.m. - 12 noon	625	606	695	634	642	594	640	4,436
12 noon - 1 p.m.	620	608	607	590	565	570	592	4,152
1 p.m. - 2 p.m.	584	570	616	593	625	605	583	4,176
2 p.m. - 3 p.m.	582	521	611	586	557	557	584	3,998
3 p.m. - 4 p.m.	554	545	574	546	548	596	573	3,936
4 p.m. - 5 p.m.	514	574	593	566	560	584	620	4,011
5 p.m. - 6 p.m.	517	601	608	563	582	579	559	4,009
6 p.m. - 7 p.m.	558	586	599	561	573	574	579	4,030
7 p.m. - 8 p.m.	538	590	588	631	588	594	568	4,097
8 p.m. - 9 p.m.	531	615	559	600	546	610	611	4,072
9 p.m. - 10 p.m.	571	623	641	563	558	628	566	4,150
10 p.m. - 11 p.m.	571	606	608	634	615	635	559	4,228
11 p.m. - 12 m	572	644	637	632	667	618	617	4,387
Unknown	1,054	1,108	1,175	1,079	1,054	1,192	1,172	7,834
TOTAL	15,830	16,490	17,375	16,577	16,529	16,602	16,547	115,950

The Journal of the Indiana State Medical Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year of 1959-60 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of $100.00, a second prize of $75.00 and a third prize of $50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1960.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.





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Indiana Births

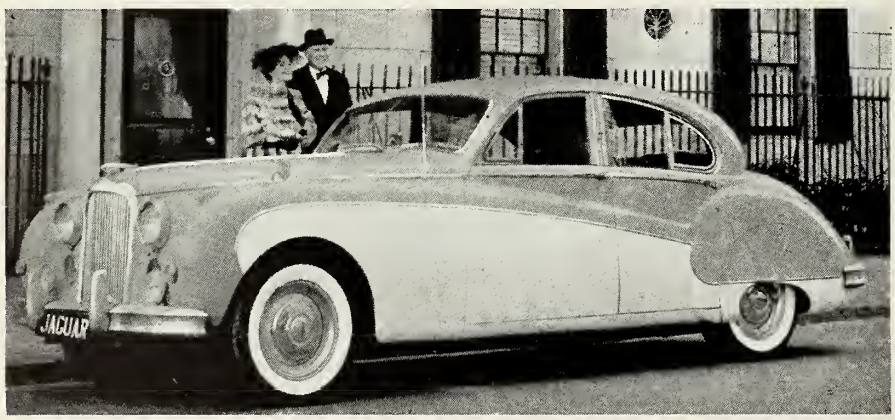
Continued

TABLE 3b.

Ten Hours of Week with Fewest Births, Indiana, 1957

Hour of Week		No. Births
Sunday	4 - 5 p.m.	514
Sunday	5 - 6 p.m.	517
Monday	2 - 3 p.m.	521
Sunday	8 - 9 p.m.	531
Sunday	7 - 8 p.m.	538
Monday	3 - 4 p.m.	545
Wednesday	3 - 4 p.m.	546
Thursday	8 - 9 p.m.	546
Thursday	3 - 4 p.m.	548
Sunday	3 - 4 p.m.	554

Generally speaking, the obtained results seem to agree quite well with those of Points in four Oklahoma City Hospitals (Points, T.C., "Twenty-Four Hours in a Day," *Obst. & Gynec.*, 8:245, 1956; Points, T.C., "Day after Day," *Obst. & Gynec.*, 8:748, 1956). While no attempt is made here to attribute any pattern of cause to the findings, the reader may find it interesting to develop his own hypothesis as to why Tuesday was the most popular day and 8 to 9 in the morning the leading hour for 1957 Indiana births. ◄



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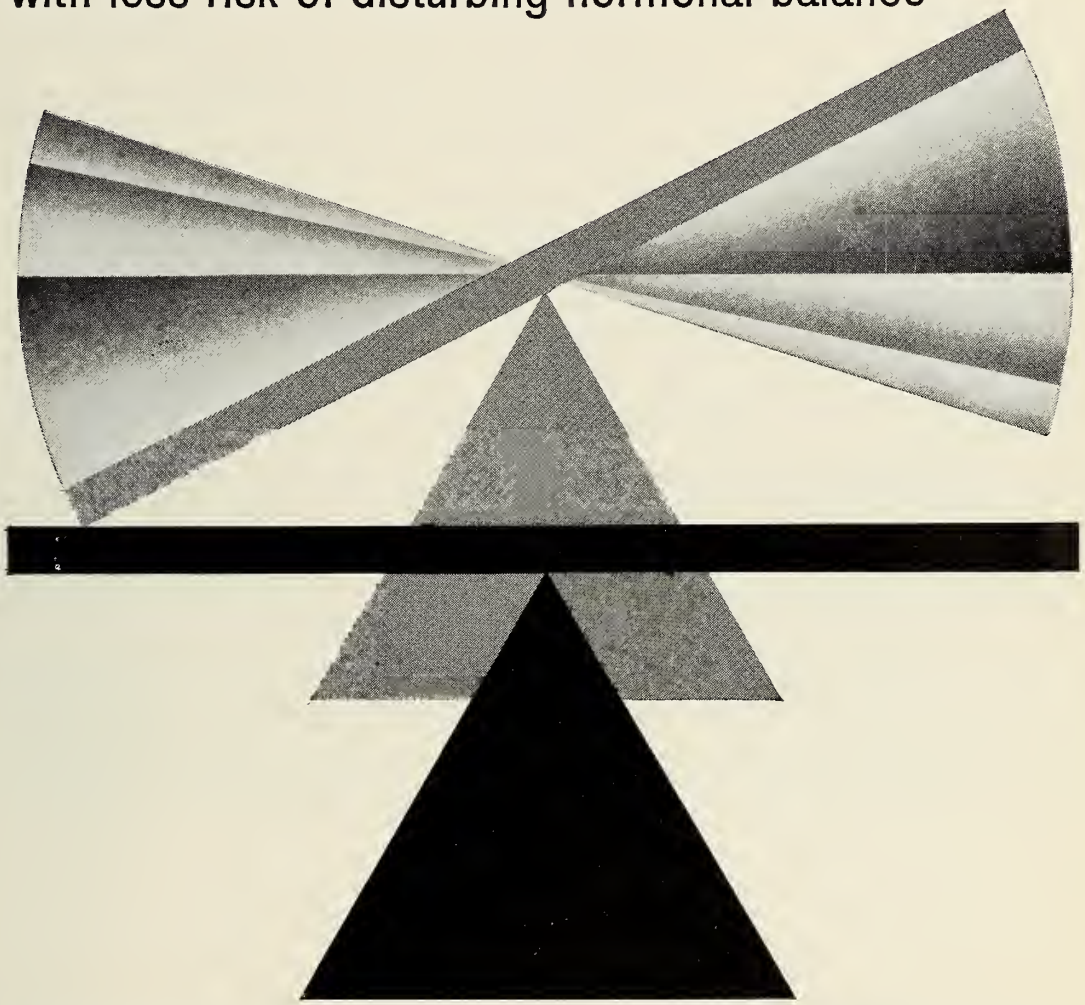
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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

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November 1959 1999

Side Effects of Exhibiting Scientifically

*MARK I. HEWITT, B.S., M.D.**

New Brunswick, N. J.

IN RECENT years physicians have come to use an increasing number of potent therapeutic remedies having rather potent side effects. Conversation among doctors teems with such phrases as "calculated risk," "touch of agranulocytosis," and "harmless hepatitis," a fact that stresses the banality today of side effects. During the same time another therapeutic tool—the scientific exhibit—has become increasingly potent. It too has side effects. But carrying on the analogy between a potent drug and a scientific exhibit breaks down when the matter of side effects is reached. Side effects of a scientific exhibit do not affect the one receiving therapeutic benefit, as in the case of drugs, but instead the "manufacturer," as it were, or author of the exhibit. Thus, this therapeutic tool turns on its maker, giving rise to a newly described psychiatric dilemma, "The Frankensteinian Complex," among those who exhibit scientifically.

Noting this subject has so far been unreported in the literature and having gained some experience with these side effects, I considered it worthy of this preliminary report.

In presenting this report, I shall describe the side effects, add a few comments on therapy, and close with a word on prevention.

Side effects of exhibiting scientifically are either extrinsic or intrinsic in origin. I shall discuss the extrinsic type, by far the more common, first:

The Proofer

This side effect can occur in an adult of either sex. In pure form, a premonitory symptom is noted by the exhibitor who senses he is being stared at. After locating the source of the telepathic psychic energizer, he finds the originator staring not at him, but at the exhibit. This side effect may go away without treatment, may become more intense, or may be recurrent. Only the latter two varieties need treatment. Faced with this side effect, the uninitiated exhibitor flirts with a panic state, wishing for only 10 minutes' time to review at least the last 40 issues of Excerpta Medica in order to prepare fully for this apparent paragon of medicine. However, initial therapy is simply to smile. The side effect will then pull the exhibitor off to one side for his earth-shattering comment. Usually, this is: "Do you know you have an inverted comma in the footnote to panel three?" Maintenance therapy includes agreeing, thinking, and promising to stay up all night to correct the error.

The Changer

This side effect has a higher incidence in the female and the onset may be precipitous or gradual. It is with the precipitous onset that the so-called "pseudo-choreic sign" predominantly manifests itself. This distinctive characteristic is made up of varying degrees of apparently purposeless positions and attitudes accompanied by biting of the lips, clenching of fists, and restless legs. If not treated at once, this state may climax by a sudden catatonic-like immobility with crossed legs and painful facies. If recognized at this point, the side effect usually whispers, "Do you happen to have any dimes?" Or, "Change for a quarter?" Treatment, consisting solely of prescribing any type of change, including at least one dime, results in instantaneous disappearance of the side effect—down the nearest hall. Only rarely does this side effect recur. Variants include requests for change for a phone call, change for a parking meter, or change for no expressed purpose. As a point of practical

Presented at the banquet of the 15th Annual Meeting, American Medical Writers' Association, Chicago, Sept. 26, 1958. Winning Essay, 1958 American Medical Writer's Association Contest on Nonmedical Writing. Reprinted from the Mississippi Valley Medical Journal, Vol. 81, No. 1, Jan., 1959.

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Side Effects

Continued

information, there is on clinical trial a new therapeutic adjunct, known as "The Scientific Exhibitor's Handy Coin Changer," intended for day-to-day rental, complete with coins and directions to all pertinent points.

The Questioner

Because convention-disease strikes more males than females, this side effect predominates in males, usually being noted when the exhibitor is his busiest. After studying the exhibit for the polite length of time, the side effect opens with a complimentary remark, professes profound interest in the subject, and then asks one of the following questions with all the professional air of the chairman of a medical society's grievance committee:

"Where's the men's room?"

"Where can a fellow get a drink around here?" (This side effect exacerbates if a water-cooler is pointed to.)

"Where're they serving lunch?"

"Have you seen a Dr. So-And-So from Placebo, Indiana?"

"How do we get out of this place?"

"Do you know where Dr. X's exhibit is?" (This usually is one prepared by an arch rival on the same subject as your own.)

Other numerous modifications of this side effect occur. There are two schools of thought as to therapy. One method, while ensuring permanent regression of the side effect, invariably is frowned upon by civil regulatory authorities. The other more common and conservative approach is to answer the question as painlessly as possible with the studied solicitousness of an airline hostess, subtly attempting to convince the side effect that your only purpose in preparing the exhibit was to answer his question.

The Snatcher is the only side effect likely to occur in the absence of the exhibitor. This usually comes on after intricate physiologic mechanisms have forced the exhibitor to leave his post unguarded for a short interval. The side effect begins at this time by approaching the exhibit, and, while viewing it, lays each hand on a different piece of literature. Then looking down as if surprised to see what his hands have found, he deftly lifts five copies of each and again views the exhibit as he walks off. If single specimen pieces of literature are securely thumb-tacked, stapled, glued, or weighted, these are an even greater challenge and must be removed, regardless of the impediment to their removal. Therapy is basically substitutive.

Sampler's Mother. This is a milder, more subtle modification of the Snatcher and has few sequelae. Manifested almost always as a woman bearing a badge stamped "GUEST," this side effect carries a shopping bag brimming with a representative sample or piece of literature from every exhibit willing or unwilling to part with it. Gently, the side effect begins with "Any samples? Any reading matter?"—all with a cursory glance at the exhibit. This assures the side effect that she has not been here before. A "yes" will cause the side effect to disappear. A "no" may bring about one of three complications: 1. sudden disappearances—5 per cent of cases; 2. a daily recurrent form—45 per cent of cases; or 3. a somewhat prolonged, acute form involving doubt, suspicion, and personal inspection of the exhibit by the side effect with eventual permanent disappearance—50 per cent of cases.

Miscellaneous side effects include "The Sitter"

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- General & Surgical Obstetrics, Two Weeks, November 2

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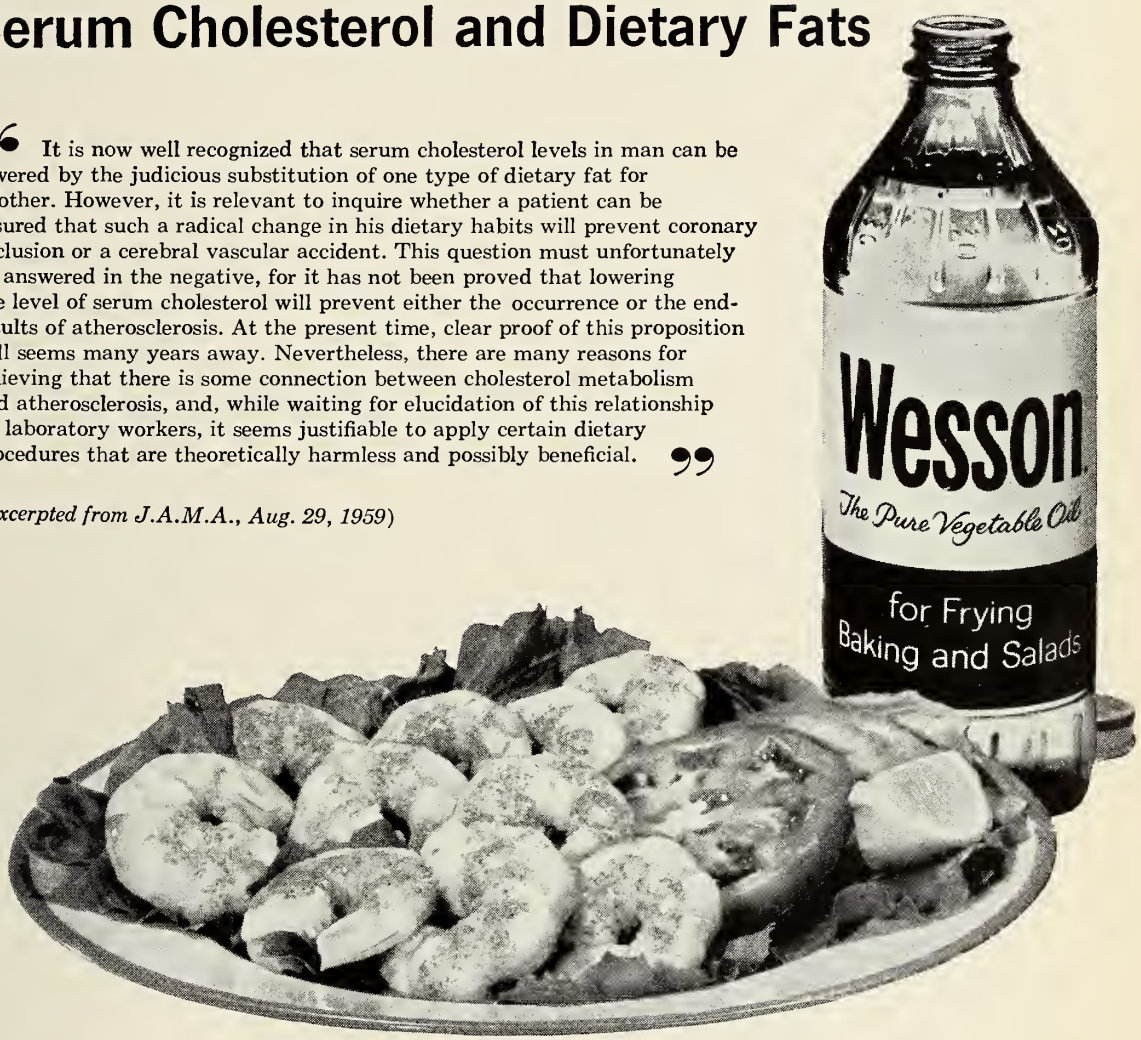
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(*Excerpted from J.A.M.A., Aug. 29, 1959*)



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Side Effects

Continued

who stays as long as four hours in a chair at the booth, meets all his friends, eats lunch out of a paper bag, and finally becomes so identified with the exhibit as to begin to answer questions and pass out literature. Finally there is "Case Report," a relatively benign side effect that, however, carries a high nuisance plasma value at times as high as 350 mg. per cent. Using the exhibit, not as a basis but as a prop, he describes a hypothetic patient, usually himself, whose malady will fall into one of three groups: 1. One with enough pathology to total half the sum of pathologic specimens in the United States; 2. One with a train of events so obvious that a first-year medical student could correctly diagnose it with a muscle-nerve preparation tied behind his back; or 3. One that is an absolutely irrelevant, illogical and inexplicable maze of symptoms that would have encouraged Cecil to write volume two. Both *The Sitter* and *Case Report* are self-limiting side effects, calling only for an exemplary bedside manner.

Side effects, intrinsic to the exhibitor, include ankle edema, pes planus (third degree), and hypertrophy of the bladder wall. Therapy is expectant.

Now, a word on prevention of these side effects. If you have an opportunity to work many months to obtain data for exhibiting scientifically, to gain the honor of constructing the exhibit itself, to enjoy the prestige of presenting the finished work, and to treat the side effects as they occur, DON'T!

Someone has suggested that America's greatest gifts to civilization are three: cornflakes, Kleenex and credit. Certainly few homes get along without all three of them. As for credit, the notion that when you want to buy something you wait until you have all the money has become hopelessly old-fashioned; in fact it has become almost unAmerican—Louis T. Benezet, Pres., Colorado College.

One teen-ager recently made what the school-crowd of our town would call a "neat" observation when he said, "You know, I'm starting to wonder what my folks were up to at my age that makes them so doggoned suspicious of me all the time!"—Margaret Blair Johnstone, *Better Homes and Gardens.*

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Clinicopathologic Conference In a Nonteaching Hospital

*F. S. HASSETT, M.D.**

Elmira, New York

ABOUT 10 years ago the medical staff of St. Joseph's Hospital began a program of monthly clinicopathologic conferences. St. Joseph's Hospital is a general hospital of 230 beds, which has no medical school affiliation, and which previously had no tradition of postgraduate medical education. The medical meetings which were held were those required for hospital accreditation. Occasionally, and without any planned program, a medical lecture would be given to the staff by an invited speaker. This was the extent of our efforts in the field of continuing medical education. Could this not be considered typical of the majority of community general hospitals at this time?

The main reason why the staff undertook this program was because we realized that there were patients being seen in the hospital whose illness, death and autopsy findings were instructive to the attending physician and his consultants, but the teaching value of these patients was lost to the remainder of the staff. In order to disseminate the lessons learned from such patients, the clinicopathologic conference seemed to be the most proved and practical form of exercise to hold.

In the beginning, and because we had no local tradition to follow, we attempted to discuss these cases ourselves. A committee of the staff picked out a suitable case and assigned the preparation of the protocol of that case to one man. Because of more interest in this type of work, the preparation of the protocols gradually fell to the lot of a few men, who thereby increased their skills in this literary form. Another member of the staff, who was presumed to be unfamiliar with the case, was requested by the committee to discuss it.

It quickly became apparent that this was not satisfactory. The difficulty was in the smallness of the staff and the awareness of the members of the events of interest occurring in the hospital. No one can adequately discuss a case at a conference when he has some knowledge of the final diagnosis. And no matter how much one tried to close one's ears to medical shoptalk around the hospital, the probabilities were that one had heard before some bit or piece of the case discussed someplace.

The form was then changed to another which was found to be equally unworkable. One member of the staff read the protocol and attempted to lead a general discussion of the possible diagnoses. The self-assured spoke up and tended to be dogmatic and scornful in the support of their points of view. The timid or shy kept quiet and achieved only a sense of frustration, especially if the diagnosis they had in mind but did not mention turned out to be the proper one. There were no personality changes accomplished by this type of exercise; the bold became bolder, the timid, more timid.

Attendance at conferences, which had tended to gradually increase, at that point dropped off sharply. The committee decided that another form must be found, or the exercises dropped. The necessity seemed to be for a discussant who, first, had teaching ability; second, did not know anything about the clinical case; and third, had sufficient knowledge of the subject and a well enough integrated personality to defend his position under questioning. To have such a discussant made it necessary for us to invite people from the surrounding area.

In justice to this invited doctor, who must travel and whose expenses would be continuing

* From the Consulting Staff, St. Joseph's Hospital (Deceased).

Reprinted from the *New York State Journal of Medicine*, Vol. 58, p. 580, Feb. 15, 1958.

while he was giving us his time, an honorarium of $50 was offered. The medical staff, through staff dues, supplied these funds. From the immediately surrounding area at first, and then from a gradually widening area as we became more sure of ourselves and more favorably known to others, the discussants were invited to come to St. Joseph's for clinicopathologic conferences. It is only rarely now, and usually for a sufficient reason, that our invitations are refused. The discussants seem to enjoy the exercises as much as we do.

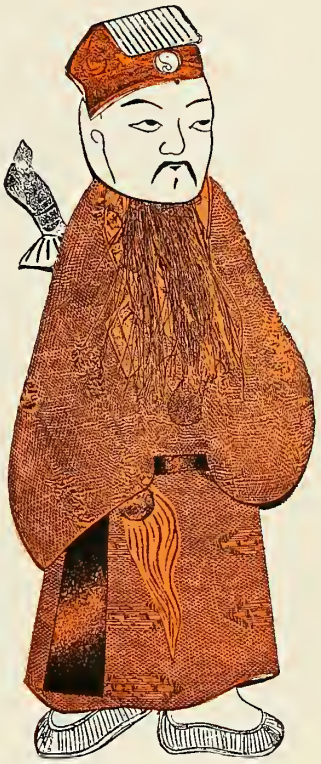
After 10 years of experience with this form of teaching exercise we are enthusiastic about it. Out of a staff of approximately 80, we can count on 40 to 50 members to attend each conference. It has become an anticipated event on the second Wednesday of each month, except for the three summer months. It begins at noon, lasts for about one hour, and is followed by luncheon served by the hospital. We have even been able to attract a few of our fellow practitioners from nearby towns, to our benefit as well as theirs.

Some of the discussions were so brilliant and instructive that we thought it a waste not to attempt to preserve them for future reference. They were, therefore, recorded on a tape recorder, transcribed and edited, and sent to the discussant to make sure they conformed to what he wished to say. They were then kept in a permanent binder in the Doctor's Library of the hospital. Some have been accepted for publication in the *New York State Journal of Medicine* where, we believe, they have been of benefit to others.

In doing this for 10 years, mistakes other than those mentioned above have been made. Lessons have been learned and rules evolved which might be of value to others. In order to help any others who might be interested in establishing clinicopathologic conferences in a nonteaching hospital, it might be well to mention them.

Care and thought must be used in choosing the case to be discussed. It must be interesting, not rare, and sufficient data must be present in the clinical work-up to allow the proper diagnosis to be made. "Trick cases," in which the evidence points to an erroneous diagnosis, must be avoided. No pertinent data may be withheld. How much negative data must be included is always a problem. As the protocol is worked and reworked in order to give a true picture of

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Clinicopathologic

Continued

the patient's condition and still have a protocol of acceptable length, much negative data will have to be sacrificed. The time spent on the preparation of the protocol cannot be shortened without sacrificing the quality of the conference.

When the case we wish to have discussed has been chosen, we attempt to fit the case to a speaker. We are located within a few hours driving distance of three medical schools located in Buffalo, Rochester and Syracuse. We have come to rely on the trained teachers of these medical schools for the majority of our discussants, although if the case warrants it, we have not hesitated to ask people from points farther away. We consider the case to be illustrative of some group of diseases and try to secure a man with special interest or experience in that field. We attempt to assure him that the case is illustrative and not tricky and that we are more interested in how he thinks about the problems presented than we are in whether his final diagnosis agrees exactly with that of the pathologist.

Since these are teaching exercises and not exercises in individual brilliance, the protocol, together with all pertinent ancillary data, such as x-rays and electrocardiograms, are in the hands of the discussant at least one week before the time of the meeting. The staff can obtain the protocol five days before the meeting. If the x-rays and electrocardiograms are photographed and displayed in the doctors' cloak room, it aids the staff in studying the protocol.

At the meeting, after the protocol has been read and the speaker has finished his presentation, the chairman makes a determined effort to elicit questions from the audience. Judgment is the faculty which is being exercised. The interest of the audience is heightened if they are offered the opportunity to test their judgment against that of the speaker. Troublesome diagnostic points and nuiances of therapy are often brought out in the questions. If nothing else is accomplished, it gives the audience a sense of participation.

We have made it a practice, after the pathologist has presented his findings, to ask the speaker to summarize the lessons which have been learned from the case. This gives him the last word, and more often than not he has something to say which is of benefit to all.

Many benefits have accrued to us over the years from these exercises. The teaching value for all of the staff is obviously one of them. The stimulus to the staff from their contact with a learned mind and a good speaker is another. Not knowing but what any case might be used for clinicopathologic conferences, the quality of the clinical records has shown improvement. More care is taken to get down on the chart a good history and a detailed physical examination. More thought has gone into the ordering of laboratory work. And consultation has been more frequently obtained.

In the beginning there was some resentment, or at least suspicion of implied criticism, when permission was asked of the attending physician to use his case. But every effort was made to conceal the identity of the attending physician. He was consulted for all details before the protocol was prepared. After that he was never referred to again. If any questions arose during the conference, the chairman answered them from his own knowledge and did not expose the attending physician by a question directed to him. As these rules became known, more and more of the staff members volunteered their cases for use at the conferences.

The hardest part of the whole program is the paper work, the preparation of the protocol and the editing of the transcription. Firmness, almost ruthlessness, in pruning and condensing must be used. When we look back at some of the early protocols and some of the first transcriptions as finally edited, we are amazed by the leniency in this regard which we permitted both ourselves and the speakers. There is no way except by doing this editing and revising to obtain proficiency in it.

From our experience with this program we would strongly urge others who are interested in developing a hospital plan for continuing medical education to try clinicopathologic conferences. They are rewarding, and they are not difficult. ◄

From the depths of Africa comes a cannibal story, reported by Clara Uqyhart, an associate of Albert Schweitzer in Lambarene:

A beautiful blonde was about to be put in the boiling pot. The chief's messenger came running up in a panic.

"Hold everything!" he yelled. "The chief wants his breakfast in bed this morning."—John G. Filler, *Saturday Review.*



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November 1959 2011

Indiana State Board of Health

DIVISION OF COMMUNICABLE DISEASE CONTROL

MONTHLY REPORT - September, 1959

Disease	Sept. 1959	Aug. 1959	July 1959	Sept. 1958	Sept. 1957
Animal Bites	601	618	605	448	308
Chickenpox	36	7	35	29	21
Conjunctivitis	91	59	43	37	20
Diphtheria	1	0	1	0	1
Dysentery, Unspecified	14	15	3	21	43
Impetigo	302	99	57	225	41
Infectious Hepatitis	12	20	17	11	13
Infectious Mononucleosis	5	4	2	6	4
Influenza	375	150	88	559	183
Measles (Rubeola-Rubella)	79	64	141	89	34
Meningitis, Meningococcal	1	2	2	2	5
Meningitis, Other	49	25	15	20	14
Mumps	40	11	65	45	44
Pertussis	81	56	65	155	79
Pneumonia	112	61	54	87	56
Poliomyelitis	55	40	24	33	45
Streptococcal Infections	182	150	124	250	52
Tinea Capitis	21	3	0	75	28

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Administrator

ESTHER L. SIMPSON, R. N.
Director of Nurses

Phone: Columbus TUXEDO 5-5381

Another Year . . .

Another year and another convention . . . marking the 110th time Hoosier physicians have met to exchange medical information, learn new technics and review old ones, give serious consideration to business matters affecting medical practice in Indiana and the nation; and last but by no means least, to meet socially at banquets, luncheons, parties and the president's reception.

Wives joined in the activities of the Indiana State Medical Association Convention, setting aside time for their own affairs of state; and representatives of the many technical exhibitors added to the education and the fun.

In addition to a full scientific program with speakers from all over the nation and from London, England, there were business sessions of the Council, the Executive Committee and the House of Delegates. Resolutions were passed, new officers were elected, a Doctor of the Year was selected. . . .

A new president for 1959-1960 took the gavel and the presiding president talked of medical care problems in present day practice, especially where costs of such care are concerned.

There was a stag party and a doe party and a cocktail party and a banquet in addition to the many business and educational luncheons.

Excitement and anxiety soared as the names of prize-winners were drawn and as judges stared thoughtfully at exhibits and at samples of physicians' artistic talents and hobbies.

There were lots of prizes, too; door prizes for the physicians, for the lady exhibitors at the doe party, for the male exhibitors at the stag party; ribbons for scientific exhibits, ribbons for the art and hobby show. And probably the "prize" story of all was when the name of Dr. Carl Williams of Gary was pulled out of the box as winner of a Corvaire . . . for he had borrowed a car to drive to the convention. Later, when he called his wife to tell her the good news, he had to ask someone else to reassure her that he had won the car before she would believe it.

On the following pages you'll find story and pictures giving a thumbnail sketch of Indiana's 1959 Doctor of the Year . . . and representative photos of ISMA's 110th Annual Convention. . . .



In his office,
John K. Kingsbury,
Indianapolis physician

Indiana's Doctor of the Year

ELECTED as Indiana's 1959 Doctor of the Year by the ISMA House of Delegates was Dr. John K. Kingsbury, 74-year-old Indianapolis general practitioner.

A graduate of Butler University in 1906 and of Indiana Medical College in 1909, Dr. Kingsbury worked in the laboratory of Dr. Frank B. Wynn to help in the study of pernicious anemia and Hodgkin's disease during the last two years of his medical studies.

He interned at St. Vincent's Hospital, Indianapolis, where he became interested in the use of autogenous bacterial vaccines which he made and used on a variety of infections. Results justified continued activity in that field after he opened his general practice. He made and used these until, after WWI, pharmaceutical laboratories began manufacturing them. (The development of sulfonamides and antibiotics later replaced the use of these vaccines.)

Dr. Kingsbury took a post-graduate course in serology at Michael Reese Hospital, Chicago, in 1913 and equipped his own lab for making tests, work which he carried on until larger laboratories became active in the field.

In 1913 he worked in the Indianapolis Board of Health laboratory, examining more than 1,000 cultures daily during the last big diphtheria epidemic there. During WWI he served as contract surgeon for a S.A.T.C. unit.

He is a 50 Year Club member of ISMA, a member of the Marion County Medical Society and AMA; a member of the Methodist, St. Vincent's and Community hospitals staffs; is a charter member and elder in the Irvington Presbyterian Church; joined the Indianapolis Athletic Club shortly after it was founded. His fraternities include Phi Rho Sigma and Phi Delta Theta.

Dr. and Mrs. Kingsbury have two sons, James L. and John E., both Indianapolis businessmen.



"To give the best possible care to his patients . . ." Here Dr. Kingsbury sees a patient, Mrs. Frances Ream of Indianapolis, who has been numbered among his patients since 1955. He's caring for the third generation of some families.

The Man and the Physician...



"Dispenses his own medications . . ." With his nurse, Mollie Surgener, he discusses dosages of a medicine to be dispensed to a patient. His former nurse, Dorothy Kitchen, was with him 37 years until she passed away last February.

by corki

WHAT WOULD be the prototype of a perfect physician? What qualifications would such a man possess to measure up to the highest standards of one of the oldest and most honored of professions . . . that of treating and curing the ill?

This is a generalized question that has been discussed since Hippocrates; a question of particular importance today in the United States when the threat of socialized medicine pushes in on the medical ranks from many sides.

It is pretty generally accepted that true "perfection" is never reached, we only strive for it; and John K. Kingsbury, M.D., would be the first to say this. In fact, any reference to him as even having come near to representing his profession in its highest light would be nothing but embarrassing to Dr. Kingsbury.

But let's look at some of these qualities of medical practitioners which are taken into consideration in the selection of the Indiana Doctor



"Patients from all over Indiana . . ." A lot of records can be accumulated in a big practice, especially one taking in patients from around the whole state. Here Dr. Kingsbury talks with Betty Hawke, his records clerk.

of the Year—a title ISMA members bestowed upon this Indianapolis physician for the year 1959.

First and foremost is the physician's never-ending striving to better his standards of medical practice, to give the best care possible to his patients—continued education to keep at his fingertips the latest advancements in medical science. Then add a personal compassion and interest in his patients without discrimination . . . the ability to be a friend to each of his patients and extract from each complete confidence in his efforts to cure wherever a cure is medically possible . . . maybe even the ability to make a patient feel better just because he is there to help.

One of the most wonderful hours I've spent in many a day was granted me when Dr. Kingsbury literally turned his office over to me to take the accompanying pictures of him, his staff and even a patient. He met me with a warm handshake that was firm and reassuring and introduced me to his staff forthwith, extolling the merits of each.

He is an humble man, dedicated to his profession, to his patients. He radiates warmth and confidence. According to his staff, he never

"He never changes—is never ruffled . . ." Thus Dorothy Burk describes her physician boss of the past 14 years. Mrs. Burk is more-or-less general office manager whose job it is to see that records are kept straight, work flow is smooth, mail taken care of, bills paid and all the business end of a busy physician's practice.





Devoted to his family as well as to his patients, Dr. Kingsbury was not left to receive his Doctor-of-the-Year award without their presence. The Kingsbury clan joined the doctors and their wives after the annual banquet to see him receive the Doctor-of-the-Year plaque and hear his speech. Shown are (l. to r.): Son James, Bill Kingsbury, Miss Kay Williams, Mrs. Olive Symms, Mrs. James Kingsbury, Son John, Mrs. John E. Kingsbury, and John, Sally and Dave Kingsbury.

changes—is never ruffled, never angry, always taking a warm, personal interest in each of his patients with no discrimination of any kind. He wants no recognition for his work other than his own satisfaction in serving his patients, in helping them get well, aiding them over the rough spots.

In the letter of nomination on behalf of Marion County Medical Society, its president, Dr. Irvin Wilkins, wrote: ". . . it is given to few men, physicians or not, to win and hold the love and respect of their communities, to be sought as friends and advisors through their sheer concern, empathy and wisdom over a lifetime, but Dr. Kingsbury is one of these."

This was my personal impression of Indiana's latest Doctor of the Year. One upheld by members of his office staff. One upheld by the fact that he has patients come to him from all over Indiana—Plainfield, Richmond, Logansport, Muncie and many other areas. His patients have said of him that they feel better simply because he walks into the room . . . and to this I will attest.

And Dr. Kingsbury is one GP who still dispenses his own medications. In fact, he is using some medications which he formulated himself; and before the large pharmaceutical houses began making antibacterial medicines, he made his own.

This is my tribute to Dr. John K. Kingsbury, who so graciously gave of his time that the *Journal* might give some slight reflection of him as a man and physician to pass on to his colleagues.

Though he wants no recognition beyond his actual accomplishments with patients, I know all Indiana will be behind him as the Hoosier nominee for the AMA's U. S. Doctor of the Year. Good luck to a man who personifies the medical profession.

HOOSIER MEDICS



Opening invacation at the first House af Delegates sessian.



SCIENTIFIC EXHIBITS — Winning baaths were "Progress in the Management af Essential Hypertensian," Dr. G. G. Duncan, Philadelphia; "Hereditary Hypertension," the Caylor-Nickel Clinic, Blufftan; and "Broad-Spectrum Antibiotics in Dermatalagy," Dr. Theodare Carnbleet and Caok Caunty Haspital.

TECHNICAL EXHIBITS attracted many af the over 2,000 physicians, auxiliary members, medical students, nurses, technicians, and guests wha registered at the 4-day session.



SCIENTIFIC SESSIONS were a highlight of the annual meeting. Haasier dactars heard over 20 speakers from the United States and England.



CONVENE



ABOVE—Exhibit halls were the center of activity between scientific sessions.



LEFT—Dr. Carl Winter, Detroit, provoked many laughs and food for thought at the annual banquet.

Past Presidents Luncheon



Annual banquet crowd pauses to smile at the "birdie."



RECOGNITION for SERVICE



DR. KENNETH OLSON, outgoing president receives recognition ploque from Dr. Eorl Mericle, Indionopolis, ot the onnuol banquet.



PHYSICIAN OF THE YEAR—Dr. John K. Kingsbury, Indianapolis.

. . . a look to the future



THE PRESIDENT'S GAVEL is handed to Dr. Eorl Mericle, Indionopolis for the 1959-60 term.

hazey highlight . . .



The onnuol stog party.

TIME OUT . . .

— to chat

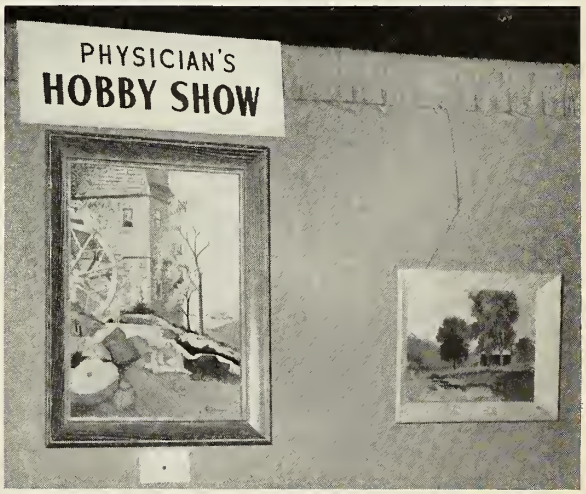


Mrs. Edward Rigley, South Bend, Auxiliary President-elect, and Mrs. Philip Holland, Bloomington, Auxiliary historian.

— see exhibits



— to share hobbies





PHYSICIANS HOBBY SHOW — Winners included Dr. Charles Schneider, Evansville, Dr. M. B. Paynter, Southport, Dr. R. Ross Fowler, Bloomington, Dr. Harry Kitterman, Indianapolis, and Dr. Richard Woolery, Bedford.



Auxiliary members register at "Petticaat and Pinafore" luncheon and style show.



WIVES AND DOE'S

ABOVE — Mesdames Jahn Greist, Indianapolis, conventian chairman, Danald White, Indianapolis, Marion Caunty Auxiliary president and J. M. Black, Seymaur, auxiliary president.



RIGHT — Auxiliary members gather at "Hail ta the Chiefs" banquet.

BELOW—Speakers' Table at the annual Auxiliary Banquet.







Convention "doe's"—lady exhibitors—and the feminine gender from headquarters office gather for dinner the first night of convention. The "roses" bloomed until a thorn invaded the scene (right).

JOIN THE CONVENTION WHIRL



RIGHT: CONVENTION "DOE'S" renew acquaintances at their annual party at the Athenaeum.

LOWER LEFT—Lois Smith, Dairy Council, proud winner of a travel iron at the Doe Party.

LOWER CENTER—Mrs. Jackie Pierce of the Association headquarters presents Ruth Ayer, Brooks Appliance, Chicago, with a set of glasses.

LOWER RIGHT — Mabel McMeans, medical assistant, Richmond, took home a Timex watch.











The Winning Smiles

Dr. Harry S. Rabb, Indianapolis, accepts Argus camera daar prize fram Haward Grindstaff, af the assaciatian field staff.



Caffee urn winner Dr. Claude D. Halmes, Frankfart, accepts his door prize.

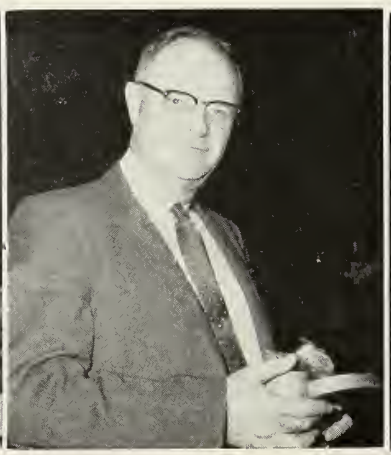
LOWER ROW, Left to Right:

Dr. Max Capestany, Indianapalis, leaves the Murat with a new portable televisian set.

Dr. J. P. Vye, Gary, winner af a pair af field glasses.

Dr. Carl Williams, Gary, who drave ta Indianapalis in a barrawed car, won a 1960 "Carvaire" autamabile.







Now—All cold symptoms can be controlled



Tussagesic

timed-release *tablets*

Controls congestion

with Triaminic,[1,2,3] the leading oral nasal decongestant.

Controls aches and fever

with well-tolerated APAP, non-addictive analgetic[4] and excellent antipyretic.[5]

Each TUSSAGESIC Tablet provides:

TRIAMINIC® 50 mg.
(phenylpropanolamine HCl 25 mg.
pheniramine maleate 12.5 mg.
pyrilamine maleate 12.5 mg.)
Dormethan
(brand of dextromethorphan HBr)..... 30 mg.
Terpin hydrate 180 mg.
APAP (N-acetyl-p-aminophenol) 325 mg.

References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

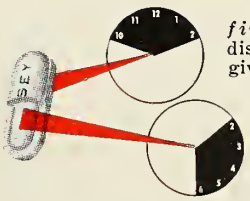
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Liquefies tenacious mucus

with terpin hydrate, classic expectorant.

Prompt and prolonged relief because of this special "timed release" design:



first — the outer layer dissolves within minutes to give 3 to 4 hours of relief

then — the inner core releases its ingredients to sustain relief for 3 to 4 more hours

Dosage: One tablet in the morning, midafternoon and at bedtime. Pediatric dosage chart for Tussagesic Suspension available on request.

TUSSAGESIC SUSPENSION provides palatability and convenience which make it especially attractive to children and other patients who prefer liquid medication.

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**Through breeding . . .
the heavy breasted bird.**

Turkey Talk for Thanksgiving

SINCE OUR pilgrim fathers first feasted in thanksgiving, the turkey has traditionally gone to the chopping block as a nation sits down to laden tables to give thanks for its blessings. Only the turkey has little reason to give thanks.

But what about this turkey . . . and those who raise this greatest of American domestic fowl? A little research with the Farm Bureau Co-Op gave us some points of interest. So let's consider the turkey.

Medically speaking, he *(she)* is a good bet. According to Co-Op, turkey has the highest protein level of any edible meat or fowl, and the lowest cholesteral level.

In addition, constant breeding through artificial insemination has produced a "heavy breasted" bird predominate in white meat.

Thus—turkey is both healthful and tasty.

But, with small families, a huge bird is impractical, and expensive. So breeders have begun to send this superior bird to the market when it is younger—and lighter. Yet, it retains its juicy white meat ratio.

This brings about another problem of the breeder. Since Thanksgiving has been the traditional turkey dinner season, the breeder can sell heavy for November—and starve the rest of the year! So, in addition to selling the younger bird, the National Turkey Federation is conducting a campaign to educate consumers' palates to turkey consumption throughout the year, is making turkey available in halves and parts, and is stressing institutional use for health reasons and more for the money invested.

Turkey breeding is quite a business in Indiana with the Elkhart area leading the field followed



**High in protein . . .
low in cholesterol.**

**All of this and . . .
turkey is tastier, too!**

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CONVENIENCE and ECONOMY

for that all-important first dose of broad-spectrum antibiotic therapy

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brand of oxytetracycline

INTRAMUSCULAR SOLUTION



Initiation of therapy in *minutes after diagnosis* with new, ready-to-inject Terramycin Intramuscular Solution provides maximum, sustained absorption of potent broad-spectrum activity.

...and for continued, compatible, coordinated therapy

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CAPSULES

Continuation with oral Cosa-Terramycin every six hours will provide highly effective antibacterial serum and tissue levels for prompt infection control.

The unsurpassed record of clinical effectiveness and safety established for Terramycin is your guide to successful antibiotic therapy.

Supply:

*Terramycin Intramuscular Solution**
100 mg./2 cc. ampules
250 mg./2 cc. ampules

Cosa-Terramycin Capsules
125 mg. and 250 mg.

Cosa-Terramycin is also available as:
Cosa-Terramycin Oral Suspension — peach flavored, 125 mg./5 cc., 2 oz. bottle
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Management Views Financing of Hospital and Medical Care

MALCOLM L. DENISE

General Industrial Relations Manager—Labor Relations,
Ford Motor Company

MANAGEMENT of the modern corporation has an interest in the subject of hospital and medical care both in its capacity as an employer of people to man its facilities, and in its capacity as an industrial citizen of the communities in which it lives and does business.

Over the past couple of decades there has been increasing awareness by corporate management of its responsibilities in both capacities. I know there have been great developments on both scores at Ford since 1946.

We come into direct contact with this problem of hospital and medical care in several ways, of which the most direct are these:

1. As the operator of our own plant medical facilities and services.
2. As a donor and solicitor of employee donations toward meeting costs of community health programs and facilities—both operating costs and capital expenditures.
3. As a purchaser of hospital and medical service for employes.

The first of these has probably the least bearing on our discussion here today, and I will not dwell upon it. We provide such facilities and services in our various locations primarily to perform employment examinations, assist in placement problems, handle emergencies, and treat work-connected injuries or illnesses not requiring hospitalization or specialized talents outside the field of industrial medicine. In addition, we keep under study and review the health environment of the working place and ways in which this can be improved. We were greatly honored to receive last year the "Health Achievement In Industry" Award from the Industrial Medical Association.

While our experience in providing medical services and facilities directly gives us some insight into the problems involved, it hardly qualifies us to pose as expert in the general field of medical and hospital administration.

The other two phases of our relationship to medical care problems—as a supporter of voluntary community agencies and, jointly with our employes, as a customer—are more relevant to the subject you are examining.

The development of proper and intelligent management attitudes, policies and actions with respect to both of them is considerably more involved and difficult. Management must relate them to a number of considerations, and attempt to reach specific solutions to the problems confronting it which reflect a sound, realistic application and balancing of these considerations.

What are these considerations? I would like to discuss several which seem to me of great importance.

I would list as perhaps the most basic our stake in the preservation of a free society and a free economy in America. The individual freedom which we Americans have been able to enjoy has been made possible by a system of institutions which has accommodated an unprecedented degree of diversity and autonomy within an overall unity. This has released the energies and ingenuity of our people to accomplish—voluntarily and largely without the compulsion of master planning and state control—the highest standard of living for the many that man has ever known.

It is, of course, a truism that freedom is inseparable from responsibility.

Continued

Delivered at the Second Institute for Hospital Administrators, University of Michigan, Ann Arbor, Mich., April 2, 1959.

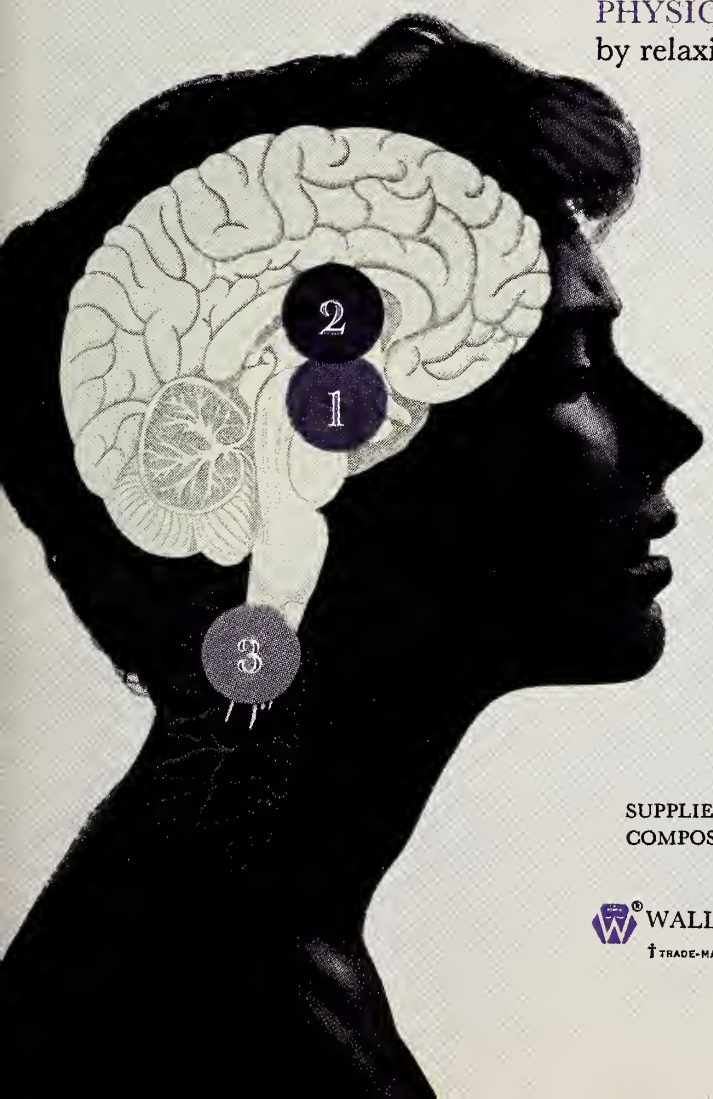
COMPREHENSIVE, THREE-LEVEL TREATMENT OF DEPRESSION

AND ASSOCIATED ANXIETY AND PHYSICAL TENSION

RELIEVES DEPRESSION
including symptoms such as crying, lethargy, loss of appetite, insomnia

RELIEVES ASSOCIATED ANXIETY
with no risk of drug-induced depression

RELIEVES ASSOCIATED PHYSICAL TENSION
by relaxing skeletal muscle



1
hypothalamus

2
thalamus and limbic system

3
spinal cord

▲Deprol▲†

benactyzine + meprobamate

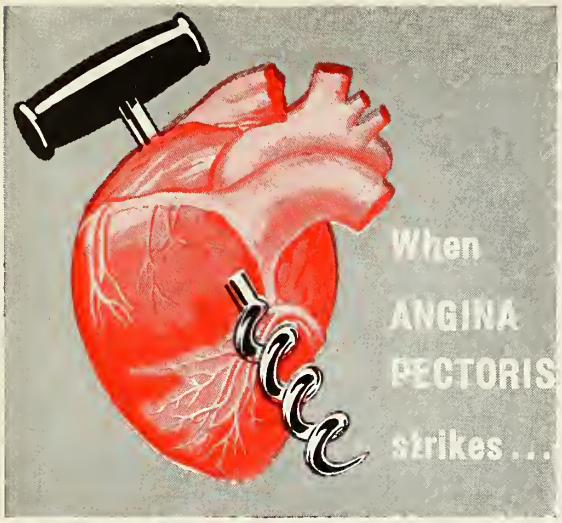
- confirmed efficacy
- documented safety

SUPPLIED: Bottles of 50 light-pink, scored tablets
COMPOSITION: Each tablet contains 1 mg. benactyzine HCl and 400 mg. meprobamate

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NIPHYLLINE

the unique specific

This exclusive development is a ***definite chemical,*** neutral in action, and ***specific in prophylaxis and treatment of angina pectoris.*** It is effective orally in about thirty minutes, for periods of 7 to 8 hours . . . and, even when given routinely, does not cause nausea or gastric upset. Niphylline is an efficient vasodilator and diuretic combining the effectiveness of Neothylline (soluble, neutral, stable derivative of theophylline) and pentaerythritol tetranitrate, substantially more effective than mannitol hexanitrate. Thus, the patient receives the benefits of both drugs without any annoying side effects.

Niphylline is safe, and well tolerated . . . exerts strengthening effect on heart muscles, and acts synergistically, remarkably reducing severity and frequency of cardiac attacks.

Indications: Relief and control of angina pectoris, cardiovascular symptoms, asthenia, coronary spasm with myocardial pain, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Dosage: One or two tablets, 3 or 4 times daily, or as directed by physician.

Supplied: Bottles of 100 and 1000 tablets.

PM **PAUL MANEY**
LABORATORIES, INC.
Cedar Rapids, Iowa

Management Views

Continued

One corollary to this broad consideration is that medicine and medical services must be able to attract and retain able people voluntarily, in competition with other callings and vocations. We live in a world of limited choice. We can either attract people or we can conscript them. If we are forced to resort to conscription, freedom dies.

Secondly, management must never lose sight of the role which is its to play in a free society. Generally speaking, management is interested in advancing the well-being of its employees and the communities in which it operates. But its responsibilities cannot end there—it has equal responsibility to consider the interest of customers, stockholders and the public at large. No matter how high our motives or how deep our desire to improve conditions of employment or conditions in the community, there is simply no escape from the proposition that wages and benefits and contributions are costs of production. Our economic system relies on management to control costs. If management fails in that duty—if it does not keep the costs of doing business at a level which enables the business itself to grow and prosper—then it fails utterly in its responsibility to customers, stockholders, public, community and employes alike.

This, quite simply, means that desirability or alleged need—which is, really, a relative term—of some particular health project or program cannot be the sole or overriding criterion for management decision. It is one of the harsh, inescapable facts of human life that we cannot have more than we can afford and if we attempt to do so in one area, we pay the penalty in another, regardless of how we organize our society.

The importance of considering the cost factor in developing policies in the medical care area is doubly emphasized by a look at what has been happening to the cost of medical care itself.

According to the Health Information Foundation, the personal expenditures of the American people for their health care in 1957 added up to more than 15 billion dollars. This is only the amount we spent privately—on hospitals, doctors, dentists, drugs, glasses and all the other things we use in our health care.

This 15-billion-dollar figure does not tell the

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Management Views

Continued

whole story. It represents only personal expenditures. We must also add the huge sums of money spent on health care by federal, state, county and city governments, by our charities and philanthropies, and by business and industry on industrial health clinics. When we include the money spent in these categories, the total estimated sum for 1957 becomes 20 billion dollars.

Even this 20 billion dollars does not cover the whole bill. It does not, for example, include public and government funds spent on medical research or on the construction, expansion and equipment of hospitals. Nor does it include the administrative and other costs incurred by employers for the health care insurance plans tens of thousands of enterprises provide their employes. Our experts tell me that if we added these amounts to the 20 billion dollars, the total probably would equal about half of this fiscal year's proposed budget for defense.

The figure is impressive. Even more significant to our thinking than the total sum, however, is the rate of increase. The 20 billion dollars known cost of health care last year is double the corresponding figure 10 years ago, and five times the figure for 25 years ago.

We see no basis for confident prediction that medical costs will level off in the near future. On the contrary, there is every reason to believe that they will continue to rise.

The rate of innovation in medical science and medical practice is rapid and promises to become even more rapid in some areas. When we think that 80 percent of the drugs used by doctors in the treatment of disease did not even exist 20 years ago, we see one example of a fact with which we are all acquainted—the rapid advances in medical science. As medical practice advances, the hospital must keep up with it. Hence, it is reasonable to suppose that the rate of change and obsolescence in hospitals will be greatly accelerated in the next decade.

Moreover, it seems likely that we will continue to use more and more hospital and medical services. This is a guess, I know, but it is based on experience. Between 1935 and 1957, annual hospital admissions per 1,000 population increased from 59 to about 130—and the curve is still rising. There is no evidence that the rate of use will diminish or level off. It seems much more likely to increase.

Moreover, there will be many more people for the hospitals to serve. Four hundred new citizens are born in this country every hour, or one about every ten seconds. In the past ten years the birth rate has increased 23 percent.

What these facts signify for hospital costs—both capital and operating expenditures—is almost immediately apparent. For one thing, the need for highly trained personnel will increase and competition for these people may become more acute and costly. For another, it is very likely that inflation will continue to affect the cost of all the things that a hospital needs.

In this connection, I would like to come back to the proposition that real improvements in the standards of our people as a whole can only come about by increasing our efficiency and productivity—in other words, by increasing our output per unit of the resources at our disposal. And, insofar as I am able to understand them, our commonly used measuring sticks are particularly ill-adapted to arrive at meaningful conclusions as to the productivity progress in professional and service fields such as health and



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DONALD R. KINZER
Manager

medical care. But one thing seems clear. To the extent that our health and medical programs do not increase their own efficiency, they can progress only at the expense of other needs and wants of our people.

The final consideration I would like to mention is this: there is a definite management self-interest in the continuing good health of employes. We know that proper care in the event of illness or accident can insure an earlier return to work, and can be a major factor in the efficient operation of the company. We know that a major share of absenteeism is caused by off-the-job illness and accidents. We have to schedule for it, make allowances for it, transfer employes to unfamiliar jobs with resultant loss of efficiency. Moreover, as management problems and industrial processes become more complex, we become increasingly dependent upon highly skilled people. The absence of just a few key people can be very costly to us. In our own self-interest it is important that our employes be healthy and productive.

At the same time it must be acknowledged that to date no one, so far as I know, has come up with a satisfactory price tag on factors such as these which enable management to determine the dimensions of cost expenditures for medical benefits which actually are recouped through such factors. It is doubtful, in my opinion, that the nature of the situation is such that reasonably precise calculations of this kind are possible.

Moreover, this line of reasoning has other limitations, notably that involved in the question of how mutual is the responsibility which should be implied from the fact of mutual advantage. It is possible to ride a good horse to death. Have you ever considered the conclusions that could be rationalized from the premise that management has an interest in assuring that there be a continuing replenishment of the work force?

Now, all of these considerations that I have discussed are not always easy for mere fallible humans—which managers, after all, are—to bring into a proper balance when deciding upon specific proposals for management policies and actions; but decisions nevertheless must be made.

I would like to discuss, in the time remaining, some conclusions to which these considerations have led us in the company I represent.

First, let's consider our role as an industrial citizen of the community, concerned with the support of community health agencies and facilities.

As a major employer, we must dispose of requests for direct contributions to innumerable voluntary agencies in this field, and to requests that we permit, undertake, administer or otherwise support appeals to our employes for contributions to such agencies.

There seems to be no natural limit to the number of groups which can form themselves for apparently worthy purposes and undertake fund drives. For the individual employer to pick and choose intelligently without risking ill-feeling, charges of favoritism and discrimination, and wasteful or unwise use of donated funds, is a virtually impossible task.

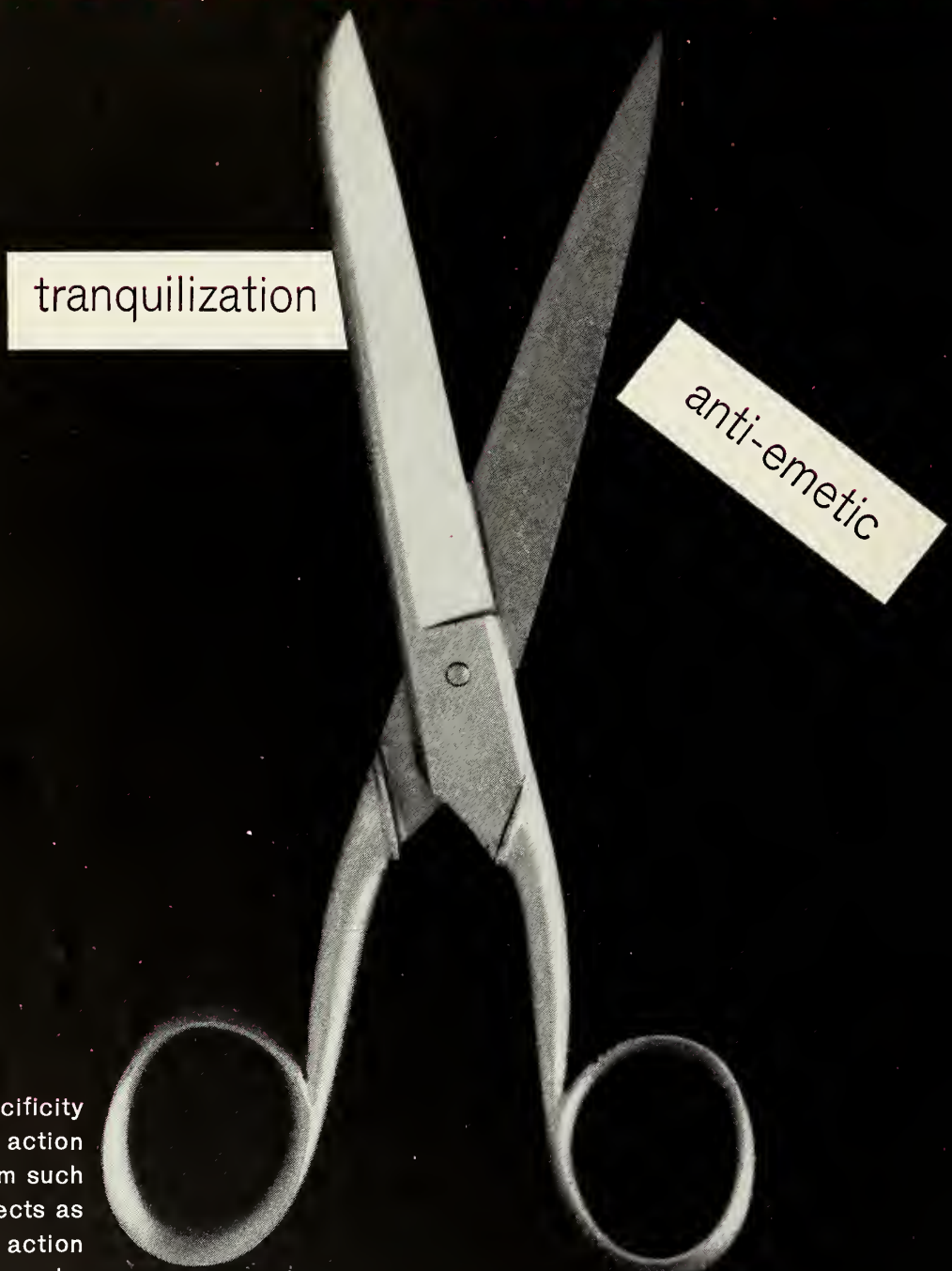
As a step towards solution of these and related problems, we endorsed the United Fund approach at its inception, and took an active part in its development.

As you probably know, ten years ago Detroit pioneered the United Foundation, and after ten years' experience we are absolutely sold on it. Year after year it has proved to be the simplest, most convenient and most economical way of doing the job for which it was designed.

Continued on page 2046



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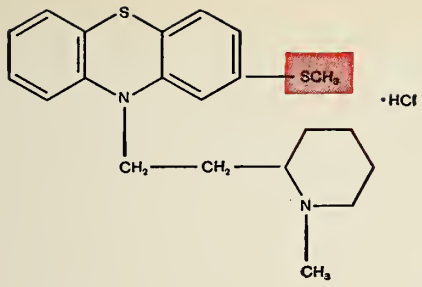
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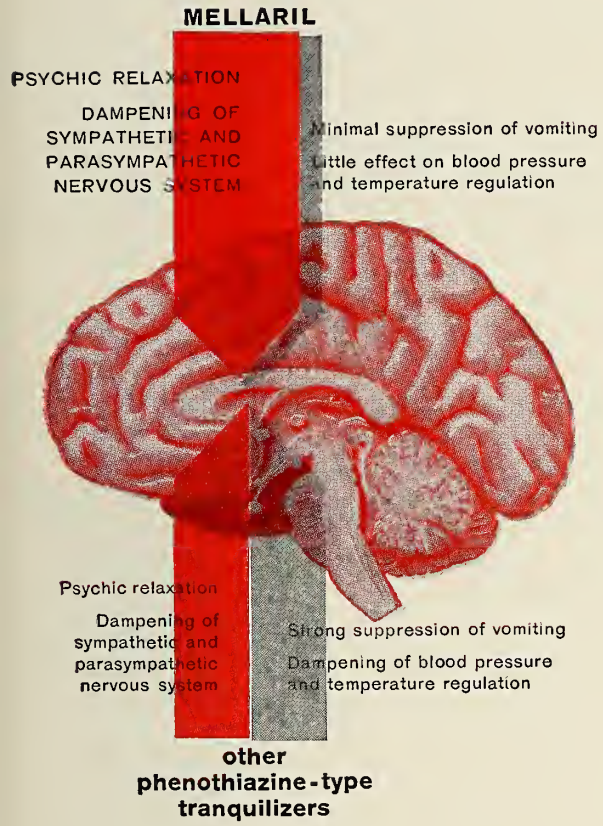
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*Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959

SANDOZ

Management Views

Continued from page 2043

We were active in developing a comparable approach to the raising of capital funds for community facilities—chiefly hospitals.

But, as we see it, the greatest selling feature of federated giving from this time onward will not be mere convenience. It will be the evidence that federation gives of thorough planning that enables it to provide all the health services a community should provide. Federation has moved beyond the stage of initial enthusiasm. It now has adult responsibilities. It will continue to enjoy success only insofar as it measures up to these responsibilities. It will maintain its place only as it proves itself capable of keeping up with the changes that affect community health services, and of serving the community well. If it is to continue its early success, it must be ready to adopt new attitudes, new disciplines and new habits of thought about community services. Above all, it must plan programs with all the care it can muster.

And here, of course, the problem of rising medical costs confronts us head-on. We see this economic problem as one of the gravest difficulties lying ahead for federation. If we are to continue our voluntary united way of handling community health problems, then we must prepare for a possible doubling of the cost of health services in the next ten years. And unless we demonstrate our ability to cope with rising costs in such a way that the community's health needs are adequately served, and for adjusting community programs to changing community patterns, then federation as we know it seems doomed.

Our voluntary community health services, including our voluntary community hospitals, have throughout our nation's history provided us with a way of dealing with our health needs that is consistent with our democratic and free enterprise society. This tradition of self-help through the neighborly sharing of our common responsibilities is part of our way of doing things. It is the medium through which the employer can best meet his responsibilities in this area as an industrial citizen of the community. It gives him the opportunity to contribute to the group effort, not only his money, but the specialized talents and knowledge that experienced business management can contribute towards realistic planning and administration, the avoidance of waste, and the necessity of living within the means available. And at the same time it reserves to the professionals and experts in the field of health and medical care primary responsibility for the design and execution of their programs, and provides a mechanism for resolving the often competing claims of the various interests which make up the community.

In our capacity as a "consumer" of medical services through contributions towards the cost of selected hospital-medical care benefits for our employes, we are not over in a separate compartment completely walled-off from that labeled "community citizenship." On the contrary, in the consideration of such programs we have kept very much in mind their relationship to and impact on the community.

Thus we have opposed the notion of special facilities and medical programs designed for the exclusive use of our own employes or the employes represented by a particular union or group of unions.

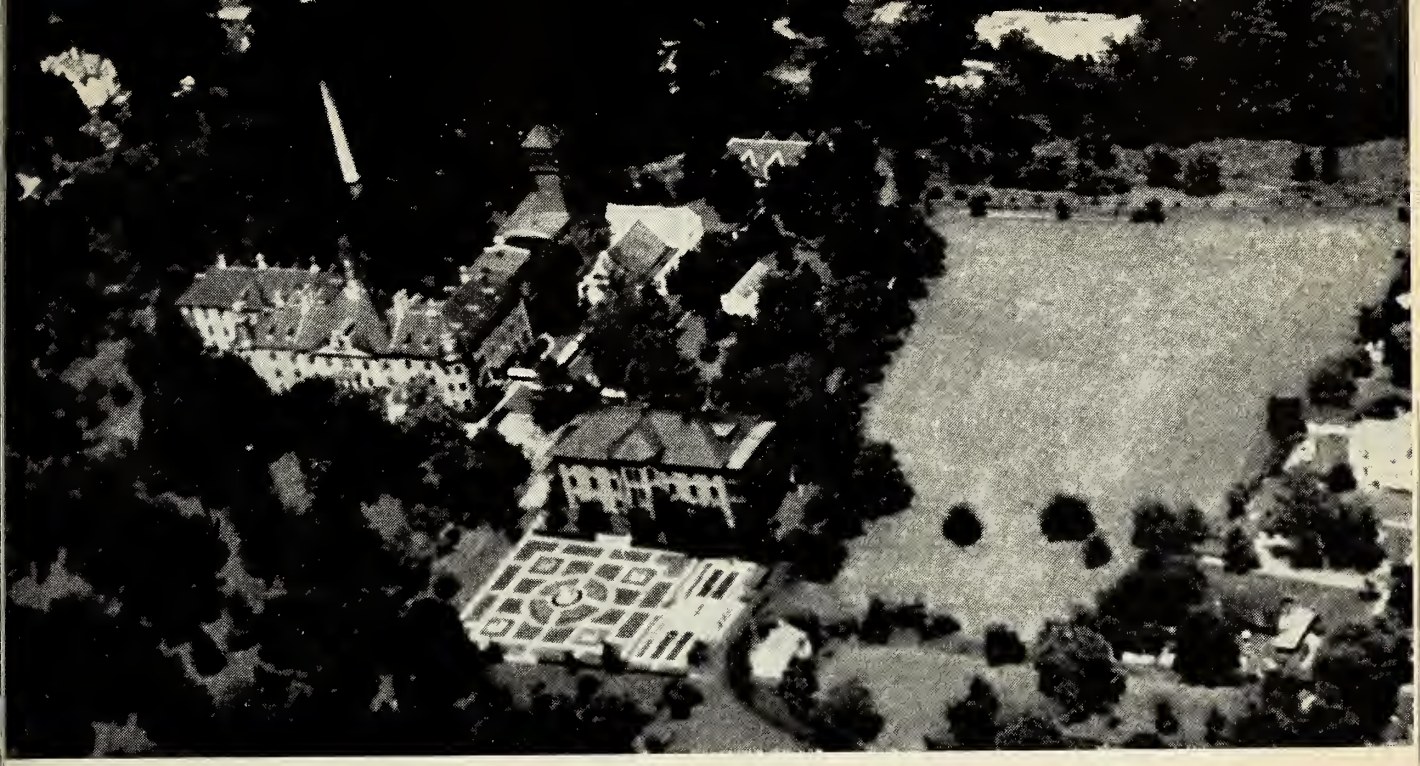
Our principal employe coverage for basic hospital-surgical protection is through Blue Cross-Blue Shield plans. Our employes are enrolled under more than 40 of these local Blue Cross-Blue Shield plans.

We attempt to select from the coverages available at each location that which provides the most nearly uniform protection for all our employes. Our standard is the Michigan Blue Cross Comprehensive Plan and Michigan Blue Shield's M-75 program.

Since Blue Cross-Blue Shield plans are local organizations, the plans which they develop are designed to meet local needs and are influenced by local considerations. In many instances, local Blue Cross-Blue Shield organizations, especially Blue Shield, have not offered plans as comprehensive as Michigan Blue Cross-Blue Shield.

About 70% of our hourly employes now have coverage that is equal to or close to the Michigan standard. It is not our policy to pressure local Blue Cross-Blue Shield organizations to devise plans that are facsimiles of Michigan Blue Cross-Blue Shield. We recognize that local conditions differ. We do, however, through Michigan Blue Cross-Blue Shield, which is our Host Plan, let other Blue Cross-Blue Shield plans know that we are ready to accept coverage that is consistent with the levels set forth in our bargaining agree-

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Management Views

Continued

ment wherever such plans are made available *to the community as a whole.* We firmly believe that any attempt to secure an exclusively Ford contract could result in an undermining of the community approach.

At the present time, in addition to Blue Cross-Blue Shield, our California employes may elect coverage under Permanente. Our bargaining agreements would also permit us to offer coverage under some other carrier or plan, but we have not done so.

Consistently with the considerations discussed earlier, these coverages are offered employes on a voluntary and contributory basis. Over 90% of our employes have elected to participate in them.

The costs to both Company and employes have risen steadily ever since we adopted such plans, and promise to continue to do so. The increases are attributable in part to improvements in the coverages themselves, and in part to the increased costs of providing the services covered. These costs have become a very considerable item in the total labor costs that must be reflected and recovered in the prices of our products.

The increasing cost of providing the covered services gives us particular concern because it is largely beyond our own control.

We could, to be sure, achieve better control of our own costs by going to indemnity-type plans. But, so far, we are not convinced that, in this field, indemnity plans give as good *value* for the money expended as do prepayment service-type hospital and surgical plans. This, coupled with our interest in community programs, has influenced us against embracing the indemnity route to date.

It has been charged that our present system, and, in particular, the service-type prepayment plans, furnish insufficient incentives for reasonable cost controls. We do not subscribe to this. If nothing else, the ever-present pressure for socialization of hospital and medical practice and care should provide incentive enough.

Keeping hospital and medical care costs under effective control should be the constant goal of hospital administrators and the medical profession. Theirs is the primary responsibility, and theirs is the competency to do so without sacrifice of medical standards and the traditional ethics and freedoms of their callings. As customers interested in value received, employers have a responsibility to see that the consumers' needs and interests are accorded real weight. As citizens, businessmen have the responsibility to see that they support only programs that merit their support, and to contribute such advice and know-how as falls within their special competency. But, ultimately, the job can only be done from inside.

At the point where we are negotiating with unions concerning our employe insurance programs, we are fully conscious of the impact that our decisions and actions could have on medical and hospital practice. Because we are aware of this potential impact, however, we have been especially careful to give weight to all of the various considerations I have mentioned in developing the positions we take and the propositions we make in collective bargaining.

The fact is, we and our major union, the UAW, have, simultaneously, a certain common interest and what appear to me to be some distinct differences in ideology and approach when we bargain on these matters.

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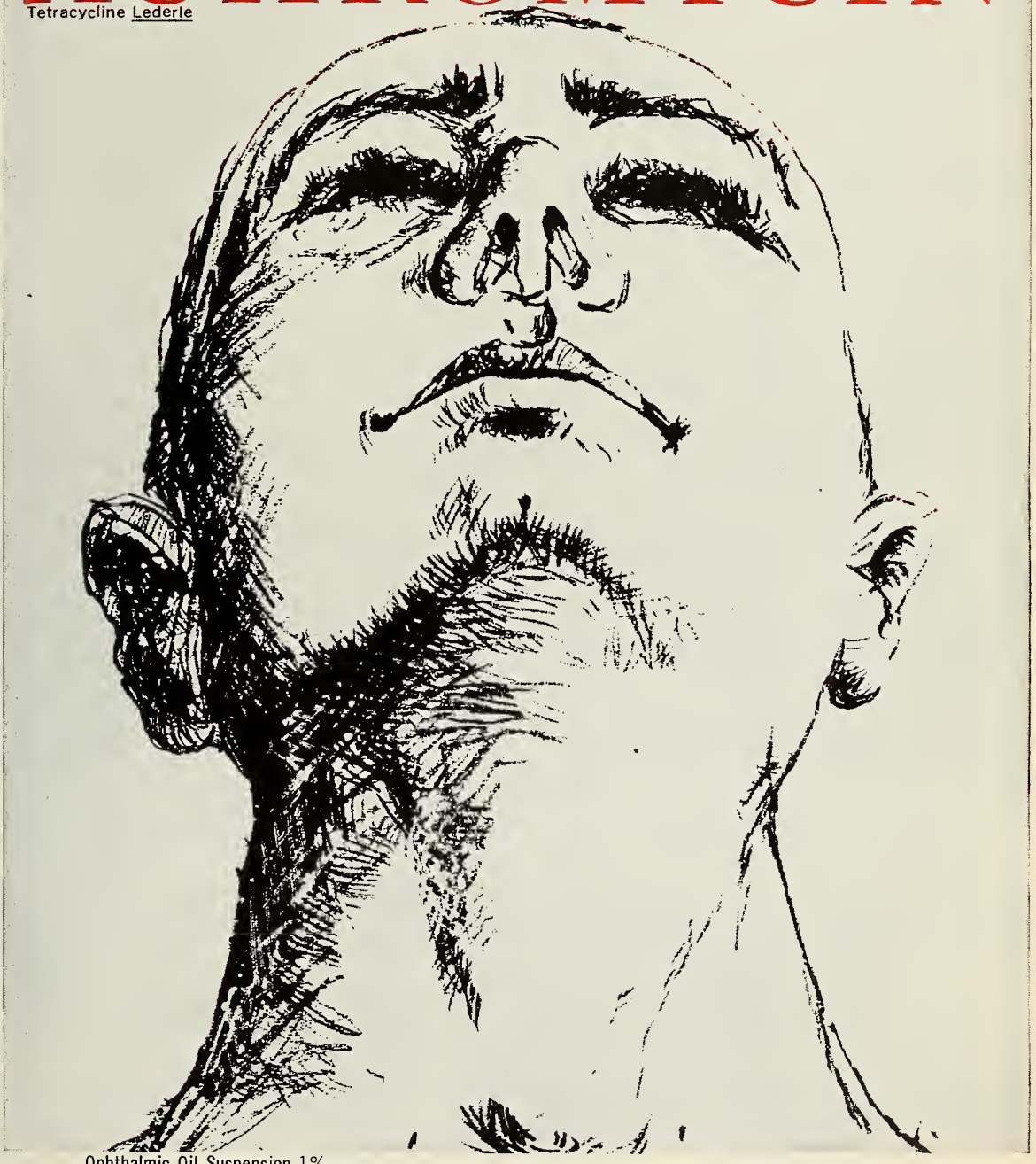
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Management Views

Continued

We have in common, of course, an interest in selecting good insurance or prepayment arrangements at good values for our employes.

I think we differ, however, on the role that collective bargaining should play in shaping hospital and medical practice as such, and in solving broad community problems. The UAW quite regularly seeks, through bargaining pressure, to force our aid in implementing its social or community objectives. We, on the other hand, have a deep conviction that the collective bargaining arena, designed to resolve labor-management differences over conditions of employment, is one of the most ill-fitted places conceivable for resolving these other kinds of problems. If they were to be permitted to become entangled in the considerations for maintaining labor peace in our plants, it would be bad both for us and the community.

There is another difference, I think, which runs much deeper. It has to do with our respective attitudes towards the proper role of government, the responsibilities of the individual, and the values in our free institutions and traditions. Thus we part company with the UAW with respect to its attitude toward our existing systems and institutions for providing care. We know they can stand improvement, like most other things in this world, but we do not view them as anti-social. And we disassociate ourselves completely from what frequently appears to us to be its war against the medical societies.

To conclude, I have faith in voluntary programs and the ability of the professions and community organizations involved to fulfill the needs of our people.

I am encouraged in this faith by the increasingly abundant evidence that our doctors, our hospitals and our voluntary community organizations are conscious of the problems, aware of their responsibilities and actively seeking better ways and means of meeting them. Given this awareness and attitude, I feel confident that they will be met within the framework of our free institutions. ◄

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—Eugene P. Bertin, *Pennsylvania School Journal.*

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The Two New Ingredients

FRANCIS BOYER
Chairman of the Board,
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ORIGINALLY the subject of this talk was to have been the part the pharmaceutical industry has played in the advances of modern medicine. Its original title, and the one which appears on the program, was "The New Ingredient," for today's drug therapy has been developed only in the last few decades.

But, as I worked on the talk, it gradually came to me that in the tremendous strides which have been taken toward the betterment of our nation's medical care, there was another new factor, economic rather than medical, the development of voluntary health insurance, which is making these advances available to all our people. So, my address has ended up with the title, not "The New Ingredient," but "The Two New Ingredients," for the combination of the new drug therapy and voluntary health insurance has indeed revolutionized the medical care of our nation. I apologize herewith for giving the wrong title to the people who printed up the program.

In the early 1930's the American Hospital Association foresaw the problem of rising hospital costs and began to convince our people that the solution should be an American solution, not reliance on government help, but through self-help, through voluntary insurance plans. In this crusade they have received invaluable assistance from the Health Information Foundation. This organization, under the leadership of my friend George Bugbee, has ably carried out the social and economic research so imperatively needed to better our health services and to secure for our people adequate coverage on a sound financial basis.

Today almost 70 out of every 100 Americans are protected by Blue Cross and Blue Shield, or by the private companies. This is an extraordinary achievement. No major nation in the world's history has ever before come so close to providing health security for all without a compulsory government system.

Of course, much remains to be done in expanding coverage so that a medical catastrophe will not wreck a family's whole financial structure. Obviously, too, the extension of the life span brought about by modern medicine is forcing us to face new problems. By 1975 it is expected that 10% of our people will be over 65 and will require 25% of all the general hospital days.

I have no easy answer to this problem, though I suppose my industry is in part responsible for it. But the groundwork for its solution has been laid, and I know that the problem will be solved by the creative ability which your association has already exemplified. A recent editorial in *The New York Times,* "Health Insurance Gaps," concluded with the words, "It is clear from the public point of view that the wider the coverage of voluntary insurance, the better . . . if we are to avoid compulsory government insuranec in the United States."

And, "Let the government do it" is pretty dangerous doctrine. Last April, Secretary of the Treasury Anderson, in his address before the Associated Press, emphasized the lesson of history.

"In writing of the Greeks and Romans, one of our greatest classical scholars summed up their story in these words: 'In the end, more than they wanted freedom, they wanted security, they wanted a comfortable life, and they lost it all—security and comfort and freedom. . . . When the Athenians finally wanted not to give to society but for society to give to them, when the freedom they wished most was freedom

Continued on page 2057

Address delivered at the 61st Annual Meeting of the American Hospital Association, New York City, Aug. 25, 1959.



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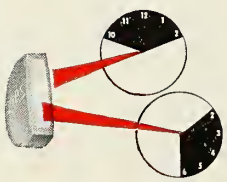
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Dosage: One tablet in the morning, mid-afternoon and at bedtime.

References: 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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Two New Ingredients

Continued from page 2051

from responsibility, then Athens ceased to be free and was never free again.' "

The outstanding document, the Bayne-Jones Report, stresses "the importance of diversity of federal and non-federal sources of support in medical research and education," and the principle is just as applicable to our hospital system. Unquestionably, government funds will to some extent have to be supplied for hospital support. For example, state or local governments must universally assume the responsibility now foisted on the hospitals for the treatment of indigent patients. Private charity will help, though under today's tax structure, individual giving is a pretty broken reed. But voluntary insurance of the whole community, the aged as well as the younger working group, must be our main reliance in the financing of hospital services.

I am convinced that in this effort private enterprise, as represented by the corporations of America, has an important role to play. If we are to avoid dependence on centralized authority, our corporations must increasingly provide adequate medical insurance covering not only their employees but also their retired group.

Progress is being made in this direction. A United States Department of Labor study of a hundred selected health plans in effect in early 1958 showed that with 43 firms the benefits for regular employees, with some limitations, were extended to retired employees and their dependents. But the remaining 57 concerns must be persuaded to follow this example.

It also seems to me that our corporations in many cases could well contribute a larger share of their earnings to charitable support. The 1955 report on company contributions of the National Industrial Conference Board reveals that, through themselves or through sponsored foundations, the companies studied gave away 0.7% of their net income before taxes. Forty per cent of this money went for social welfare, including the Community Chest; 31% for education. Hospitals received only 8.6% of the money contributed. That means that representative corporations gave to hospitals direct only *six one-hundredths of one per cent* of their income before taxes.

One often hears the objection that the officers of a corporation have no right "to give away the stockholders' money," but after all there is an easy mechanism for meeting this objection. Let there *be* a decision of the stockholders on this point. Let management, after due consideration, bring in a proposal at the annual meeting that x per cent of profits before taxes be expended for charitable purposes. I definitely feel that most stockholders would approve a higher percentage for such giving than is at present in effect. (As you know, the government allows 5% of profits to be classed as a charitable deduction.)

Admittedly, really effective support cannot come from industrial management alone. It must have a wide base. It can only come when enough members of the community from all walks of life become aware of the problems faced by the hospitals and are more active in trying to aid the hospitals. But the corporation again can help bring this about. At Smith Kline & French we recently inaugurated a plan to add to hospital funds and at the same time to strengthen our employees' understanding of, and concern with, hospital problems. The plan is a simple one. It consists of a matching gift program, through which the company will duplicate any gift up to two thousand dollars which



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Two New Ingredients

Continued

an employee donates to a hospital of his choice. The plan is not too difficult to carry out, and it encourages voluntary, grass roots support.

You see, I have a deadly fear of centralization, of the "from each according to his abilities, to each according to his needs" of the Marxian doctrine. It sounds so nice, but look what it has produced. I vastly prefer utilizing our existing system of private enterprise, which after all has made American life the envy of other nations, including even our Russian antagonists.

In our Western democracies today there seems to be a kind of inferiority complex, a rather morbid wave of self-criticism, a tendency to point out all the possible defects in our private enterprise system, while turning a blind eye on what it has accomplished. As that outstanding publication of the Foreign Policy Research Institute, "Protracted Conflict," phrases it, "So defensive has the Western mentality become that many intellectuals devote most of their time to apologizing for the institutions and the process of liberal society." And regrettably, the spokesmen for private industry have on a whole been pretty inarticulate in pointing out what the American system has accomplished.

This is certainly true for the pharmaceutical industry. There is indeed some recognition that the new "miracle drugs" are to a great extent responsible for our gains in the battle against disease. Curiously enough, however, the public at large—and its representatives in Congress—seem unaware of the part which the pharmaceutical industry has played in the development of these miracles. The great majority of our people would credit the creation of the new drugs to the medical profession, to research institutes, or—more recently—to government research. Let me give you an example of what I mean.

The National Health Education Committee recently issued a beautifully done facts book on the major killing and crippling diseases in the United States today. Its principal emphasis is upon what medical research has accomplished in the past and what, with increased support, it can accomplish in the future. It points out, for example, the reduction in the tuberculosis death rate from 45 per 100 thousand in 1939 to 7.5 per 100 thousand in 1957. It emphasizes the new era in the field of mental illness brought about by the tranquilizing drugs. And in the almost 300 pages of the facts book I have been able to find but one page which mentions the part played in these accomplishments by the pharmaceutical industry.

It seems to me, therefore, that the time has come to make our people and our legislators more conscious of the part played by the pharmaceutical industry in the medical advances of the last few decades. I shall point out in a moment that in the final analysis these advances are due to the cooperation of the whole health team.

The chief reason for the anonymous character of pharmaceutical research is that our business has never told its own story. The ethical pharmaceutical industry has been understandably reluctant to claim credit for advances in medicine for fear that by so doing we might seem to belittle the role played by the medical fraternity. The medical profession is our senior partner and also the customer on whom our well-being depends.

Indeed, the outstanding development in medical research during the last few decades has been the inauguration of a close and effective cooperation between the pharmaceutical industry and academic scientists, clinical investigators and practicing physicians. This cooperation is increasingly being carried out in an atmosphere of mutual trust and confidence.

In 1943, only 16 years ago, there was published my sole contribution to medical literature, a paper in *The New England Journal of Medicine,* entitled "The Pharmaceutical Manufacturer and Academic Research."

In this paper I made an earnest plea for increased cooperation between academic scientists and commercial houses. In 1954 in behalf of my firm I had the honor of accepting an award from the American Medical Association for the "outstanding contributions to medicine" of SK&F's television programs. In my little speech of acceptance I was able to point out that my *New England Journal* article had really been pretty naive. It had considered academic-commercial collaboration as a Utopian vision of the distant future, whereas in 11 years it had become an accomplished fact.

This is just one illustration of the newness of today's pharmaceutical industry. It is indeed a

very recent phenomenon. Even up through the 19th century, the discovery and development of new therapeutic agents was almost invariably made by academic medicine, chemistry or pharmacy. For example, Professor Geiger and his co-workers in pharmacy at Heidelberg isolated atropine in 1835, and aspirin was discovered in 1853 by an academic chemist, Charles Gerhardt, a member of the Science Faculty of Montpellier. The development in Germany of industrial chemical research toward the end of the 1800's foreshadowed a new era, but the United States was terribly backward in both chemical and pharmaceutical research until the outbreak of World War I.

It is a bit futile to try to put an exact date on the beginning in America of the production of new and effective drugs by the pharmaceutical industry, but, roughly speaking, the present flow of products from pharmaceutical laboratories might be said to have begun with the collaboration of Eli Lilly and Company with Doctors Banting and Best in the production of insulin in 1921, to be followed in 1928 by their similar collaboration on liver extract with Doctor George Minot. The liver extract story will always be particularly vivid in my own rememberance since I happened at that time to be seeing a good bit of Doctor Minot. He had roomed with my brother at Harvard and did much to guide SK&F's faltering first steps in research. In those days, SK&F's whole research establishment consisted of one M.D. and two Ph.D.'s in chemistry, another illustration of how recent the whole process has been. Today our Research Division comprises 750 people in Philadelphia with another 50 in the SK&F Institute in London.

It is fair to say that the American pharmaceutical industry began to have an important part in the health drama only some 30 years ago, and it is, therefore, not surprising that the public at large still has a tendency to think in terms of the prior situation, when drug discoveries were indeed made, as I have indicated, almost wholly by individual physicians, pharmacists and chemists.

But as time goes on, more and more the birth of the new compound, the original idea, takes place in the laboratory of a commercial concern. A recent article in the *Financial Times of London* refers to penicillin as "one of the last of the great free lance discoveries," and Doctor Watt, director of our National Heart Institute, recently reported to the Senate Appropriations Commitee, "The major strides in drug discoveries of the past few years . . . have been made within commercial pharmaceutical houses."

For example, folic acid was synthesized by Lederle in 1945 after four years of work. Isoniazid, which as you know, is today the standard anti-tuberculosis drug, was announced in 1952 after a neck-and-neck race between Squibb, Hoffman-LaRoche and Bayer. I might add that the United States pharmaceutical industry in 1958 spent approximately $177 million in research and development, of which some $20 million was given for the support of medical schools, hospitals and similar institutes, or for the financing in them of medical research.

Let us turn for a moment to the other side of the Atlantic. Here again we find a similar picture. The antihistamines came into being in the laboratories of the great French house of Rhône Poulenc, their genesis being the work of Bovet in 1937. At Rhône Poulenc under Bovet were likewise developed in 1946, 'Diparcol', the first synthetic derivative effective against Parkinson's disease, and in 1947 the first synthetic curare product.

These are only some of the advances in medicine which might not exist if it were not for pharmaceutical research. The accomplishments of this research are the result of medico-industrial collaboration and of an alert, dynamic industry's unceasing efforts to succeed in a highly competitive market. They are the result, in short, of a free economic system. If one accepts around 1920 as the date when the modern pharmaceutical industry really began to function, it would appear that it is of about the same age as the Soviet Republic. There are holes in the analogy, of course, but it is at least interesting to note the new therapeutic agents contributed by individual enerprises in the western world and then to look in vain for their counterparts in the monolithic Soviet system.

One certainly does not associate present-day Great Britain with any prejudice in favor of private medicine or private industry, so that the following statements from the so-called Hinchliffe Report are of particular significance. I should explain that the Hinchliffe "Committee on Cost of Prescribing" made its report to

Two New Ingredients

Continued

the British Ministry of Health in regard to the cost of prescriptions issued under the National Health Service.

The section of the report entitled "The Discovery of New Drugs" gives a number of illustrations of how "some of the significant discoveries of the last 30 years were made." It points out that "the first drug to be effective in the treatment of bacterial infections," prontosil red, was discovered by Domagk and Mietzsch and Klarer, "all working in the laboratories of the German firm, I. G. Farbenindustrie." The Pasteur Institute found that the activiy of prontosil was due to sulfanilamide; but May and Baker developed sulfapyridine, and "all subsequent sulphonamides, such as sulphathiazole, sulphadiazine and sulphadimidine were developed in the laboratories of pharmaceutical firms."

The report then gives a brief history of penicillin from the original work of Sir Alexander Fleming at Saint Mary's Hospital, notes the contributions of Florey and Chain and points out "the development of processes for the production of penicillin on a commercial scale was carried out in the U. S. A." It recounts the discovery of streptomycin in 1944 by Waksman and his colleagues at Rutgers and then adds, "All subsequent antibiotics have been discovered by scientists working in the laboratories of pharmaceutical firms, almost all in the U. S. A." (Incidentally, and not mentioned in the report, Waksman did his work under a grant from Merck.)

This section of the report ends with the history of cortisone, from the isolation of the cortical steroids by Reichstein, working both in the University of Basle and in the Ciba Laboratories, the isolation of compound E by Kendal and the great clinical advance made by Hench. It adds "the exremely difficult technical problem of commercial production of cortisone was tackeld by the firm of Merck & Co. in the U. S. A. . . . further developments such as the discovery and manufacture of hydrocortisone and of prednisolone and of their fluoro-derivatives came from the pharmaceutical firms."

In another section of the report, the Hinchliffe Committee makes the point which is the fundamental justification for my talk before you here:

"We were concerned to note the totally inadequate publicity given to the remarkable saving in life, improvement in health, increase in efficiency and saving on expensive institutional treatment which all stem from, among other things, the use of new drugs."

For our own country, consider the statistics presented by Dr. William S. Middleton, Veterans Administration medical director, before the Senate Appropriations Committee this June. Doctor Middleton said the VA had almost 16,000 tuberculosis patients in its hospitals in 1954. Last year that figure had declined to about 10,000. Doctor Middleton added, "If we were to resolve that reduction into the actual cost of maintenance of beds for tuberculosis, it would amount to $107 million," and he gave full credit to new chemical agents developed by private industry. Doctor Middleton's testimony also revealed that the VA is now discharging about 41,000 mental patients a year, in contrast to about 28,000 a year before the tranquilizing drugs were developed.

Now these are cold statistics, albeit impressive ones. But think of them in human terms; the thousands of people who in all probability would have been dead or crippled, who would have been locked in the back wards of our mental hospitals, who would have been bedridden invalids—but who, today, are leading normal, productive lives. Then perhaps we can better realize the contribution to our nation's welfare made by modern drug therapy, the first of the new ingredients in the prescription for our nation's health.

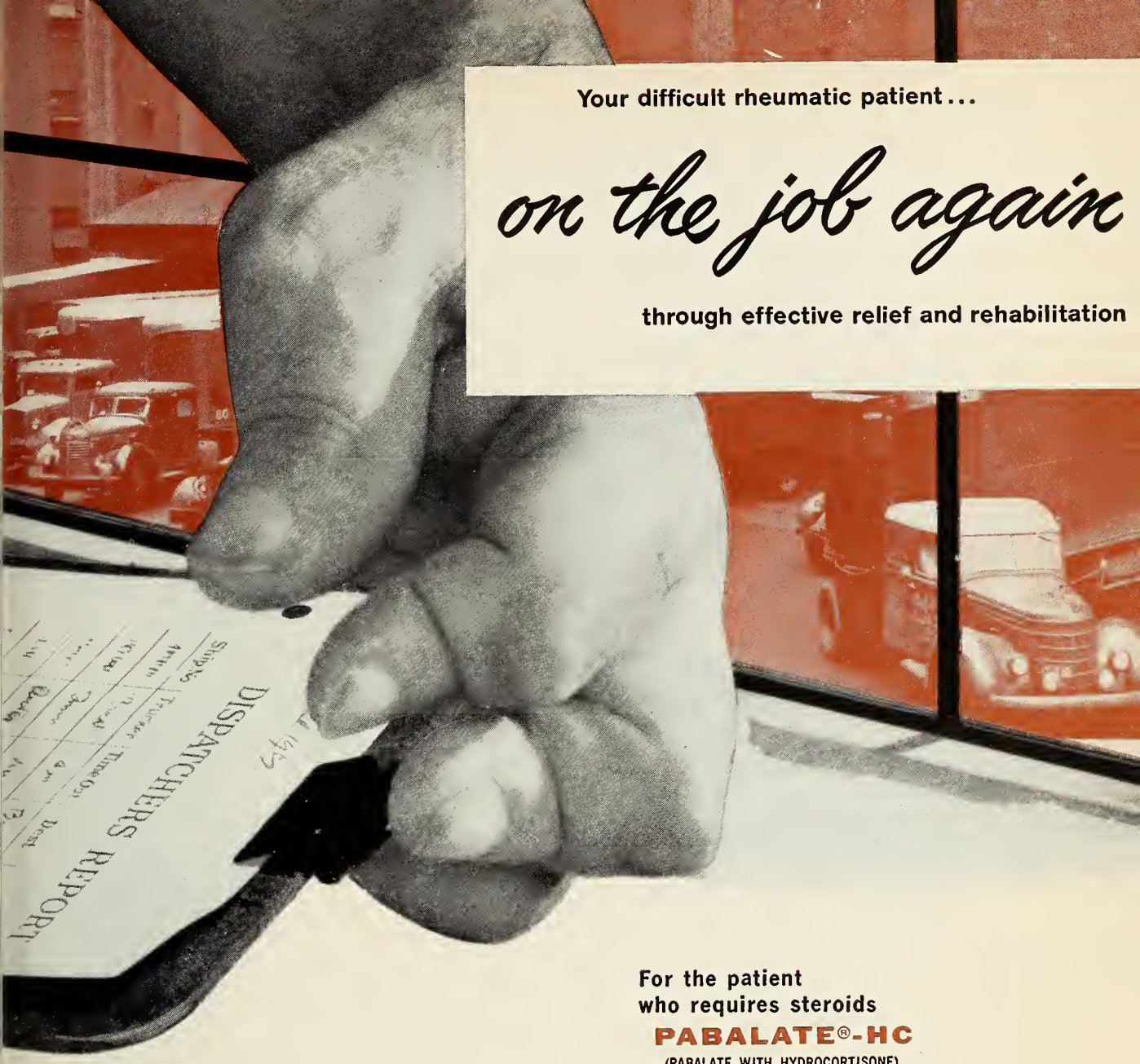
As to the second new ingredient, voluntary health insurance, I am certain that this association will provide the imaginative leadership it has so signally demonstrated in the past. Our people will follow this leadership. They will not abandon the economic problem of modern medicine to the mercies of a socialized government. They will solve it by private initiative, by the American way. ◄

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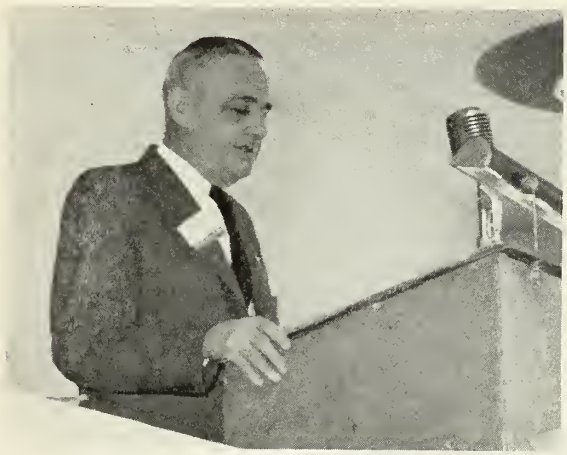
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NEWS NOTES—from State and Nation

ISMA Council Chairman from Hartford City Named Association's 1959-1960 President-elect



DR. OWSLEY gives his acceptance speech as ISMA president-elect before the final House of Delegates meeting Oct. 6, 1959.

Dr. Guy A. Owsley of Hartford City was chosen as president-elect of the Indiana State Medical Association by the House of Delegates on October 9.

Long active in medical affairs, Dr. Owsley has served as president of the Delaware-Blackford Medical Society, as secretary of the 9th Councilor District Society, as delegate to the ISMA, and as district councilor since 1953. He was most recently chairman of the Council.

He received the M.D. degree from Indiana University and interned at Letterman Army Hospital. After four years in general practice at Thorntown he served with the Army Medical Department, specializing in eye, ear, nose and throat. He is now in his twenty-fifth year of specialty practice in Hartford City.

During World War II, Dr. Owsley returned to the Army, and was assigned as executive officer of Billings General Hospital. Later he was commanding officer of the hospital ship "Emily H. M. Weder," Surgeon of the Port of Los Angeles, and then chief of the EENT Section of Borden General Hospital. His military service was concluded by service as director of the Hearing Center of Walter Reed Army Hospital.

Dr. Owsley has been active in several medical organizations beyond his parent medical societies. He is a Fellow of the American College of Surgeons, of the International College of Surgeons, the American Society of Ear, Eye, Nose and Throat Allergists, and of the American Academy of Ophthalmology and Otolaryngology; an Associate Fellow of the American College of Allergists; a Diplomate of the American Board of Otolaryngology, and a member of the Muncie Academy of Medicine and of the Pan-American Association of Ophthalmology.

International Angiology Meeting Scheduled for Mexico City

The International College of Angiology will hold its first regional meeting in the Hotel Continental, Mexico City, Mexico, Dec. 29-30, 1959. The scientific program will consist of 20 papers being presented by distinguished scientists from North and South America, four round-table breakfasts and luncheons. An annual "honors night" banquet will be held the evening of December 29 and among the guest speakers will be Dr. Fernando Monterel, professor of surgery, University of Madrid, Spain.

Scientific sessions will cover areas of arterial occlusive disease and thrombo-embolic phenomena. Following the meeting there will be two planning conferences in Acapulco under joint auspices of The Angiology Research Foundation and The International College of Angiology.

Dr. Hector Quijano Mendez, Professor Clinical Surgery, National University, Mexico City, is chairman of the meeting.

A number of special pre- and post-convention tours have been planned by the committee.

Information and travel arrangements may be obtained by writing to Mr. Joseph Tigani, Committee For Travel and Housing, 150 East 50th Street, New York City.

Hoosiers Score Again

Central State Hospital Wins Outstanding Award For Food Service Design



The Central State Hospital, Indianapolis, won first award in the *Institutions Magazine* contest for outstanding achievement in food service design. The contest was sponsored by *Institutions Magazine,* a leading publication of mass feeding and mass housing.

This award was presented in conjunction with the National Restaurant Convention and Exposition at the Navy Pier in Chicago, May 12, 1959. Judgment of the hundreds of entries in the contest was based on high standards of sanitation, superior efficiency and superlative achievement in the storing, handling, preparation and serving of food.

The dietary and feeding facilities at the hospital before the start of this project were numerous, some of them very aged, out-dated, inefficient, and it was very difficult to maintain sanitation in the handling of food. The following kitchens were in operation:

(1) A kitchen for the Women's Department which apparently was built at the time the Women's Building was constructed between 1875 and 1878, making this kitchen approximately 87 years of age. Various pieces of equipment in the kitchen had been replaced from time to time as they were worn out. Concrete floors were eroded and pitted so that many of the stones, one-quarter inch to one-half inch in diameter, had come out of the concrete, leaving the floor pitted and impossible to clean.

Floors were multi-level with steps here and there, which led to hazards in the movement in the kitchen area. Steam kettles were of iron and they were not of smooth finish, so that they were rather rough and its was impossible to clean all the food off of them, and this food would burn into the pits, making them black and unsanitary. There were many pipes through the upper part of the kitchen and some were quite high, so that they were inaccessible for cleaning, and dust and dirt would collect on them and sometimes fall into the food.

(2) There was a kitchen in the Hospital Building which was built sometime in the early 1890's, making this kitchen approximately 65 to 70 years of age. It was outmoded; however, floors were smooth concrete and there was much more light in it than in the Women's Kitchen; and it was so arranged that it could be kept clean, making it easier to provide sanitation in the handling of food and utensils.

(3) There was a kitchen known as the Officers No. 1, and it is not known how old this kitchen was. It was in a dark basement room and took care of a small dining room in the Women's Building for staff members employed in that building, and also for the former superintendent's dining room on the second floor of the Women's Building.

(4) There was a kitchen called Officers No. 2, which was installed when the Men's-Employees Building was constructed between 1937-1939. This kitchen was in good condition but was

Hoosiers Score Again

Continued

very small, providing facilities only for the residents in the building and the staff and office help. As adjunctive therapies were added to the program of the hospital, all the employees wanted to eat in this dining room and it was inadequate to take care of this number of employees.

(5) There was a kitchen in the Men's Department which was built about 1939. This kitchen had a red quarry tile floor and was fairly up to date and could be kept clean and sanitary.

(6) The kitchen at the Farm Colony, which is about two miles north of the main part of the hospital and has approximately 300 patients, received certain improvements in the dietary improvement program.

Operation of six separate kitchens led to marked difficulties; first, in personnel problems. It was practically impossible to employ a sufficient number of employees for three shifts to operate these kitchens and to allow the time off to which the employees were entitled. Not only the personnel problem created difficulties, but also the supervision of the employees in these kitchens was inadequate. There was little trained supervision to see that vegetables were properly cleaned and prepared for cooking; that food was cooked and seasoned tastefully; that food was served properly and in as good a manner as possible; that sanitation facilities were utilized to the extent possible.

The State Board of Health made several surveys of the dietary facilities in the years preceding the installation of the present dietary facilities and their recommendations were numerous; but it was next to impossible to carry out the recommendations that were made. The condition of dietary facilities was studied and estimates were prepared as to the amount of money necessary to request from the legislature for rehabilitating our dietary facilities to meet the sanitary requirements of the State Board of Health. A request for an appropriation was made to the 1955 legislature and that legislature appropriated $668,117 for the rehabilitation of hospital dietary facilities.

Following appropriation made by the legislature, Fleck, Quebe & Reid Associates were selected as the architects for the project. The superintendent requested services of Miss Arlene Wilson, dietary consultant for the Department of Health, to work with the architects in studying the project. The architects and Miss Wilson spent several weeks studying the dietary facilities which were in operation. They were shown the State Board of Health surveys and asked to prepare plans and specifications as to how dietary problems could be solved to meet recommendations of the State Board of Health. First, they studied the rehabilitation of existing kitchens, such as replacing floors in the old kitchen in the Women's Building, putting in new drop ceilings to cover pipes, insulation, new lighting, and installation of new equipment where indicated.

As they studied each kitchen and dining area, it developed that they were going to require so much money to rehabilitate each individual area to present-day requirements, there would be an insufficient amount in the appropriation. After considering a number of plans, none of which would really solve the problem for a period of 10 years or more, the plan was conceived to combine the Women's Kitchen, the Men's Kitchen and the Officers No. 2 Kitchen into one new central kitchen and add to it a cafeteria for all employees. (The Officers No. 1 Kitchen had been closed and put out of operation several months previously.)

Studies at this time *showed* that *it was feasible to build a new central kitchen and employees cafeteria cheaper than it would be to rehabilitate each of the old kitchens.* Further, by combining the kitchens into one, it would be a saving as far as personnel was concerned and would allow much better supervision for cleaning, preparation and storage of vegetables, cooking of foods, and washing and cleaning of dishes and utensils.

This plan was presented to the Division of Mental Health and the Budget Department, and all were in agreement that this was the proper plan to pursue. After this plan was approved, studies were made as to equipment that would be necessary to do the mass cooking for the patients and employees and for a building to house this equipment. A few dietary facilities were visited, plans were prepared and contracts were awarded so that construction was started in September, 1956. The kitchen and employees cafeteria were completed and put into operation in January, 1958.

Advantages of this facility are that food for

Continued on page 2068

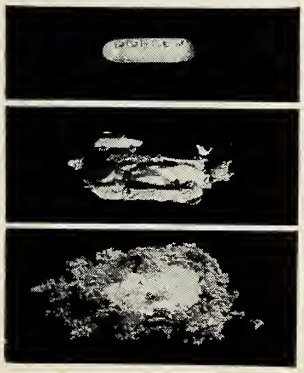
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References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. 257:278 (Aug.) 1957.

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Hoosiers Score Again

Continued

all the patients (excepting those in the hospital section and at the farm colony) as well as the food for all employees, is prepared in one kitchen. This works to great advantage when one menu is used for all patients and employees.

And this one feature has done much to eliminate complaints on food. Since food preparation is centralized and all of our dietary employees have been placed into one centralized kitchen, it has allowed enough employees in the Dietary Department to properly staff the department and to allow for more supervision in cleaning, preparation and cooking of the food.

One factor which had to be considered in the selection of the site for the centralized kitchen was that it had to be located more than several hundred feet from the patients' dining room where cafeterias had been installed in the last few years. In order to overcome this transportation difficulty, a large van-type truck was purchased to transport food in electrically heated and insulated food containers to the patients' dining rooms.

Where patients on various wards are unable to go to the dining room, food is transported to the wards along with utensils and dinnerware. As soon as the meal is over, dinnerware, utensils and garbage is picked up and the tables cleaned. Utensils and dinnerware are returned to the main kitchen so that they can be properly washed.

This has corrected a very unsanitary condition, as previously dinnerware and utensils were stored on the wards where there were no adequate dishwashing facilities or any possibility for proper sterilizing of utensils and dishes.

On other wards where dining facilities were made available with a small dining room, food carts are filled with the required amount of food and transported to the dining rooms where the heated food cart is placed in a cafeteria line so that the patients from that ward can go through the line in the dining room for their food. In these areas, dishwashers have been installed in the dining rooms for proper washing of dinnerware and utensils.

Following construction and the utilization of the kitchen and cafeteria, the architects and Miss Wilson prepared an exhibit and submitted it in the contest for dietary facilities conducted by *Institutions Magazine*. Awards were classified as first and there were only seven first awards in the various categories.

In studying the brochure of the contest, it appears that this is the first time a state hospital has won a first award during the 13 years that *Institutions Magazine* has been conducting these contests. Awards were given for dietary facilities from Switzerland to Hawaii.

Note: Above article prepared by Central State Hospital.

I. U. Med School Merges Six 4-Year Allied Courses

Merger of six 4-year courses in the Indiana University School of Medicine at Indianapolis into a new administrative division of allied health sciences has received approval of the University's Board of Trustees.

Dean John D. Van Nuys of the School of Medicine has announced the new division will be headed by Aaron L. Andrews, health scientist, who for the past four years has been assistant professor of health education in the Schools of Medicine and Dentistry.

The six courses in the new division are medical technology, medical record library science, sanitary science, occupational therapy, physical therapy and public health education. All lead to the bachelor of science degree. The division also will advise on curricula, student admissions and administration of 2-year courses in dental hygiene and x-ray technology, graduates of which receive certificates for professional practice.

Prof. Andrews is a native of Ohio, graduate of the University of Louisville, and received masters' degrees from the University of North Carolina and I. U.

Dr. J. E. McCabe, Otterbein, has retired after 50 years of medical practice. A senior member of ISMA, Dr. McCabe has practiced in Otterbein for 40 years, and served as Benton County health officer for the past 13 years.

The Poseyville, Ind. community recently honored Dr. A. L. Woods, who retired after 50 years of medical practice, most of which was in that community.

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Registration Required From Indiana Radiation Sources

During September, registration of radiation sources was begun in Indiana. Registration became mandatory by the "Radiation Control Act" passed by the 1959 session of the Indiana General Assembly.

This act created a Radiation Control Advisory Commission from the specialized fields of the radiological sciences to recommend policies and to provide technical guidance for implementing the law. The commission is comprised of six appointed members and three ex-officio members. The six members, "appointed on the basis of recognized knowledge in the field of radiation," include an engineer from Standard Oil Company, a scientist from Eli Lilly and Company, a professor of pharmacy from Purdue University, a radiologist, a physician who is in general practice, and a dentist. The three ex-officio members represent the State Board of Health, the Public Service Commission and the Labor Division.

Shortly after the act became effective, the Advisory Commission met to consider the details of registering radiation sources in the state. A regulation which outlines the details of registration was approved by the commission and became effective on September 14.

Registration forms have been mailed to all physicians, dentists, osteopaths, chiropractors, veterinarians and hospitals and to a number of industries that may be working with radiation machines or radioactive materials. The forms have been simplified as much as possible consistent with their importance in fact finding. It is expected that a large number of radiation sources will be registered because of their wide application in industry, medicine and research. Such sources as radioisotopes, x-ray machines, fluoroscopes, electron microscopes, x-ray diffraction units, static elimination devices containing polonium or radium, and liquid level gages using radium will be included.

Sources of radiation are being registered with the Sanitary Engineering Division, Indiana State Board of Health, 1330 West Michigan Street, Indianapolis, Ind. The deadline for registration is Jan. 21, 1960.

Information obtained by registration will be used as an up-to-date record on the many sources of radiation in the state. On the basis of the information received, personnel in the Indiana State Board of Health can best direct their efforts in the radiological health program. Field inspections will be made and assistance and consultation offered in conjunction with the program. Indiana is one of a number of states taking this type of action in the increasingly important field of radiological health.

Nationwide Meeting to Present 'Future of the Internship'

A nationwide meeting on "The Future of the Internship" will be convened at Michael Reese Hospital and Medical Center, Chicago, on Saturday, Nov. 28. The special session to which medical students, physicians and educators across the country have been invited will take place in Rothschild Auditorium, 2816 Ellis Ave., from 9:30 a.m. to 12:45 p.m.

"The role of the internship in today's hospitals is one of the liveliest subjects in the entire field of medical education," declares Dr. Rachmiel Levine, director of medical education at Michael Reese and chairman of the department of medicine. "The program is an attempt to evaluate which type of post-graduate training is best suited to present-day medicine. We look forward to a spirited exchange of ideas between all the discussants and the audience."

The internship of the present and two views of its future will be discussed by E. Hugh Luckey, M.D., chairman of the department of medicine at Cornell University Medical College, and Victor Johnson, M.D., director of the Mayo Foundation for Medical Education and Research as well as past chairman of the AMA Advisory Committee on Internships to the Council on Medical Education and Hospitals.

"The Internship as It Appears to Today's Interns" will be reviewed by Richard H. Saunders, Jr., M.D. Dr. Saunders is director of the Internship Study, Association of American Med-

ical Colleges, and associate director of graduate education for medicine at Highland Hospital, Rochester, N. Y.

A panel discussion will complete the half-day session. Participants will be William R. Kirkham, president, Student American Medical Association; E. H. Lamkin, Jr., vice-president, Student AMA; John A. Oates, M.D., of the National Heart Institute, Bethesda, Md.; and Robert H. Wilkins, M.D., intern at Duke University Hospital, Durham, N. C.

The November 28 meeting is open to all interested medical and educational personnel. It is sponsored by the administration of Michael Reese in the interests of improved medical education.

Obstetrics-Gynecology Exam Set for January, 1960

Part I Examinations of the American Board of Obstetrics and Gynecology, will be held in various parts of the United States and Canada, on Friday, Jan. 16, 1960, at 2:00 p.m.

Candidates notified of their eligibility to participate in Part I must submit their case abstracts within 30 days of notification of eligibility. No candidate may take the written examination unless the case abstracts have been received in the office of the secretary.

Current bulletins outlining present requirements may be obtained by writing to the secretary, Robert L. Faulkner, M.D., American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

An East Chicago physician, Dr. E. L. C. Broomes, recently received the Mason of the Year award at the annual Communication of the Most Worshipful Prince Hall Grand Lodge F and A M Jurisdiction of Indiana.

Dr. Harold D. Caylor of Bluffton was named president-elect and vice-president of the American Association of Medical Clinics at a recent annual meeting.

Dr. Walter L. Portteus, Franklin, past president of ISMA, has been reappointed to the economic security committee of the Chamber of Commerce of the United States.

Hoosiers Elected to A.M.A. Offices

Dr. Charles Alvey of Muncie was elected as vice-chairman of the Section on General Practice of the AMA at the Scientific Assembly in Atlantic City. Dr. Lester Bibler of Indianapolis was re-elected as delegate for the section.

Dr. Alexander Ross of Indianapolis was nominated by the Section on Nervous and Mental Diseases for director of the American Board of Psychiatry and Neurology.

Dr. Lall Montgomery of Muncie was re-elected as delegate by the Section on Pathology and Physiology.

Dr. Myron Nourse of Indianapolis was elected assistant secretary of the Section on Urology.

Dr. C. E. Whipps, Carlisle, was recently honored at a community program commemorating his 50th year of practice in Sullivan County. He began his practice in Carlisle after graduation from Northwestern University Medical School in 1909. ◄

Give Generously to A.M.E.F.



"For heaven's sake, when you're showing them our surgical instruments, stop asking them if they'd like their choice of weapons!"

Add 1

What About the Birds and the Bees? Christmas Before Thanksgiving; Tributes

by corki

Isn't there something about the birds and bees in May? Well, anyhow, next May better than 300 young scientists who probably know as much about the birds and bees as any of us (perhaps more?) will converge on Indianapolis to astound us with their scientific know-how and to tour some of the highly scientific facilities offered in the Hoosier capital area.

In case you haven't heard (and if you haven't, *where were you* when the mailman delivered your last few *Journals?*), ISMA is a co-sponsor in staging this terrific exhibition of our nation's teenagers as they explore the exciting possibilities in our modern world of science.

A brochure is out now to tell the world about "Science You Can See in Indianapolis, Ind." And these brochures not only go to all the science clubs, etc., in the U. S., its territories and possessions, but also to some other great nations!

Facilities mentioned in the blurb include Butler U. (where the fair will be held), Allison Powerama (Allison Div. of G-M), Diamond Chain, I. U. Med Center, the Speedway, Eli Lilly, P. R. Mallory, U. S. Naval Avionics Facility, Pitman-Moore and Western Electric.

If you notice, of 10 facilities listed, three are medical! So medicine will play a big part in this, the 11th National Science Fair to be held May 11-14 in Nap Town, Hoosierland, U. S. A.

Doctor (and Mrs. Doctor, too!), after seeing the fair last May at Hartford, I feel sure you'll find it well worth your while to plan on attending this exhibit in Butler Field House. We'll let you know, in plenty of time, the dates for public viewing of the work these kids are doing. You may find it hard to believe that these exhibits are done all by high school students.

More on this subject at a later date.



Red X Release Reminds Me

A news release from the Indianapolis Chapter of American Red Cross sure took me back to the years I spent with the Army and Air Force!

I remember each and every year in October when this particular release came rolling in and the hours spent trying to dream up a new way to remind people to send Christmas gifts to our Armed Forces personnel overseas in time for them to Open on Christmas Day!

Trying to mail parcels can become quite a hassel and many of us are prone to "put off."

And it's pretty cotton pickin' hard to get the Christmas spirit before Thanksgiving (tho, unfortunately, many commercial enterprises are doing all too well at jumping the proverbial gun on Thanksgiving with Christmas decorations!).

So anyhow, like mail your gifts to men and women stationed overseas on time! Red Cross says to mail surface packages between November 1 and 20; and air mail by December 10.

And, by the by, the Red X also points out



"Here's my pint!"

that "There's no cooking like home cooking" to the service man overseas; but cautioned that things like cookies should be wrapped in a heavy corrugated pasteboard box.

Merry Christmas!

Jean Green—She's Real!

Editors, as a rule (and I've seen few exceptions to that rule), don't like personal ballyhoo in their own publications. (Sometimes a legitimate news story makes this necessary, but even then most of us quell at the thought!)

But I'm real glad staff members of *The Hoosier Doctor's Wife* slipped a fast story past Editor Jean Green while she was on vacation. Tho I just met Jean a little more than a year ago, I've enjoyed her delightful personality in our contacts of cooperation between her publication and the *Journal.* But I learned a lot more about her many accomplishments from this story to zoom my respect for her even higher.

Like she's been a feature writer for the *Washington Times* and *Washington Post,* was once a mag editor, was listed in the first edition of *Who's Who of American Women* and even taught school at one time.

Tho she and her husband, Dr. Frank B. Green, have three strapping sons to whom Jean devotes much time, she still finds additional time to be active in the Women's National Press Club, Woman's Press Club of Indiana (it was Jean who suggested my membership in that organization, an association I've found extremely rewarding), Kappa Kappa Kappa Sorority, Rush County Hospital and ISMA auxiliaries and the Rushville School Board. Wow! And just to fill in spare hours, she edits *The Hoosier Doctor's Wife,* a fine paper.

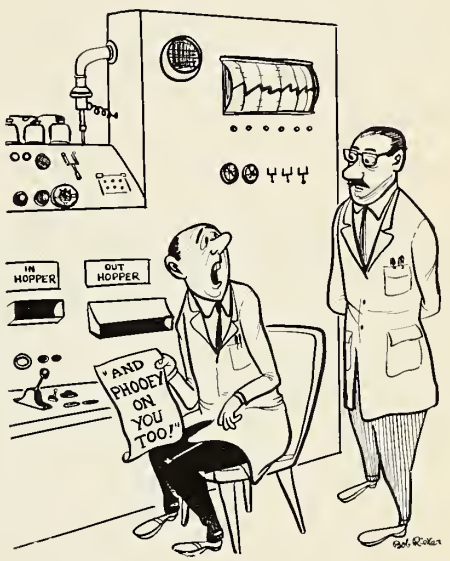
As they say in beatnik land, she's *real!* Like I hope she can stand up under the embarrassment of being featured in her own paper! Jean deserves such a salute—wholeheartedly.

. . . bravery beyond call of duty

And in the same issue—words I never expected to hear! In writing a thumbnail sketch of his wife, Ellen, who is ISMA auxiliary historian, Dr. Philip T. Holland of Bloomington gave her the supreme compliment:

"To pay her a further compliment, she's even fun to take on a deep sea fishing trip."

Bless you, doctor, for having the courage to put that in print. We gals should pin a silver star on your lapel.



"I can't understand it—all I did was accidentally drop a piece of paper in the intake hopper which had the word 'phooey' written on it!"

And now I'll slip one by on my boss, Dr. Frank Ramsey . . . to show you what a versatile guy he is (and I've lost my head before for similar stunts!). Not *only* is he a surgeon and the editor of your state *Journal,* but he also is a cartoonist! Although Bob Riker did the actual artwork, Dr. Frank dreamed up the above cartoon.

Now . . . anyone in need of a good assistant editor? ◄

Deaths . . .

John L. Carpenter, M.D.

An Alexandria, Ind. general practitioner, Dr. John L. Carpenter, died Sept. 22 at Ball Memorial Hospital, Muncie. He was 59.

Dr. Carpenter, who this year completed 30 years of practice, graduated from Indiana University Medical School in 1928. He had been associated with the Alexandria Clinic 12 years.

William F. Craft, M.D.

Dr. William F. Craft, 73-year-old Linton, Ind. senior ISMA member, died Sept. 8. He had practiced medicine for 46 years.

Dr. Craft was a graduate of Indiana University School of Medicine and a veteran of World War I.

Claude A. Curry, M.D.

Dr. Claude A. Curry, retired Terre Haute pediatrician, died Sept. 20 at his Allendale home.

A graduate of Indiana University School of Medicine, Dr. Curry had practiced in Terre Haute since 1930. He was Union Hospital staff treasurer for 20 years, past president of the Vigo County Medical Society, and a member of Phi Chi, Sigma Xi, and the Mansonic Lodge.

Edgar C. Denny, M.D.

A 75-year-old Milton, Ind., physician, Dr. Edgar C. Denny, died Sept. 24 at Reid Memorial Hospital, Richmond.

A graduate of Valparaiso University and the Indiana University School of Medicine, Dr. Denny practiced medicine in Scotland, Ind. before going to Milton in 1916.

Dr. Denny was former president of the Wayne County Medical Society, and served on the staff of Richmond State Hospital from 1941 to 1950.

He was also a past president of the Wayne County Tuberculosis Association, and a member of the Milton Town Board for 12 years.

H. Dean Hinshaw, M.D.

Dr. H. Dean Hinshaw, LaPorte City Health officer and a general practitioner, died Sept. 16 at Robert Long Hospital, Indianapolis. He was 30.

A graduate of Indiana University School of Medicine in 1955, Dr. Hinshaw had practiced in LaPorte since 1956, and served as health officer since 1957.

Continued

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District and County Society Reports

Eleventh District

Dr. George M. Jewell, Kokomo, was elected president of the Eleventh District Medical Society at a Sept. 16 meeting in Monticello. Assisting him will be Dr. C. L. Wise, Camden, the new secretary-treasurer.

Clinton

Dr. William M. Mount, Crawfordsville, spoke to fourteen members of the Clinton County Medical Society at their Sept. 15 meeting.

Decatur

Nine members of the Decatur County Medical Society met for business meeting and general discussion at Greensburg on Sept. 16.

Henry

The Henry County Medical Society met Sept. 17 at New Castle for a general business meeting. Fourteen members were present.

Montgomery

Wabash College and Crawfordsville High School coaches were guests of the Montgomery County Medical Society on Sept. 17 at Crawfordsville. Dr. Edward V. Schaffer, Indianapolis, spoke to the group on common athletic injuries.

Orange

Six members of the Orange County Medical Society met at Spring Mill Inn on Sept. 29 for a general business meeting.

Owen-Monroe

Dr. T. C. Fong, Madison, spoke on Geriatric Psychiatry at the Sept. 24 meeting of the Owen-Monroe Medical Society, held at the Bloomington Country Club. Thirty-four members attended.

Deaths

Continued

Dr. Hinshaw served on the staffs of Fairview and Holy Family Hospitals in LaPorte.

Alva L. Spinning, M.D.

Dr. Alva L. Spinning, 93, founder of the first hospital at the State Prison in 1895 and its first physician, died Sept. 30 in Riverside, California.

Dr. Spinning retired in 1941, having practiced medicine for more than 50 years. He was Fountain County health commissioner for more than 20 years and served as city manager of Covington early in his career.

Charles Wood, M.D.

Dr. Charles Wood, 79-year-old Westport, Ind. general practioner, died Oct. 5 in his home. He had practiced medicine for 51 years.

Dr. Wood received his medical degree from Louisville Medical School in 1908, and had practiced in Westport since 1914. He practiced only part time for the past two years. Prior to entering medical school, he taught school for nine years.

Charles E. Woodcock, M.D.

Dr. Charles E. Woodcock, retired Greenwood physician, died October 2 at his home at the age of 72. He had practiced medicine for 42 years prior to his retirement in 1948.

A graduate of Franklin College and the Indiana University School of Medicine, Dr. Woodcock was a World War I veteran, and a member of the American Legion, Chamber of Commerce, and the Masonic lodge.



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Association Reports

THE EXECUTIVE COMMITTEE

October 5, 1959.

Meeting called to order at noon.

Roll call showed the following present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Kenneth L. Olson, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; Okla W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of *The Journal;* Robert Hollowell, attorney, and James A. Waggener, executive secretary.

Guests: John K. Folck, M.D., and Robert S. McElroy, M.D., both of Princeton.

Minutes of the meeting held July 11, 1959, were approved on motions of Drs. Owsley and Olson.

Membership Report

Number of members as of September 30, 1958		4,156
1959 members as of September 30, 1959:		
Full dues paying	3,545	
Interns	39	
Residents	169	
Council remitted	39	
Senior	396	
Military	43	
Honorary	1	
Total 1959 members as of September 30, 1959		4,231
Gain over last year		75
Number of members December 31, 1958		4,201
Delinquent members as of September 30, 1959		9
Number of AMA members as of September 30, 1958		4,011
1959 AMA members:		
Dues paying	3,376	
Exempt, but active	725	
Total 1959 AMA members as of September 30, 1959		4,101
Gain over last year		90
Number of AMA members as of December 31, 1958		4,052
Delinquent AMA members as of September 30, 1959		13
(The above paid 1958 AMA dues but not 1959)		
Number who have paid state dues but not AMA dues in 1959		117
		130

Upon motion of Drs. Mericle and Owsley, the Council was to have their attention called to the resolution appearing in the report of the chairman of the Council concerning AMA dues.

Headquarters Office

The secretary reported on the activities of the field secretaries, stating they had been busy calling on non-members of the AMA and the Indiana State Medical Association, if consent had been given by the officers of the component county medical societies.

Treasurer's Office

The treasurer's report was approved by consent.

Legislative Matters
National

Dr. Wood, chairman of the Commission on Legislation, reported on legislative activities and the recent meeting in St. Louis on the Forand Bill. By consent it was agreed that the Executive Committee should recommend to the Council that the Association adopt a resolution opposing the Forand Bill.

1959 Annual Convention
Indianapolis, Oct. 6 to 9, 1959

(1) The president called attention to the resolutions presented at the annual meeting of the Kentucky State Medical Association, one calling for compulsory immunization, one calling for an investigation of violations of corporate practice, and a third resolution calling for a reduction of the length of stay of patients in hospitals.

(2) Report on the sale of exhibit space was received and the secretary commended for the success of this sale.

Organization Matters

(1) **Osteopathic question.** The osteopathic question was reviewed. Drs. Folck and McElroy explained the situation in Princeton, and it was decided to refer this entire question to the Council.

(2) The request of Dr. B. V. Klain for space in the scientific exhibit to exhibit his therapy cart was approved by consent.

(3) Request of the National Society for Medical Research for a contribution of $100.00 was approved on motion of Drs. Mericle and Owsley.

(4) A letter from Evan B. Walker, treasurer of the 1960 National Science Fair, thanking the Association for its $5,000.00 contribution, was read.

(5) A letter from Dr. A. C. Offutt regarding the problem of physicians serving as health officers was read and by consent the secretary was directed to prepare a letter over the president's signature, addressed to all county medical societies, pointing out their responsibility for assuming that the offices of city and county health officers are filled by physicians.

(6) The secretary reviewed the minutes of the 1959 annual meeting of the Board of Directors of the North Central District Blood Bank Clearing

House, pointing out that the Clearing House was in a better financial condition and that they were repaying some of the loans that had been advanced to them by some of the various states.

(7) A letter regarding a representative to the decennial meeting of the United States Pharmacopoeial Convention was read and information supplied that Dr. R. A. Solomon who previously had been selected by the committee as a representative would be unable to attend. On motion of Drs. Mericle and Owsley, the chairman of the Executive Committee is to talk with several prospects and make a recommendation as to who should represent the Indiana State Medical Association at this meeting.

(8) The entry blank for the President's Award to the "Handicapped American of the Year" was presented, and upon motion of Drs. Mericle and Owsley this is to be referred to the Industrial Health Subcommittee.

(9) Modifications in the Medicare contract, covering the provisions for continued obstetrical and maternity care after a sponsor's death, were approved for signature by the president and secretary, by consent.

New Business

The president's speech and that of the president-elect were both approved by consent.

The Journal

Report from the State Medical Journal Advertising Bureau showing a 20.3% increase in billing over a year ago was read and approved by consent.

Future Meetings

(1) Seventh National Conference on Physicians and Schools, Highland Park, Ill., Oct. 13-15, 1959. On motion of Dr. Mericle, taken by consent, the chairman of the Commission on Public Health is to attend.

(2) Board of Directors meeting, Indiana State Chamber of Commerce, French Lick, Oct. 16-18, 1959. Dr. Wood will attend.

(3) Tenth County Medical Societies Civil Defense Conference, Nov. 7 and 8, 1959, Chicago. By consent the chairman of the Commission on Governmental Medical Services is to attend this meeting.

(4) Fifth Annual Conference of Mental Health Representatives of State Medical Associations, Chicago, Nov. 20 and 21, 1959. Dr. Mericle is to select a representative to attend this meeting.

(5) Conference on Aging, Oct. 28 and 29, 1959, Cleveland. Dr. Mericle, Dr. Lamb and the secretary will attend this meeting.

There being no further business the committee adjourned to meet again in regular session on November 11, 1959, at 4:00 p.m.

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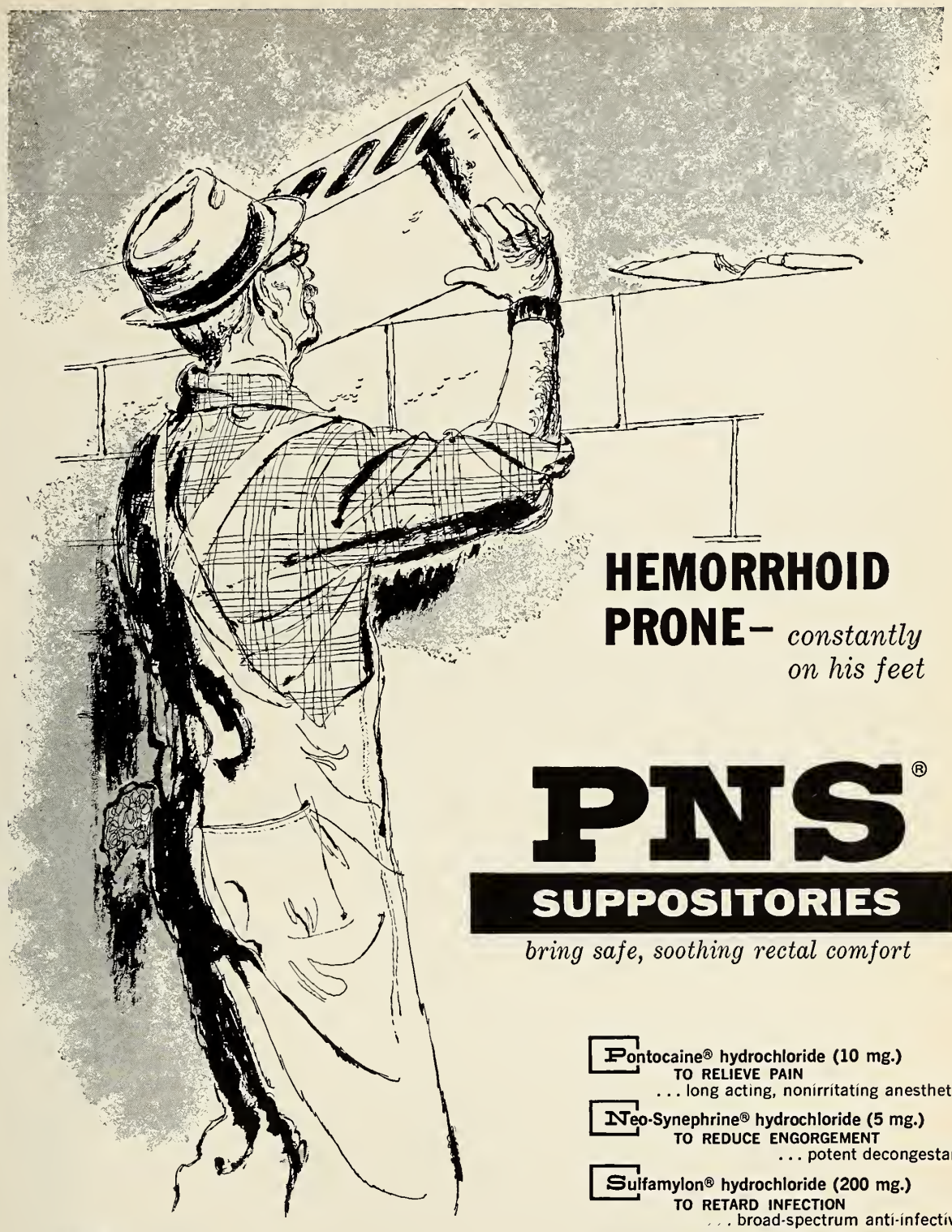
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4.	Robert M. Reid, M.D., Columbus	David L. Adler, M.D., Columbus	Columbus, May 11, 1960
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7.	Arthur Records, M.D., Franklin	Herbert L. Egbert, M.D., Indianapolis	1960
8.	Richard C. Swan, M.D., Anderson		Anderson, June 8, 1960
9.	Harry E. Klepinger, M.D., Lafayette	Forrest J. Babb, M.D., Stockwell	Lafayette, May 18, 1960
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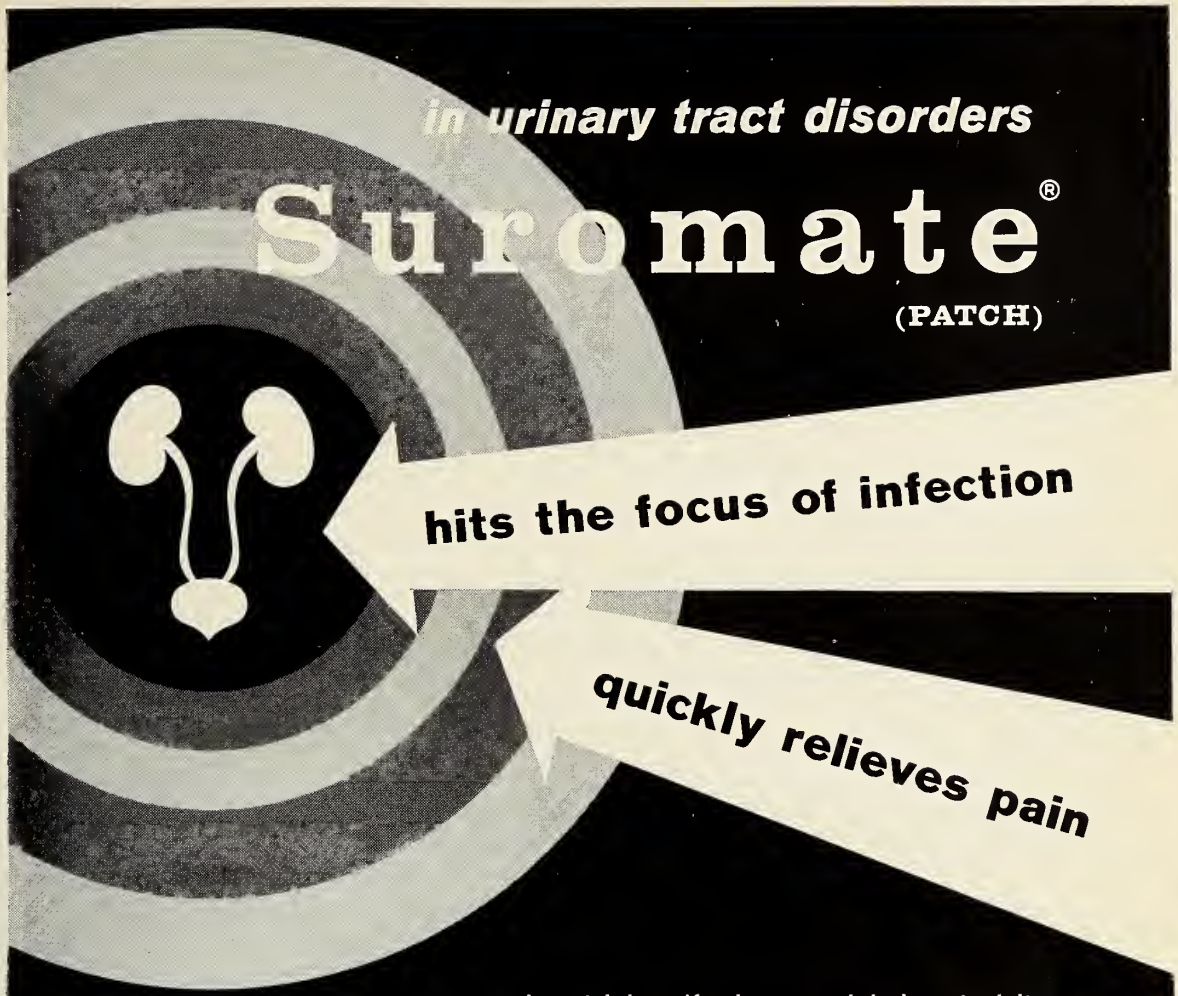
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THE MONTH IN WASHINGTON

Washington, D. C.--A special committee of consultants to the Federal government has recommended what was termed an urgent, essential program designed to maintain the present ratio of physicians in a sharply expanding population.

Dr. Leroy E. Burney, surgeon general of the Public Health Service, gave his personal approval to the recommendations made by his 22-member Consultant Group on Medical Education after about a year's study. But he said he couldn't indicate yet "the extent to which they can be incorporated" in next year's proposals of the Department of Health, Education and Welfare.

The consultant group recommended expansion of existing medical schools and construction of 20 to 24 new ones with federal help, federal scholarships for medical students, and greater efforts in the field by states, local communities, foundations, individuals, industry and voluntary agencies.

The group said the present ratio of 133 doctors of medicine and eight doctors of osteopathy per 100,000 population is "a minimum essential to protection of the health of the people of the United States."

To maintain this ratio the group said, "the number of physicians graduated annually by schools of medicine and osteopahy must be increased from the present 7,400 a year to some 11,000 by 1975--an increase of 3,600 graduated.

"To meet the country's need for physicians for medical care, teaching, research and other essential purposes will require an immediate and strenuous program of action by the nation as a whole," the group's 95-page report stated.

"This program must safeguard and improve the quality of medical education as well as bring about the needed substantial increase in the number of physicians."

The No. 1 recommendation of the group was for the federal government to appropriate over the next 10 years funds--estimated at about $500 million--"on a matching basis to meet construction needs for medical education," including necessary teaching hospitals.

"The consultant group is convinced that the nation's physician supply will continue to lag behind the needs created by increasing population unless the federal government makes an emergency financing contribution on a matching basis toward the construction of medical school facilities," the report said.

The group also said research grants to medical schools "should cover

full indirect costs so that medical schools are properly reimbursed for the contribution of medical education to medical research."

These two recommendations were in line with American Medical Association positions on the matters.

The group also urged "more generous public and private support for the basic operations of medical schools." Such support, the report added, "must come from many sources, including state and local appropriations, endowments, gifts and grants, universities, and reimbursement for patient care."

Most of the consultants were physicians or educators. They included Dr. Julian Price of Florence, S. C., a member of the AMA Board of Trustees, and Dr. Edward L. Turner, Director of the AMA Division of Scientific Activities.

Highlights of the Group's report included:

---To maintain the present physician-population ratio, the expected 1975 population of 235 million will require a total of 330,000 doctors of medicine and osteopathy.

---There also must be 12,000 entering students in 1971, as against about 7,600 a year now.

---"In a very real sense, the needs for physicians cannot be met by numbers alone. They will be met only as an expanded program maintains and enhances the quality of medical education."

---The entry of more physicians into research, industrial medicine and similar activities "has made possible much of the progress of modern medicine." But it also has resulted in "relatively fewer physicians devoting full time to patient care."



The Fourth Estate Looks at Medicine

More Patrolling the Answer

Deputies said his auto, traveling at high speed, went out of control on a curve, slammed into a utility pole and burst into flame. . . .

Mrs. K. told police another car forced her off the road. . . .

Authorities said the child opened the rear door of an auto driven by his mother and tumbled out onto the highway. . . .

He died when he lost control of his sports car as it hit a railroad track while passing another auto. . . .

His car veered across the center of the road and the other driver failed to pull his auto far enough away to avoid the collision. . . .

Quoted above are parts of news stories which Indiana newspapers carried this week after another incredibly high death toll on Hoosier streets and highways during the past week-end. Eighteen persons died in those accidents—six more than during the 78-hour Labor Day holiday.

How do you persuade drivers to be more careful? They seem to resist advice and warnings—at least some of them do.

How are you going to convince them to slow down on curves and stop dangerous weaving in and out of heavy traffic? There is a percentage who will drive arrogantly no matter what the risk.

The only influence we have noticed that causes motorists to use greater care is the police patrol car. Many drivers observe all the traffic rules when they see a trooper's car, but throw caution to the winds when they think there are no police in the vicinity.

Heavier patrolling of highways by the police may be the only answer to this problem.

Kokomo Tribune
Sept. 16, 1959

The Casualty Lists

The "killed in action" and "wounded in action" casualty lists of wartime are being matched every week by the peacetime highway traffic toll of dead and maimed.

Indiana last weekend had one of its worst blood baths from motor car collisions and attendant pedestrian slaughter.

Three Indianapolis residents were killed in two accidents and at least 11 other persons were crushed to death over the state.

Combined efforts of law enforcement officers on recent holiday weekends have resulted in a commendable reduction in automobile casualties for those periods.

But in between these concentrated efforts for safety are all the "ordinary" weekends—and the days of the week in between them. There seems to be a disposition to crack down on special occasions and then relax.

The drivers themselves who, of course, are most to blame for the carelessness and excessive speeds which cause the crashes, seem to think they have a license to relax and take chances when the authorities are not looking so closely.

They are courting disaster.

These weekly casualty lists of dead and injured are nothing less than a state and national disaster.

A study of the tables made by insurance companies only leads to the conclusion that the great majority of casualties occur in accidents for which the driver is directly responsible. We can't blame slippery roads or bad weather for what is happening.

We cannot blame inexperienced drivers or decrepit vehicles, nor can we blame the horsepower of the vehicle itself.

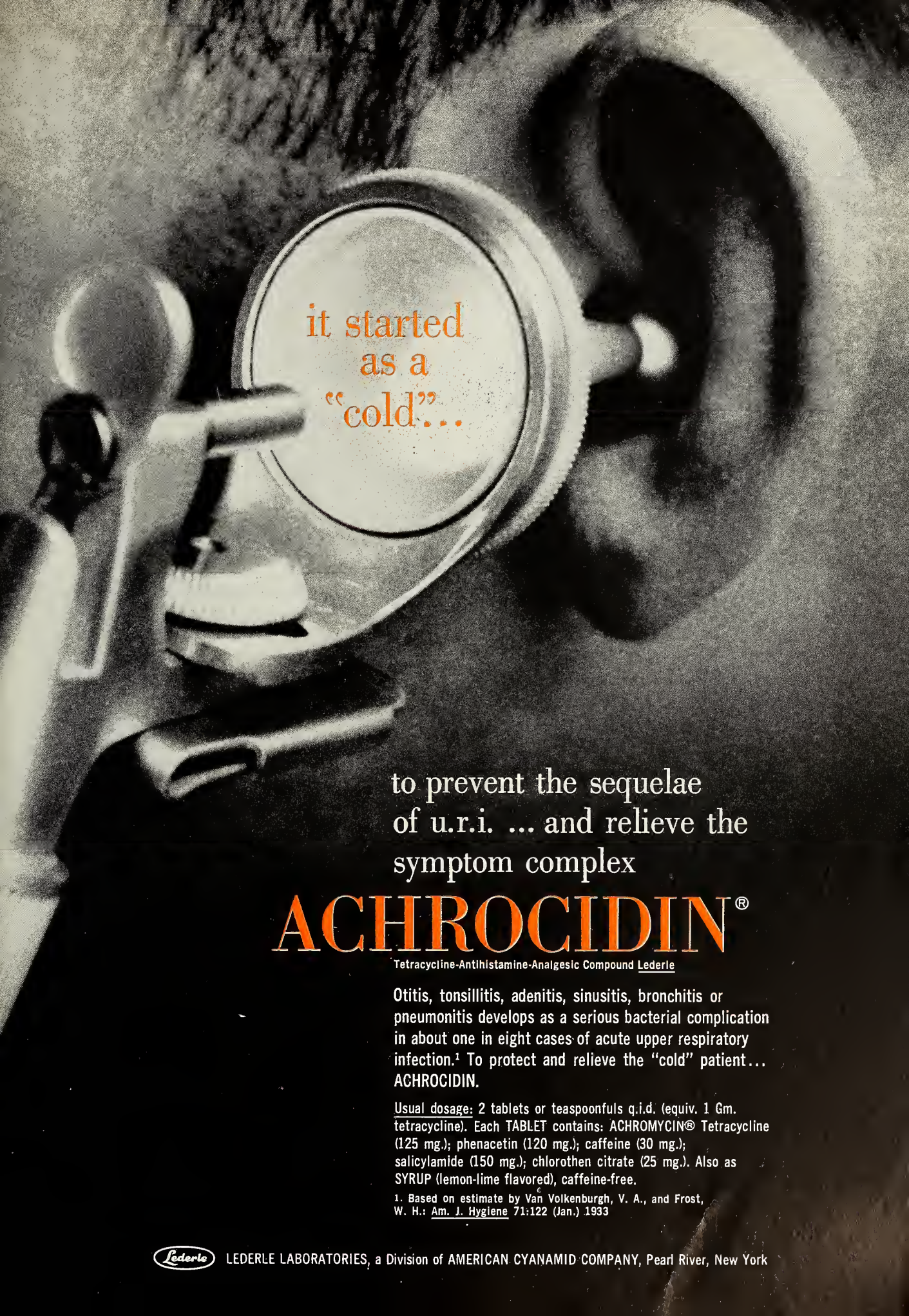
But we can blame the driver who misuses the horsepower, who uses clear weather and dry roads as an excuse to "step on it," who refuses to slow down to caution speeds in case of bad conditions and who refuses to recognize the rights of other drivers and of pedestrians.

This highway slaughter cannot be combated by the authorities alone. It has assumed proportions so alarming that the general public must become aroused to the danger to individual survival.

Through a mass public consciousness this rending of bodies and shattering of families must be ended through drastic self-control.

Indianapolis News
Aug. 18, 1959

Continued



to prevent the sequelae of u.r.i. ... and relieve the symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Otitis, tonsillitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Continued

Fourteen in One Weekend!

Last weekend was a shocker in the traffic toll in Indiana.

Fourteen dead, and a number injured.

Two persons died because their station wagon was involved in a collision with a driver who had been drinking.

One teen age motorist drove around another car at a traffic light and into the path of a truck. He was killed and three other young people, as well as the truck driver, were injured.

Another driver wasn't careful enough in passing a car, sideswiped it and caused the other man to drive against a bridge abutment, killing him.

One truck involved in a fatal collision had faulty brakes.

Those were examples of what happened on Indiana highways. In Missouri, during the same weekend, a three-car crash took the lives of 11 persons, the worst automobile accident in that state in many years.

Law enforcement and traffic authorities are racking their brains trying to come up with answers to the problem of preventing such slaughter. They beg motorists to be more careful, to be more patient and not be so determined to pass other cars recklessly, to stop the habit of taking a drink or more before they get behind the wheel.

And yet the people go on taking chances.

In some states governors have heavily increased the state police force and patrolled the roads with a vengeance, nabbing drivers right and left for unsafe conduct. It has resulted in fewer deaths and injuries.

It has also been costly, for adding to the personnel or highway police means a large increase in the police budget. Yet maybe that is the price the public will have to pay in order to be assured of safety.

Kokomo Tribune
Aug. 19, 1959

Polio Immunization Just Common Sense

For those who have not yet had polio shots, the Sunday clinic sponsored by the A.F.L.-C.I.O. in cooperation with the Vanderburgh County Medical Society and other community organizations offers an invaluable opportunity



Despite hopes of a few years ago, discovery of the Salk polio vaccine did not automatically wipe out the disease. It is effective only for persons who make use of it. Surgeon General Leroy E. Burney has urged block-by-block vaccination campaigns, an effort even more strenuous than the one being made Sunday in Evansville.

Paralytic polio is being reported at about twice the rate of last year and Burney warned against "tragic outbreaks" if communities continue to delay in pushing major drives to reach the unvaccinated, most of whom are concentrated in the lower socio-economic groups.

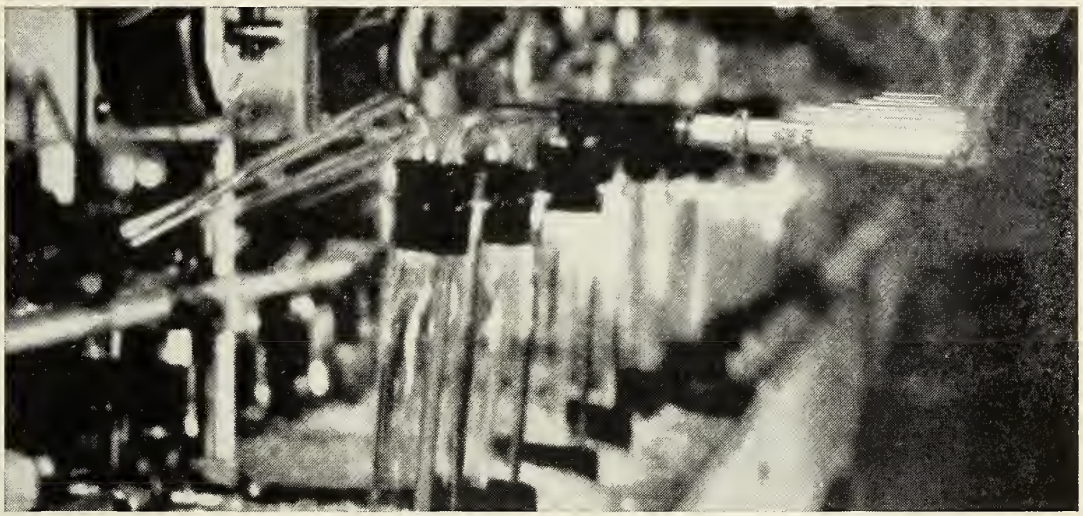
Despite its low cost, the Evansville shot clinic is not especially for the indigent. It's open to anyone. Everyone needs the immunization, and many have failed to obtain it in the past. Primary aim of the mass participation campaign is simply to raise the percentage of Evansville residents who will be protected against a disease that remains one of the most terrifying to afflict the nation.

A word of warning should be sounded, though, for a few persons. Like most drugs, the Salk vaccine produces violent allergic reactions in a very small number of cases. Any person who has been treated by a physician for severe allergic attacks should consult that physician about polio immunization.

With that minor exception, the mass immunization clinic Sunday is an opportunity that shouldn't be overlooked. Running a risk of polio when virtually certain protection is available just doesn't make sense.

Evansville Courier
Aug. 8, 1959

HOW KENT BLAZED THE TRAIL TO LOW TAR AND NICOTINE CONTENT



A major independent research foundation, under Lorillard sponsorship, determined that the average puff of cigarette smoke contains over 12 billion semi-solid particles. Further research revealed that inhaled smoke from ordinary cigarettes has a predominant proportion of particles, from 0.1 to 1 micron in diameter, averaging 0.6 micron.

Ordinary filter fibers are so large that they create spaces through which the small semi-solid smoke particle can easily pass. However, in the extraordinary Kent filter, the fibers are mechanically manipulated in such a manner as to create a multitude of baffles and extremely tortuous passageways for the smoke. This is the "Micronite" Filter.

Lorillard pioneered research into filtration—creating a filter of extraordinary ability to decrease smoke solids. So—from the very start—Kent blazed the trail to the lowest level of tars and nicotine among all leading brands. And today, tars and nicotine are at the lowest level in Kent's history.



This Kent achievement in the field of filtration was done without sacrifice of rich tobacco flavor. Kent uses only 100% natural tobaccos—the finest in the world today—to give you real tobacco taste. Kent satisfies your appetite for a real good smoke.

If you would like the booklet, for your own use, "The Story of Kent," write to: P. Lorillard Company, Research Department, 200 East 42nd Street, New York 17, N. Y.

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KENT FILTERS BEST
for the flavor you like

A Product of P. Lorillard Company—First with the finest cigarettes—through Lorillard Research!

to the editor:

Dear Sir:

I just want to tell you how happy I am in the honor bestowed upon Dr. John Kingsbury, who so richly deserves it. Irvington people feel the same way, knowing him so well.

He is a *wonderful doctor* and a *wonderful friend*. I know him as both since 1917. His family are wonderful to me; I am one of the family at Thanksgiving. This means so much to me since I'm left alone.

Dr. John kept me going in my work for 40 years at the Irvington Branch of what is now AFNB. He doesn't take any credit for it, says he just pushed my own efforts.

He has seen me through major operations, severe cases of bronchial pneumonia, as well as other things that hit me. Not only has he been my mainstay through illnesses but through deaths of my parents and three brothers.

I retired Jan. 1, 1958. It hasn't been a very pleasant retirement, not as I had planned. Five weeks after I left the bank I took down with virus influenza with complications. I just hit the bottom; I couldn't throw it off. Then this spring I was hit again and April the 30th I went into Community hospital, was interned 22 days; x-rays showed spinal arthritis. I saw Dr. John twice a day. Through all these past months since I retired Doctor has stopped time after time for a check up and to help me. He goes out of his way to help people.

Doctor's patients as well as other people just love him; he gives so much of himself, he loves his work and enjoys and wants to help people. When he comes into the room one feels better. There is never anything so satisfactory and so comforting in time of illness as to have a good Family Doctor, one in whom there is full confidence, come into the home.

Doctor is a charter member and an Elder of Irvington Presbyterian Church, of which I have been a member since 1917.

I could write page after page the good Doctor has done covering all these years I have known J.K.K. He is a True *Family Doctor* and *Friend*. What I have written here is only a mention of what he has done for me, and I am only one of the *many*.

Any help I can render Doctor and his family, I am only too happy to do so.

Sincerely,

Miss Merle Davis,
Indianapolis

Dear Sir:

I assume that the little fact I am passing on to you is well known to you to to Becton B. Dickinson *et al*. But it is hard to know when a bit of truth may never be related in some way to something of value. So here goes.

I took 35 hypodermic needles, all completely occluded in course of ordinary office work and, therefore, useless and ready to be discarded. I dropped them in a glass jar containing ½ water and ½ vaseline. After three months I tried them with a syringe and hot water and 35 of 35 opened easily.

Perhaps some of your physicians with whom you do business might be grateful for this stray bit of information. Penicillin suspensions and salt solutions, etc., caused the occlusions and nearly all are salvaged. Thanks for listening.

Now, to recompense you for your time, here is an old story:

An M.D. went by an insane asylum on a cold snowy day and had a puncture. No help near so he took off the hub cap and carefully placed the taps from the wheel in the hub cap. As he got up he inadvertently kicked over the hub cap which rolled down a ravine and so he lost all the taps in the deep snow.

An inmate from the asylum came over and asked, could he "be of any help?'

"Well I guess not, I'm stuck," said the doctor.

"Why don't you take one tap from each of the other wheels and go ahead?" asked the inmate.

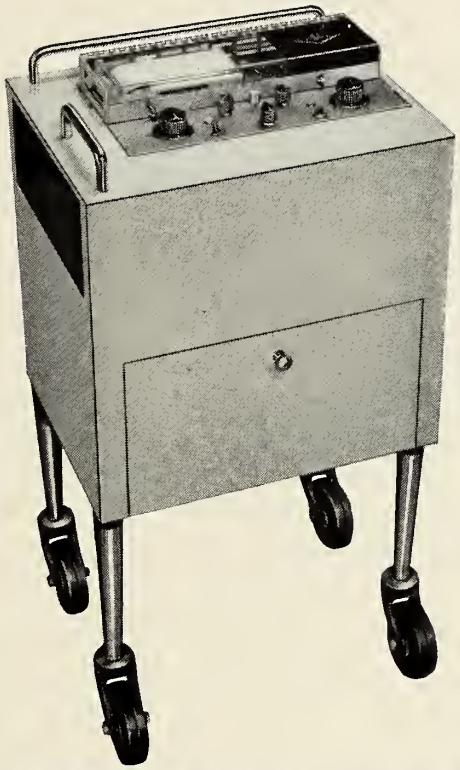
"Brilliant, my man. Do you mean to tell me that they think you're crazy?"

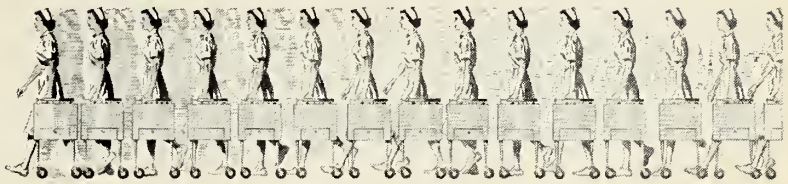
"Well, I may be crazy, Mr., but I ain't stupid."

Dan Tucker Miller, M.D.
Class of 1909 ◄

You may not know when you're well off, but the Internal Revenue Department does.—Arnold H. Glasgow.

"Quick as a wink" used to be considered the fastest unit of time. Nowadays it's the honk of the nitwit's horn behind you when the light changes.—*Durex Molder*, Durex Plastics Division, Hooker Electrochemcal Co.





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with 2 recording speeds • 3 sensitivities • provision for recording other waveforms • provision for visual monitoring

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. . . the recently announced Model 100 Viso in a handsome mahogany case, price $850 delivered, continental U.S.A. You can convert your present table-top 100 Viso into the mobile unit of your choice at any time by purchasing the new 100M mobile cabinet separately. (Price, $120 delivered, continental U.S.A.)





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Abstracts:

BONE TUMORS

Louis Lichtenstein, M.D., Chief Pathologist, General Medical and Surgical Hospital, Veterans Administration Center, Los Angeles; Fellow, New York Academy of Medicine; Professor Extraordinario National University of Mexico; Consultant in Bone Tumors, Tumor Tissue Registry of California Medical Association Cancer Commission; Consultant in Pathology, Los Angeles County Hospital; Consultant, City of Hope Medical Center, 402 pp. Price $12.00. Second Edition, The C. V. Mosby Company, 1959.

The second edition of "Bone Tumors" is a book which should prove very useful to all concerned in the diagnosis and treatment of tumors of bones. As the author states, the prime emphasis of the work is directed towards accuracy in diagnosis, and he is quick to take to task the roentgenologist who makes unequivocal diagnosis from x-ray features alone as well as the pathologist who functions "as a slide reader without benefit of good clinical orientation."

The author gives careful descriptions of the clinical features, roentgenographic features and the pathology of bone tumors, although some of the photomicrographs are too dark to be very useful. The author devotes 34 pages to multiple myeloma but gives no attention to bone cysts. The "ossifying fibroma" of the jaw bones is interpreted by the author as a localized lesion of fibrous dysplasia.

Dr. Lichtenstein, in even mentioning the idea of supplementing radical surgery for osteogenic sarcoma by irradiation of the lung fields through multiple ports as an experimental therapeutic procedure in the hope of "destroying microscopic tumor foci before they become encased in a coat of armor," seems unduly enchanted by the benefits of x-ray therapy to a degree all out of proportion to that expressed elsewhere in this writing.

The book is well written and is well worth placing in the smallest medical library.

Jene R. Bennett, M.D.,
South Bend

CHILDBEARING BEFORE AND AFTER 35

Adrien Bleyer, M.D. Vantage Press; 120 W. 31st St.; New York 1, New York; 1950. Edition I.

The author discusses the social and biological implications of maternal aging in relation to its association with the decreased chances of a successful obstetrical outcome. Although the title of the book suggests the age of 35 as the turning point, the statistics presented would appear to place the point of diminishing returns at the age of 30. A considerable amount of statistics deal with the incidence of mongolism and dwarfism. But the author also correlates incidence of prematurity, congenital heart defects, miscarriages and stillbirths with maternal aging.

In general the author presents a strong case for the advantage of childbearing before 35. He also discusses the chances of the occurrence of a second defective child, and states that the parents having had one defective child allow a few years to pass before venturing upon another pregnancy. The reason for postponement of pregnancy is that during this time the tendency to produce a defective will often decrease and probably disappear. This statement would seem to be a variation from the general implication of the book.

Doctor Bleyer also discusses the increased incidence of maternal obesity, hypertension, oversized babies, diabetes, fibroids and twin in relation to maternal aging.

Considerable research and analysis of statistics has gone into the making of Doctor Bleyer's book, which is easy to read and informative but inconclusive.

John K. MacLeod, M.D.,
South Bend

COLD INJURY, GROUND TYPE

Col. Thomas F. Whayne and Michael E. DeBakey, Washington, 1958. Office of the Surgeon General, Department of the Army. 570 pp. $6.25.

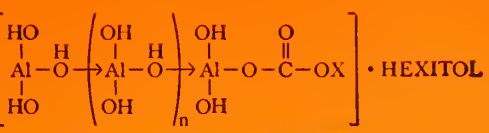
This volume, augmenting the Clinical Series of "The Official History of the Medical Department of the United States Army in World War II," is more than a simple monograph on the ground type of cold injury. It is part of a comprehensive view of World War II through the eyes of the Army Medical Service. Here it is seen, as it were, through eyes focused at feet, with a constant kaleidoscope of warfare passing through the background. Lavishly illustrated with color plates and black and white photographs, charts, diagrams and tables, it would seem that the last drop of serum had been squeezed from this subject. One would hardly believe it, but there is a section on cold injury in the tropics!

One has the feeling after reviewing the book that there must have been extensive information on literally thousands of problems successfully solved during the second World War which were not nearly so well appraised or documented, where hard-won knowledge has already evaporated into oblivion. Not so with cold injury however, and this reference volume will have a deserved place in the collections and archives of the medical libraries of teaching institutions here and abroad.

One is constantly fascinated by the detailed documentation of the interest in the problems of cold injury by the highest staff echelons of the Army. Much of the foot soldiers' suffering was the result of unfortunate "calculated risk" type of decisions by high ranking officers, whose expectations of

Continued on page 2118

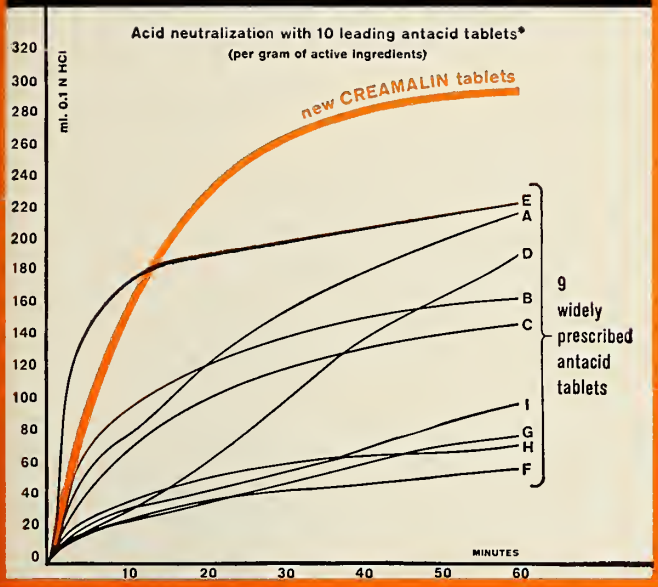
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n is at least 1 and averages less than 6. X is a cation.

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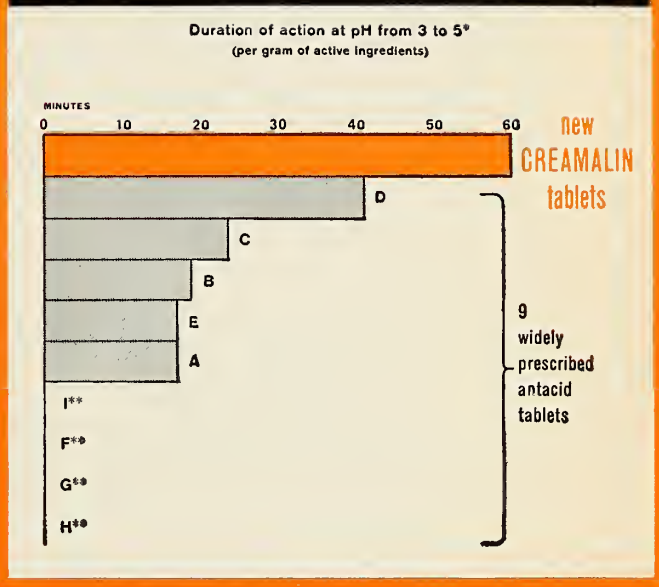
Quicker Relief • Greater Relief



Tablets were powdered and suspended in distilled water in a constant temperature container (37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour.

CREAMALIN NEUTRALIZES *MORE* ACID *LONGER*

More Lasting Relief



*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**pH stayed below 3.





No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

• NO ACID REBOUND • NO CONSTIPATION
• NO SYSTEMIC EFFECT

Adult Dosage: Gastric hyperacidity: 2 to 4 tablets as necessary. Peptic ulcer or gastritis: 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

Supplied: Bottles of 50, 100, 200 and 1000.

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NIPHYLLINE

the unique specific

This exclusive development is a ***definite chemical,*** neutral in action, and ***specific in prophylaxis and treatment of angina pectoris.*** It is effective orally in about thirty minutes, for periods of 7 to 8 hours . . . and, even when given routinely, does not cause nausea or gastric upset. Niphylline is an efficient vasodilator and diuretic combining the effectiveness of Neothylline (soluble, neutral, stable derivative of theophylline) and pentaerythritol tetranitrate, substantially more effective than mannitol hexanitrate. Thus, the patient receives the benefits of both drugs without any annoying side effects.

Niphylline is safe, and well tolerated . . . exerts strengthening effect on heart muscles, and acts synergistically, remarkably reducing severity and frequency of cardiac attacks.

Indications: Relief and control of angina pectoris, cardiovascular symptoms, asthenia, coronary spasm with myocardial pain, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Dosage: One or two tablets, 3 or 4 times daily, or as directed by physician.

Supplied: Bottles of 100 and 1000 tablets.

PM **PAUL MANEY**
LABORATORIES, INC.
Cedar Rapids, Iowa

Abstracts

Continued from page 2114

early victory in Europe deprived troops of winter clothing by giving ammunition and gasoline priority over boots and warm clothing. Indeed, to this viewer, one of the book's drawbacks is the overdocumentation of the administrative activities involved in the attempt to prevent the occurrence of immersion foot and other cold injury problems at the eleventh hour, by orders and directives to the poorly prepared, embattled doughboy.

A section devoted to the experiences of other armies is included. This is fascinating. It is particularly enlightening to read that during the European fighting in 1944 and 1945 the British and Canadian troops had an extremely low incidence of cold injury (206 cases, as compared with 46,000 American cases). Perusal of the facts shows that although there was a smaller total number of divisional combat days engaged in by British and Canadian troops, the main difference was that the British and Canadian soldiers were dressed warmer, had warmer socks, and better footgear than their GI counterparts. Furthermore, the British and Canadian soldiers were rested and warmed more frequently by their commanders, and the preventive measures practiced in these armies were better conceived and more rigidly enforced than in the United States Army.

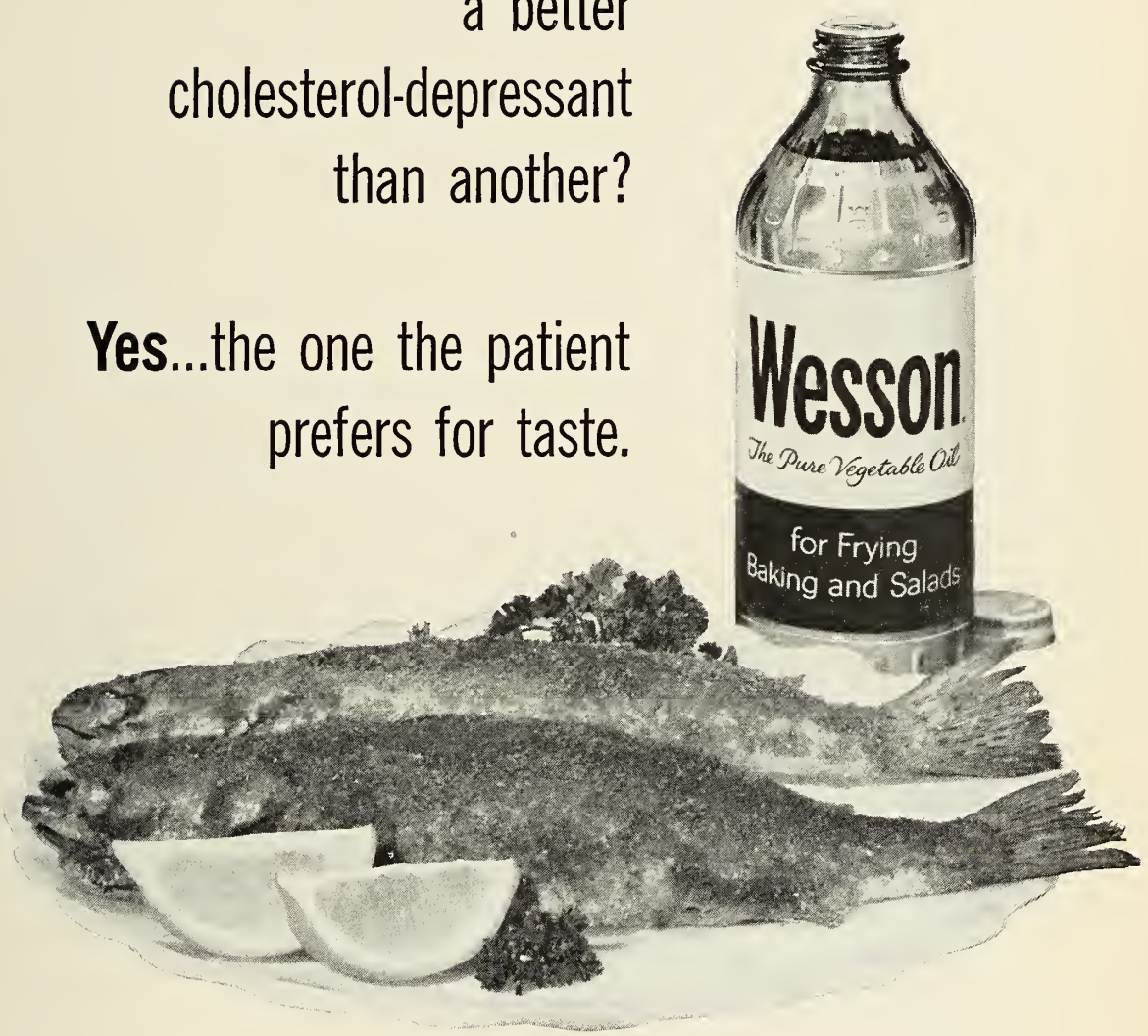
The German troops, while they were fighting in a disciplined and orderly fashion (prior to December, 1944), fared far better than the American troops. The harrowing experiences of winter warfare on the Eastern front resulted in seasoned soldiers who knew the dangers of cold injury. Consequently, German troops suffered little from this disease. The Russian troops were not issued socks at all, but wrapped their feet in cloth and newspapers and were issued boots in one of the three possible sizes. Ivan, too, fared far better than GI Joe, for he was also accustomed to cold weather warfare. In both the German and the Russian armies trench foot in general was considered a self-mutilation and the afflicted soldier was subject to court martial with death a possible sentence on conviction.

The reviewer's personal experience in the Arctic suggests that there is no such thing as one ideal footgear, mukluks being better for dry cold conditions and rubber boots more practical for wet and melting conditions; but even more important than footgear is the individual attention given to the feet and awareness of the danger of cold injury. For a period of three and a half months in the central Greenland Icecap, with weather conditions varying from wet to dry snow and —30°F to +30°F temperatures, there was no incidence of cold injury in our expedition for one slightly frostbitten ear. It is obvious that experience plays a tremendous part, for the Eskimo rarely is injured by cold although he lives in the midst of it.

Continued

Is one vegetable oil a better cholesterol-depressant than another?

Yes...the one the patient prefers for taste.



No leading vegetable oil can claim superiority over Wesson in its serum cholesterol-depressant effect. As a diet must be eaten to be effective, *the preferred appetite appeal of Wesson* is most important. Through the years, Wesson has been consistently favored over the next selling oil, particularly for flavor (blandness), odor and lightness of color*. Wesson *encourages* the patient to stay on the prescribed diet.

Quality and uniformity you can depend on. Wesson has a poly-unsaturated content better than 50% . Only the lightest cottonseed oils of the highest iodine number are selected for Wesson and no significant variations in standards are permitted in the 22 exacting specifications required before bottling.

Each pint of Wesson contains 437-524 Int. Units of Vitamin E.

Where a poly-unsaturated oil is called for in the diet, Wesson satisfies the most exacting requirements (and the most exacting palates!).

Wesson's Important Ingredients:

Linoleic acid glycerides	50% to 55%
Phytosterol (predominantly beta sitosterol)	0.4% to 0.7%
Total tocopherols	0.09% to 0.12%

Never hydrogenoted—completely solt free

*Substantiated by sales leadership for 59 years and reconfirmed by recent tests against the next leading brand with brand identification removed, among a national probability sample.

Abstracts

Continued

Economy and efficiency of operation would seem to demand that the American foot soldier needs to be equipped with one uniform, serviceable in all weather and for all purposes, loosely fitted over a well conditioned, well instructed, and well disciplined body as the best protection from climatic injury. Perhaps after the next war, in which the foot soldier will inevitably play the predominant role, such a volume as this will not need to be published.

Robert W. Christie, M.D.,
Associate Pathologist,
Ball Memorial Hospital,
Muncie

ERYTHROBLASTOSIS FETALIS

Including Exchange Technic. By Fred H. Allen, Jr., and Lewis K. Diamond, M.D., Boston, 1957. $4.00

This excellent little monograph does well and easily what other ponderous texts do with difficulty. One of the *New England Journal of Medicine's* Progress Series, it is an expanded presentation of the subject "Erythroblastosis Fetalis" printed in 1957. Its authors, Doctors Diamond and Allen, are well known and need no introduction to those who have followed the course of this now well-known, fascinating disease through the last decade.

Although small (it will fit into your side coat pocket), the presentation is authoritative and comprehensive and includes introductory, simply stated information regarding blood group factors, maternal sensitization and pathologic physiology of erythroblastosis fetalis. Further chapters are on diagnosis, treatment (including technics of exchange transfusion) and prevention of the disease, in as much as this is presently possible. Indeed, there are even suggestions for nurses and hints to laboratory technologists concerning some of the more difficult technical problems which give this volume a broad scope and should consequently give it a wide audience.

Those who have been bewildered and confused by the ponderous literature on blood group factors, antigen-antibody problems and sensitization phenomena will find this volume a handy reference guide to help them thread their way through the maze of bewildering detail in the periodical literature. The underlying principles are simply and concisely stated and most of the passages read easily and rapidly.

There is in addition to a very satisfactory index a glossary of words and terms having special meaning which make it easy for those not recently conversant with the field to acquire a ready and handy vocabulary. Further, there is a limited but selective reference list at the end of the volume.

This little book with jaundiced covers should be always obvious in the bookcases of the general practitioners, obstetricians, pediatricians and pa-

Continued on page 2124



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Health Care: A Community Responsibility

This article is the tenth in a series prepared by Blue Cross-Blue Shield.

The term "community responsibility" may mean a variety of things to the average citizen, ranging from participation in the local school Parent-Teacher's Association to keeping one's yard and home in presentable condition. But to Indiana Blue Shield and Blue Cross, now protecting one-third of the state's population, community responsibility means taking care of people. It means providing health care benefits to those who need them to the limit of all the money available.

Blue Shield and Blue Cross accept the responsibility of attempting to enroll all segments of the population. "All persons" includes those of high, medium and low income. The protection is continuous, and is not canceled or waivered because of utilization, condition of health or change in employment status.

To this end, varied Blue Shield and Blue Cross programs have been devised to meet the needs of employed workers, pensioners, self-employed workers, college students, over-age and retired individuals.

It was just this past September that the third state-wide Blue Cross-Blue Shield Open Enrollment Compaign was held, enabling all population segments to obtain health care protection. Particular emphasis was placed on meeting the health care needs of the senior citizen.

Of the nearly 30,000 Hoosiers enrolling during this 12-day special campaign, approximately one of every three new members or some 10,190 persons were in the over-65 category. Twenty-five per cent of these were over 75 years of age, with at least 4 new members 100 years or older.

Of the 64% of the state's over-65 population that would be interested in a special health protection program, Blue Cross-Blue Shield now covers 29% or some 115,000 senior citizens.

Important as health care for the senior citizen is, Blue Cross-Blue Shield, in fulfilling its community responsibility, maintains a diversified membership.

Nearly 11,000 aoccounts composed mainly of business firms, but also including professional groups such as teachers, lawyers, nurses, physicians and college students, make up a group membership of 1,113,837.

Individuals leaving an account may continue membership in what is called a "termination account." By permitting membership for those who have changed employment status, 177,923 persons currently are continuing their Blue Cross-Blue Shield coverage on a direct pay basis.

Membership is also available to those self-employed or unable to obtain group membership. There are 167,855 enrolled in this category at this time.

Open enrollment campaigns with membership available regardless of age or physical condition were conducted in 1954 and 1955. Response to these campaigns added 110,000 to Blue Cross-Blue Shield health coverage.

The practice of "excluding" certain individuals from coverage is not a part of Blue Cross-Blue Shield. Every effort is made to include all persons. Evidence of this is illustrated through the acceptance of individuals with Blue Cross-Blue Shield membership from another plan transferring to Indiana. Some 600 such transfers are processed each month. Coverage without further waiting periods is extended to those dependents 19 years of age and no longer carried under a family certificate. Or, those dependents who marry under 19, are permitted to continue coverage in their own name. Divorced spouses, too, may each continue membership separately.

Blue Cross-Blue Shield believe that taking care of people is its "community responsibility." They are confident in assuming that obligation. An obligation of not only serving as the means for financing health care, but in meeting the needs of the people. The goal is service rather than profit, the concern is protection rather than price.

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References: 1. Cecil, R. L., et al.: J.A.M.A. 124:8 (Jan. 1) 1944. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Beckman, H.: Drugs, Their Nature, Action & Use, Saunders, Philadelphia, 1958, p. 527.

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Abstracts

Continued from page 2120

thologists who are frequently confronted with the problems in diagnosing and handling the situations which arise when mothers and infants have Rh and AB incompatibilities. Medical students will find this book particularly valuable as an introduction to an absorbing field in medicine which has responded to research and the perseverant approach.

Robert W. Christie, M.D.,
Associate Pathologist,
Ball Memorial Hospital,
Muncie ◄

Committee work is like a soft chair—easy to get into but hard to get out of.—Kenneth J. Shively, *Secretary.*

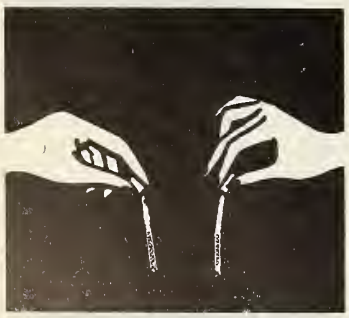
A weekend is when you slow down to let the strain go by.—*Office Economist.*

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It is generally agreed that it is ideal to withhold antibiotic and chemotherapeutic drugs until after sensitivity tests show which antibacterial agent will be most effective. But very often, in actual practice, the physician knows that delay in starting antibacterial treatment may be detrimental to the welfare of his patient. He must then select the therapy to meet the most serious and immediate threats to the patient.

Why Combination Therapy?

Certain infections do not respond as well to a single agent as to a combination. *Hemophilus influenzae* infections, which are frequent in children, are a particularly serious threat to infants and children up to about 3 or 4 years of age since they have not yet built up any appreciable immunity. Serious complications such as influenzal pneumonia, empyema, or meningitis may develop, especially in this age group. In fact, except for those periods when meningococcal meningitis is epidemic, *H. influenzae* is the most frequent cause of meningitis.[1] This gram-negative organism is highly susceptible both to the tetracyclines and to the sulfonamides. Even in severe infections, therapeutic failure can be virtually eliminated by giving sulfonamides plus tetracycline.[1] These two agents together constitute the treatment of choice, and give better results than either alone.[2]

Sulfonamides remain the drugs of choice for all meningococcal infections, including meningitis. They readily penetrate the blood-brain barrier and pass into the cerebrospinal fluid in good concentrations.[3] In treating overwhelming meningococcal infections, and complicating infections of the upper respiratory tract caused by other organisms, the addition of tetracycline to sulfas can be valuable.[4]

In recent years the sulfonamides have again been prescribed more and more frequently. In certain serious infections, better results can be obtained with a combination of antibiotic and sulfonamide than with either drug alone (e.g., severe pneumococcal pneumonia or pneumococcal meningitis[5]). Furthermore, mixed infections, to which young children are particularly susceptible, often respond only to combination therapy such as tetracycline with sulfonamides (TETREX c̄ T/S).

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Some sulfonamides, though therapeutically useful, frequently crystallize and cause renal damage. Sulfonamide mixtures are designed to prevent this effect. It is known that different substances can coexist in solution without interfering with each other's solubility. In such a solution each component behaves as if it alone were present. Thus, a much larger total amount of sulfonamide can exist in the urine without precipitating if a mixture is administered than if the same amount of only one compound is given.

Similarly, there is less danger of hypersensitivity with mixtures. The incidence of sensitization varies directly with the dosage and is limited to the particular sulfa given. Simultaneous use of several sulfa compounds, each in partial dosage, tends to keep each drug below its own sensitization level.[3] As with all sulfonamides, it is advisable to check for possible blood dyscrasias, rash, or renal toxicity during extended administration.

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References: 1. Alexander, H. E.: The hemophilus group. In: Dubois, R. J.: Bacterial and Mycotic Infections of Man. Ed. 3, Philadelphia, J. B. Lippincott Co., 1958, p. 470ff. 2. Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics. Ed. 2, New York, The Macmillan Co., 1956, pp. 1322-1323. 3. Beckman, H.: Drugs — Their Nature, Action, and Use. Philadelphia, W. B. Saunders Co., 1958, pp. 527-528. 4. Dingle, J. H.: Meningococcal infections. In: Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine. Ed. 9, Philadelphia, W. B. Saunders Co., 1955, p. 196ff. 5. Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics. Ed. 2, New York, The Macmillan Co., 1956, p. 1308.

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 52 — December 1959 — Number 12

The medical considerations of the world's biggest and most successful employer of the disabled.

Medical and Psychosocial Research In the Disabled Worker

ALVIN SLIPYAN, M.D., F.A.C.P.
*HENRY VISCARDI JR., LL.D.(Hon.) L.H. D.(Hon.)**
HAROLD E. YUKER, Ph.D.

Albertson, N. Y.

Introduction

A PROGRAM to employ disabled workers is not unique in our time. However, in the program at Abilities Inc., there are features which are unusual.

The shop was started in 1952 in a vacant garage in West Hempstead, Long Island. Its first four employees were totally disabled. They had but one usable leg and but five usable arms among them. Today the group has grown to more than 350 employees and is housed in their new plant of 40,000 square feet built out of earnings.

No exception to the original rule has been made. All of the employees are severely disabled.

In addition to earning prevailing wages they have all the benefits of enlightened modern industry: company paid life insurance, Blue Cross and Blue Shield hospitalization and medical benefits, paid holidays, vacation and sick leave.

From such opportunity great benefits accrue to the individual. The new sense of purpose and dignity of a paying job brings great rewards and many changes to one's life. There are marriages, cars and homes are bought, children born that might not otherwise have been. A sense of purpose and dignity comes into lives that before were meaningless.

The changes for the disabled individual are

This research was supported by a grant from The Insurance Company of North America Companies.

* President and chairman, Board of Directors, of Abilities Inc. The paper was prepared for the *Journal* as a result of Mr. Viscardi's lecture at the 1958 ISMA convention.

not the only result. There are psychosocial, medical and economic factors worthy of consideration.

Economically, this course of action, by utilizing manpower adds great new wealth to the community. People otherwise idle are now employed. In 1952, the year Abilities Inc. was founded, the personnel grew to 57 workers. In the second year to 104, the third year to 163. Today the total is more than 350 persons.

These disabled workers, operating their own company, have in six years produced goods valued at $5,641,000. They have earned wages of $2,982,000. Their company has paid $450,000 in taxes and $1,983,000 in insurance, rehabilitation expenditures, public education.

During this same six year period, it would have cost $1,640,000 to have maintained these people on public relief rolls. If we add this saving to the value of goods produced, wages paid and other expenditures, we have a total of $12,690,000 in new wealth they have added to the community.

Economically this is decidedly good business.

More than this is necessary in our opinion. From this experience must come a new pattern of knowledge about the disabled worker. This group of disabled workers representing every known general category of progressive and static illness, represents a priceless laboratory where studies can be made. Cardiacs, paraplegics, epileptics, amputees are here gathered under competative working conditions.

To study what is happening to them, a second corporation, Human Resources Corp., was created. This group of scientists is engaged in a long range series of medical, psychosocial and engineering project studies. They are also actively engaged in a continuing teaching program to disseminate this experience as it is gathered.

There is yet a great deal to be learned about the disabled worker and how he will relate to the complex equipment and machinery of the current and future industrial era. There is much to learn about specific disease categories, psychosocial and emotional problems.

This paper is added to the growing data of Human Resources Corp. research studies which, one day, may help us establish that there are really no disabled workers, but only workers with varying degrees of ability, not disability.

Medical Research in the Disabled Worker

There are multiple avenues of approach in research programs relating to the disabled worker. In order to logically evaluate any such studies, a definate methodology has been outlined and followed at Abilities Inc.

A. General history and physical examination, which includes routine laboratory procedure, *i.e.*, complete blood count, urinalysis and chest x-ray.

B. Detailed evaluation of specific disability with an evaluation of present functional capacity.

C. Natural history of present disability and its complications.

D. Variations from natural history.

General classification of disability has been listed as follows:

A. Neurological
B. Traumatic Deformities
C. Peripheral Vascular Diseases
D. Cardiacs
E. Arthritic Disease
F. Auditory Defects
G. Infectious Diseases
H. Congenital Deformities
I. Speech Defects
J. Visual Defects
K. Allergic Disturbances
L. Geriatric Group

Each disability under the general classification has been further subdivided.

A. Neurological

1) Cerebral Palsy
2) Dystonia
3) Epilepsy
4) Erbs Palsy—congenital or acquired
5) Multiple Sclerosis
6) Anterior Poliomyelitis
7) Cord Injuries
8) Parkinson's Disease
9) Guillain-Barre Syndrome

B. Traumatic Deformities

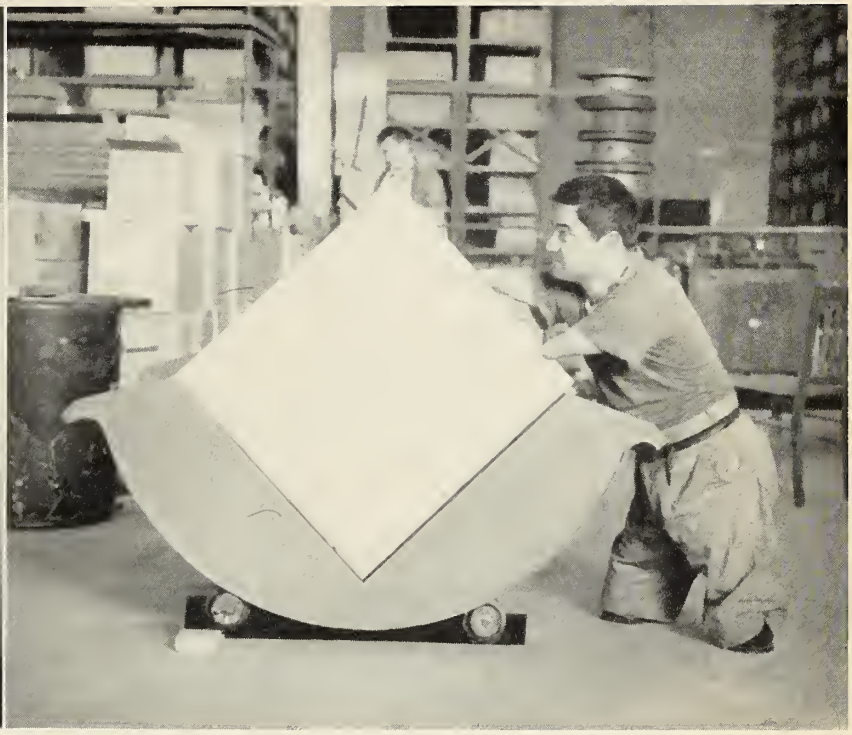
Range from destroyed digits to bilateral amputations

C. Peripheral Vacular Disease

1) Buerger's Disease
2) Arteriosclerosis and Diabetic endaritis
3) Hemiplegia



BORN A quadrilateral amputee, this man graduated from high school and took some college work. He is completely self-sufficient.



HE SOLD papers for 16 years, then was unemployed until Abilities, Inc., gave him opportunity to prove himself. Now he is a capable packaging department supervisor, drives a modified car, is married and a father.

D. Cardiac

1) Rheumatic Heart Disease
2) Arteriosclerotic Heart Disease—Coronary Artery Disease
3) Hypertensive Heart Disease
4) Congenital

E. Arthritic Disease

1) Rheumatoid—both peripheral and spinal
2) Osteoarthritis
3) Arthritic deformans

F. Auditory Defects

1) Congenital
2) Acquired—oto sclerosis, infected, traumatic

G. Infective Disease

1) Tuberculosis (Pulmonary)
2) Osteomyelitis
3) Bronchiectasis and Emphysema

H. Congenital Deformities

Range from extensive structural defects to mildly deformed extremities

I. Speech Defects

1) Dumb
2) Severe stammering and stuttering

J. Visual Defects

1) Acquired—infection, traumatic, metabolic
2) Congenital

K. Allergic Disturbance

1) Asthma (disabling with emphysema)

L. Geriatric Group

It is to be noted that many employees in this group also could be placed in several of above categories and should rightly be classified as multiple disabilities.

Three hundred employees have been evaluated in the past several years and the accumulated data is now being correlated. The Cardiac Group has already been published[1] and the findings at Abilities have been corroborated by many others.[2,3] The beneficial effects of industrial activities in the (dread) traumatic paraplegic and the finding that he is a safe, competent worker will be published soon.[4]

A medical and psychosocial investigation of a so-called completely disabled worker will serve as a typical case report.

Case History

Born with congenital absence of both forearms, elbows, hands, both legs and feet, but with a right knee joint and immature toes. There was complete absence of knee joint on the left. This man is perfectly normal in every other respect. Walks on stumps enclosed in leather casings and is able to perform all activities of daily living. Attended primary and high school in the usual manner and, although this employee had several minor jobs, *i.e.,* selling papers, this is his first real job. The arm stumps are tapered so that the man can grasp objects in both stumps with great facility.

In 1953, surgical amputation of the toe vestiges was accomplished and an attempt was made to fit him with artificial legs. After much training, it was found that the prosthesis caused too much irritation of the stumps and in 1954, he developed a sarcomatous wart on the left stump. This was removed and he was told to use his leather boots only. He has become very proficient in the packaging department and now is foreman of the section. His general health is excellent and there has been no absenteeism due to illness except during the time of the surgical restorative attempt. He has never had any compensable accidents since employed at Abilities.

The photographs will give you visual summary of this very capable man.

Psychological Study

Although born a quadrilateral amputee, this person has managed to make a very superior adjustment to life. He went through grammar school and high school and even took several college courses. He is completely self sufficient, able to dress, feed himself, etc. At present, he drives his own car to and from work, after having made adaptations in the car so that it could be operated by a quadrilateral amputee.

After high school, he sold papers at a newsstand for 16 years, and then was unemployed for 1½ years. At present, he is very successfully performing the job of supervisor. Psychological test scores indicate that the subject shows average adjustment in his attitude toward work and his attitude toward disabled persons. He scored very low on the test for anxiety, indicating self acceptance and lack of worry either about his physical condition or his psychological status. The adequacy of his adjustment is attested by the fact that he married several years after coming to Abilities and now has a 2-year-old daughter.

Comment

The above case demonstrates that even the severely handicapped can, with proper training and motivation, perform as competently and reliably as the nondisabled with benefit to himself, industry, and the community.

Drs. T. J. Doyle and R. J. Murray,[5] in an article entitled, "The Chronically Ill Are Employable," succintly summarized the changing medical philosophy in industrial employment of the handicapped as follows: "Today the industrial physician must adopt a more enlightened view of the physical capacity of the employee or candidate for employment in terms of ability to perform a specific job assignment. Competency need not be measured in terms of anatomic perfection. Similarly, the chronically ill are to be evaluated according to current physiological and functional concepts of medicine. Although physically or medically disabled, the individual is rarely vocationally handicapped."

ACKNOWLEDGEMENT

We wish to thank Miss Mary Kotsay and Mrs. Loretta Farley for their technical and clerical assistance in preparing this article.

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Actifed, A Combination of Pseudoephedrine With an Antihistamine In the Symptomatic Treatment Of Resistant Allergic Rhinitis

SAMUEL M. FEINBERG, M.D.
ALAN R. FEINBERG, M.D.
ELMER W. FISHERMAN, M.D.

Chicago

THE antihistamines have been disappointing in many instances of nasal allergy. This is particularly true of the very severe cases of hay fever, and of the boggy intumescent condition of the nasal mucosa in the latter stages of this allergy and in perennial allergic rhinitis. The advent of more potent antihistamines has not solved this problem. It is true that in such cases temporary relief can be obtained by topical application of vasoconstricting solutions, but the penalty of rebound action, resulting in increased swelling of the nasal structures, limits their usefulness.

The use of ephedrine orally in conjunction with an antihistamine has been of some help, although the undesirable symptoms induced by the dose required to produce the vasoconstricting effect have often limited this therapy. The combination of cyclopentamine hydrochloride with an antihistamine has been useful in a large number of cases of stuffy noses. The lack of effectiveness in many or overstimulation in others with this combination has spurred the search for a more satisfactory agent.

D-pseudoephedrine is an optical isomer of l-ephedrine (the usual ephedrine product employed in the therapy of asthma). Pseudoephedrine has been found to produce less pressor effect than ephedrine in the laboratory animal and in man.[1,2,3] It also produces less cerebral stimulation than ephedrine, and induces coronary artery dilatation,[4] whereas ephedrine is contraindicated in coronary insufficiency. The first experimental work with pseudoephedrine was reported by Chen in 1927.[1] In the next three decades several reports on its clinical effects have been published.[5,6,7]

About 3 or 4 years ago we began to employ pseudoephedrine* in difficult cases of allergic rhinitis and found it helpful in some instances where the antihistamines were not effective. Earlier we had put to clinical test the antihistamine triprolidine hydrochloride, known chemically as trans-1-(4-methylphenyl)-1-(2-pyridyl)-3-pyrrolidino-prop-l-ene hydrochloride.

This antihistamine has been found to be potent by European investigators.[8,9,10,11] Given in doses of 2.5 mg this drug** was found by us to compare favorably with other antihistamines, had a duration of effect lasting 6 to 12 hours, was tasteless, and had only moderate sedative effects. However, as expected, and in common with other antihistamines, it failed in the stubborn types of cases under discussion. When pseudoephedrine was combined with the antihistamine, the combination was found to be effective in a significant percentage of the stuffy noses usually not responsive to antihistamines alone and often not yielding to pseudoephedrine alone.

Results

The usual dose used was a combination of 60 mg of pseudoephedrine with 2.5 mg triprolidine hydrochloride.*** This was combined in tablet form and administered as needed and no oftener than 3 times daily. The majority of both children

* Kindly supplied as "Sudafed" by Burroughs, Wellcome and Co.

** Kindly supplied as "Actidil" by Burroughs, Wellcome and Co.

*** Supplied as "Actifed" by Burroughs, Wellcome and Co.

TABLE I

Results in 287 Cases of Allergic Rhinitis in Phases Resistant to Antihistamine Therapy.

	SEASONAL HAY FEVER					NONSEASONAL RHINITIS					
	Total	Excellent	Good	Fair	Poor		Total	Excellent	Good	Fair	Poor
Children	76	35	9	6	26	Children	70	10	21	18	21
Adults	61	31	12	5	13	Adults	80	13	14	27	26

and adults took a whole tablet at each dose, while only a few took ½ tablet doses. It was also available in the form of a syrup preparation. It was tried in a series of cases, the majority of which failed to respond to antihistamines. The cases included very severe types of hay fever, and hay fever and perennial rhinitis in the stuffy, obstructive stages.

Those patients responding well to the usual antihistamine therapy were not subjected to a therapeutic study with this medication.

The results are listed in Table I. Of the 76 children with seasonal hay fever not responding well to the usual medication, 35 had excellent results and nine good, making a total of 44 with satisfactory results. Of the 61 adults (those 15 years or older) 43 had satisfactory results. In the nonseasonal antihistamine-resistant group 31 out of 70 children and 27 out of 80 adults had satisfactory relief.

TABLE II
Side Effects

	Percent
Sedation	23 - 8.0
Stimulation	4 - 0.14
Nausea	2 - 0.07
Tachycardia	2 - 0.07
Children	- 14 out of 146
Adults	- 13 out of 150

The side effects are outlined in Table II. Of the 287 patients treated, 27 had side effects with a total of 31 complaints. Sedation, usually not marked, was present in 23, stimulation in 4, nausea in 2 and tachycardia in 2. Side effects were about equally divided between the children and adults, although no children had side effects from ½ tablet doses.

Summary

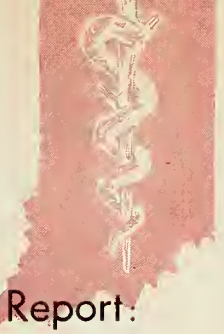
A combination of pseudoephedrine and antihistamine (triprolidine hydrochloride) was found to be effective in a significant percentage of cases of seasonal and nonseasonal allergic rhinitis failing to respond to antihistamines alone.

Since this manuscript was prepared, treatment with this compound of an additional 178 patients with seasonal hay fever indicates that the incidence of effective relief in difficult cases was even greater than that listed in Table I.

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Report of a patient with gonadal dysgenesis and diabetes mellitus currently receiving therapy in the Gynecological Endocrinology Section of Indiana University Medical Center.

A Case Report:

Gonadal Dysgenesis

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IN 1938, Turner[1] described a syndrome composed of the triad, webbed neck, cubitus valgus and sexual infantitism. He ascribed the condition to an absence of pituitary hormones. Subsequent investigation[2,3] has indicated that the syndrome is associated with gonadal dysgenesis rather than failure of the pituitary gland to secrete tropic hormones. Turner[4] has given the salient features in detail. Among these is congenital ovarian failure, the result of congenital ovarian aplasia which need not be complete. Genital hypoplasia is invariably present with infantile vagina, uterus, breasts; absence to sparse pubic and axillary hair, and primary amenorrhea. These patients are of short stature—48 to 56 inches. Other features encountered are cubitus valgus and webbed neck; eye disorders; aberrations in body build with the upper measurements being greater than the lower; and miscellaneous abnormalities such as coarctation of the aorta, Madelung's deformity, syndactylism, spina bifida, cleft palate and urinary tract malformations. They may acquire the symptoms of hypertension and osteoporosis.

The following case of gondal dysgenesis illustrates several features common to this disorder. Of additional interest is the associated diabetes mellitus.

Case Report

A 21-year-old, white female was referred to the clinic in January, 1959, with the chief complaint of never having had a menstrual period. Her childhood had been perfectly normal with the exception of the failure to attain adequate stature. Her siblings and parents were of normal height, but she was much shorter. At the expected time of menarche, not only did she fail to menstruate, but in addition, her breasts did not mature.

Six months prior to examination at the Indiana University Medical Center, a diagnosis of diabetes mellitus was made elsewhere following the complaints of polydipsia, polyphagia and polyuria of several months duration. Since then she has been taking 30 units of NPH insulin daily. The only other serious illness was bilateral pneumonitis as a small child. She had been married for 18 months and enjoyed a normal and happy marital life.

Her blood pressure was 114/64 in the right arm and 110/68 in the left arm. The breasts contained adipose tissue, but no palpable glandular tissue. The areola were pale pink, smooth and shiny. Almost no axillary hair was present, and the pubic hair was sparse. The height was 55 inches and her general physical appearance is demonstrated in Figure 1. On pelvic examination, the clitoris, vagina and introitus were hypoplastic. The cervix was small and pale pink. Bimanual examination revealed an extension of tissue above and connected to the cervix, and nothing could be palpated in the adnexae.

The following laboratory reports were obtained. The fasting blood sugar was 310 mg%, a normal total cholestrol of 143 mg%, a negative blood serology, a normal protein bound iodine

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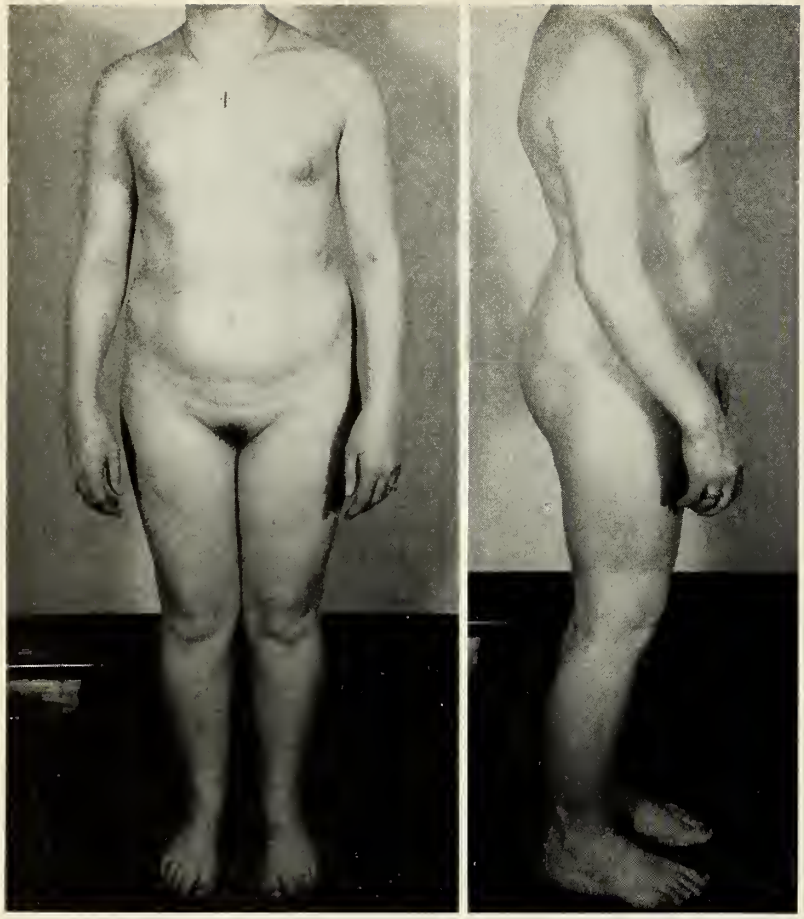


FIGURE 1
General Physical Appearance

of 7.0 gamma%, and normal 17 ketosteroids of 11.18 mg/24-hour urine specimen. The urinary gonadotropin test was positive for the three hour specimen and negative for the one hour specimen, which is normal. The hemogram and urinalysis were within normal limits.

An intravenous pyelogram revealed a horseshoe kidney as shown in Figure 2. A PA chest film revealed an abnormality in the right chest, but upper GI series, a small bowel series and cardiac fluoroscopy demonstrated a pleural thickening which probably is a result of the pneumonitis the patient had as a small child. Bone survey films revealed the bone age to be compatible with that of a 14-year-old girl.

A low maturation index of the vaginal smear indicated estrogen deficiency, and the buccal smear showed a female chormosomal sex pattern.

The patient was started on one milligram of stilbestrol every day in an attempt to accentuate the secondary sexual characteristics. A follow-up visit on May 23, 1959, revealed the breast changes as shown in Fig. 3. The breasts were larger and the areola were darker. Hair growth had started in the right axilla, and was increased in amount over the mons pubis. The uterine fundus was easily palpable, and the vagina was more pliable and had more folds.

The patient had started spotting vaginally May 5, and this persisted in spite of an increase in the stilbestrol. Consequently, estrogen and progesterone therapy was started for one cycle to shed the endometrium and following this, the daily estrogen doses will be reinstituted for an indefinite period.

Discussion

This is a rather typical case of gonadal dysgenesis except that there are not many associated congenital abnormalities, and in addition, the patient has diabetes mellitus.

Following Turner's original observations, Wilkins and Fleischmann[5,6] in 1944, stated that they felt that the stunted growth was due to an associated germinal or genetic defect and could not be accounted for by an endocrine deficiency. They also felt it was probable that at times the development of the ovary may reach a more ad-

vanced stage than that of the genital ridge before becoming arrested.

Polani[7] and his associates in 1954 noted the high incidence of coarctation of the aorta in gonadal dysgenesis. Since in the general population coarctation is more common in males, he reasoned that perhaps these patients were really chromosomal males. Sun and Rakoff[8] demonstrated that the majority of them were chromosomal males by the use of peripheral blood smears.

Hoffenberg[9] in 1957, presented 27 cases of gonadal dysgenesis, providing an excellent discussion and the largest series to date. He particularly points out the relative infrequent occurrence of the classical congenital anomalies described in textbooks.

The etiology of the syndrome is still obscure. Ingalls[10,11,12,13] performed many interesting experiments in which laboratory animals were subjected to a specific stress during a critical stage of gestation, followed by reproducable congenital anomalies. The complexity of the problem has been noted by Jost.[14] Fetal endocrinology is complicated by the rapid transformations, the precocious "determination" of some embryonic receptors, and the multiplicity of possible hormone sources—the fetus, mother and the placenta.

Several studies[15,16] are now under way attempting to determine if there is some stress factor present in the prenatal course of the mothers of infants that are afflicted with congenital defects. These may ultimately show that many defects previously thought to be genetic in origin, may in reality be due to prenatal environmental factors. This, we hope, will result in some practical means of prophylaxis.

Acknowledgment: I wish to acknowledge the counsel of Richard Stander, M.D.

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FIGURE 2

PYELOGRAM revealed horseshoe kidney.

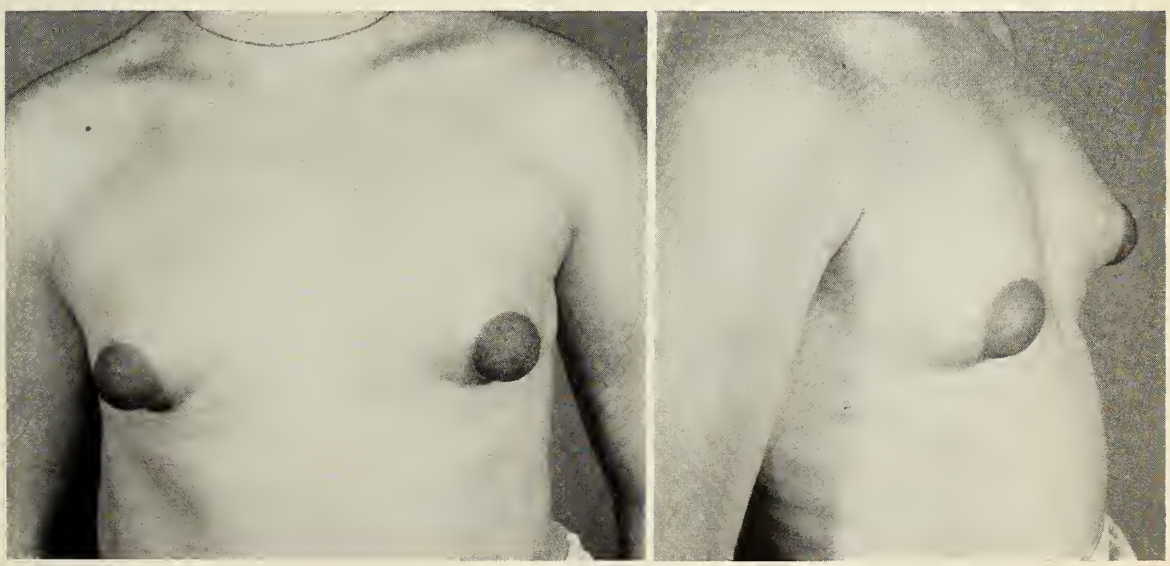


FIGURE 3

BREAST CHANGES on follow up visit. The breasts were larger, the areola darker.

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To Be a Writer—Write!

An emotional problem which all writers must face and overcome is called "writer's block." He is tempted not to write. He makes all sorts of alibis to himself and others to avoid writing. He has other duties or he feels terrible, or he must do more research, or the environment is wrong.

"No one can write under these circumstances," the writer says. "If I could just go to a little cabin in the mountains to write." To such a remark, a seasoned writer retorted, "I always go to the typewriter to write. Excellent writing has been done in front-line trenches, in jails, in hospitals, in railroad stations, in bars, in monasteries and on ships at sea . . . To be a writer, one must write."

Ed Andreopoulos
"The Ink-Stained Way of Life"
Public Relations Journal
Sept. 1959



Up-to-date knowledge concerning hemoglobins and hemoglobinopathies is reviewed in terms of their discovery, incidence, identification, nomenclature and clinical as well as hematologic manifestations. Diagnoses and treatments of the hemoglobinopathies are briefly discussed.

Hemoglobins and Hemoglobinopathies

*WEI-PING LOH, M.D., Ph.D.**

Gary

HEMOGLOBINOPATHY is a subject of recent decade and has gained increasing importance in clinical medicine. It is the purpose of the present communication to give a pertinent review of the up-to-date knowledge concerning various types of hemoglobins and the diseases or syndromes caused by the abnormal hemoglobins.

Hemoglobins: Discovery And Incidence

Differences in the hemoglobins of the normal adult (Hb-A) and the newborn (Hb-F) have been recognized since 1866.[1] Rapid advances in the discovery of various types of hemoglobins actually began in 1949, when Pauling *et al*[2] identified hemoglobin S in sickle cell anemia, using the technic of electrophoresis. Since that time, at least 14 different types of hemoglobins have been identified. A summary concerning these hemoglobins and their combinations and racial distributions is presented in Table I.

A few additional types of hemoglobin are still not clearly classified. Among these are abnormal fetal hemoglobin reported by Fessas and Papaspyron in 1957,[26] Hopkins I and II types reported by Smith and Torbert in 1958[27] and Bart's hemoglobin reported by Ager and Lehmann in 1958.[28]

Hemoglobins: Nomenclature and Confusion

The existing system is to designate the capital letters A for normal adult, F for fetal and S for sickling hemoglobin, and consecutive letters of the alphabets for either abnormal types in order of their identification. The system is defective in view that only 26 letters of the alphabet are available and the total number of hemoglobins may go beyond that figure in the future. There has been confusion in the literature that several types of hemoglobin were reported under the same name of hemoglobin or a single type of hemoglobin was described under several names. One of the examples is that the present hemoglobin K was previously called hemoglobin I, and then hemoglobin J, for the reason that the authors did not realize that letters I and J had been previously designated to other hemoglobins. Confusion may also arise from the difference in electrophoretic mobility of the same hemoglobin in different buffer and at a different pH.

Hemoglobins: Identification

The various types of hemoglobins have been identified and separated by means of electrophoresis, chromatography, spectroscopic examination and analysis of their amino acid contents with or without supplementary measures based on their differences in solubility, resistance to denaturation by alkali, immunologic specificity, etc.[29] The single procedure commonly applied is electrophoresis, in form of moving-boundary electrophoresis (Tiselius), paper electrophoresis or zone electrophoresis using starch gel or agar as supporting medium. Most of the hemoglobins have difference in their electrophoretic mobility. A schematic diagram of their electromigration on paper strips (paper electrophoresis) is presented in Figure 1.

As shown in the Figure 1, paper electrophoresis of the hemoglobins at pH 8.6 does not permit clear distinction between hemoglobins S and D, I and H, F and G, A or K and J. It

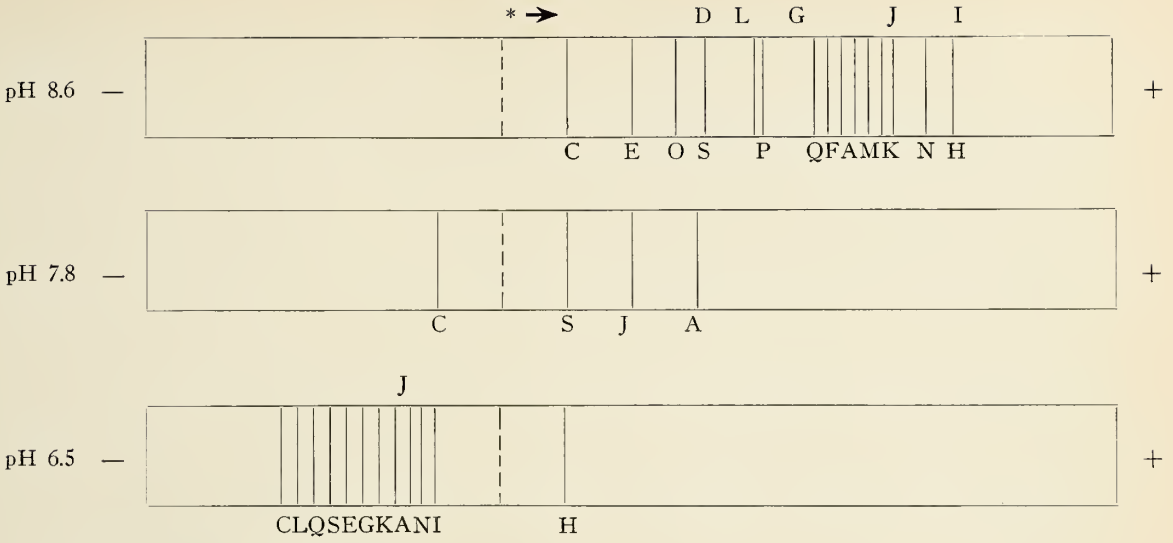
* Pathologist, Methodist Hospital of Gary, Gary, Indiana; Associate in Pathology, Chicago Medical School, Chicago 12.

TABLE I

Discovery and Incidence of Human Hemoglobins

HEMOGLOBIN TYPE	DISCOVERY		RACIAL DISTRIBUTION	COMBINATIONS WITH OTHER HEMOGLOBINS
	Year	Authors		
Hb-A	—	—	Present in normal adults of all races.	See below.
Hb-S (B)	1949	Pauling *et al.* (2)	Highest incidence in Africa. Found in 9-10% Negro population in U. S. Also found in Portugal, Italy, France, Turkey, Arabia, Persia, India, Indonesia, etc.	A+S, C+S, D+S, E+S, G+S, A+S+F, G+S+F, S+S, etc.
Hb-C	1950	Itano & Neel (3)	Chiefly in West Africa (up to 25% population). Found in about 2% Negroes in U. S. Also found in Dutch Guiana and South America.	A+C, C+C, S+C, A+C+F.
Hb-D	1951	Itano (4)	Rather rare. Found in about 3% in the Sikhs in Punjab and 1% in Gujaratis (India). Also found in Persia, Turkey, North African Whites, England and U. S. A. (0.05%).	A+D, D+D, S+D.
Hb-E	1954	Itano (5)	Found in northeast Malaya (up to 15%), Siam (10-15%), Burma (10-15%), India, Ceylon, Indonesia, Java, etc.	A+E, E+E, S+E, A+E+F.
Hb-F	1866	von Körbor (1)	Found in 60-80% of hemoglobin in newborns. No appreciable amount detectable after 6 months after birth. Small amount also found in normal adults and increased amount found in pernicious anemia, sickle-cell anemia, Cooley's anemia (20-95%), Hb-C disease, etc.	A+F, A+S+F, A+C+F, A+E+F, G+S+F.
Hb-G	1954	Edington *et al* (6)	Found in one family on the Gold Coast and in one Italian family (7).	A+G, G+G, G+S+F.
Hb-H	1955	Rigas *et al* (8)	Found in China, Phillipines, Siam, Malaya, Greece, Arabia, Indonesia and Singapore.	A+H
Hb-I	1955	Page *et al.* (9, 10)	Found in only a few cases in the U. S. A. and Algiers.	A+I
Hb-J	1955 1956	Thorup *et al* (11)	Found in Negro family in the U. S. A., families in Indonesia, India, etc. ? identical with Liberian I type.	A+J
Hb-K	1956	Cabannes *et al* (12, 13, 14, 15, 16)	Found in Berber families in North Africa, ? identical with Liberian II type.	A+K
Hb-L	1957	Ager *et al* (17)	Found in one family of Hindu ancestry.	A+L
Hb-M	1948	Horlein & Weber (18, 19)	Found in German families. Associated with cyanosis.	A+M
Hb-N	1956	Robinson *et al* (20, 21)	Found in West Africa, ? identical with Liberian I.	A+N
Hb-O	1956 1958	Eng (22, 23)	Found in more than 1% of Buginese (Indonesian Island).	A+O
Hb-P	1957	Schneider & Haggard (24)	Rather rare. Confused with Primitive Hemoglobin P and ? identical with Galveston type of hemoglobin.	A+P
Hb-Q	1958	Vella *et al* (25)	Found in a Chinese in Singapore.	A+Q, H+Q.

FIGURE 1



* Site of application of hemoglobin.

Fig. 1 Electromigration of Hemoglobins on paper strips

is therefore necessary to perform the test with several different buffers at pH 7.8, 6.5, etc.[30] The possible separations of the other hemoglobins by the same mechanism are clearly illustrated in the figure. The hemoglobin F is relatively easy to be identified and separated from the other hemoglobins on basis of its high resistance to denaturation by alkali. The hemoglobin S is relatively insoluble and has its specific "sickling effect." Under oxygen-unsaturated state the Hb-S molecules form long chains resulting in birefringent tactoids and distortion of the red cell membrane (sickling effect). The red cells usually fail to show sickling if less than 7% of their hemoglobin is in form of hemoblobin S. However, the small amount of hemoglobin S can be identified by means of electrophoresis. The electrophoretic pattern of the hemoglobin in Cooley's anemia (thalassemia) resembles a mixture of hemoglobin A and hemoglobin F.

Hemoglobinopathies

Many people possessing abnormal hemoglobins, especially under the trait state, are asymptomatic and deserve little attention clinically. The two symptomatic and most frequently encountered diseases are sickle-cell disease (anemia and trait) and Cooley's anemia (thalassemia major and minor). The clinical pictures of these conditions are well known and will not be discussed in detail. The conditions of next importance usually include hemoglobins C, D, E and G and their combinations with thalassemia or hemoglobin S.

A. Heterozygous Normal—Abnormal Hemoglobin Combinations (Abnormal Hemoglobin Traits)

1. *Hemoglobin S Trait (AS):* The patients usually have no significant clinical findings. They may occasionally show hematuria or hyposthenuria. The red cells show sickling phenomenon and 5 to 50% of their hemoglobin content is in form of hemoglobin S. Hemoglobin F is usually not elevated. A few target cells (4%) may be seen in the peripheral blood smear.
2. *Hemoglobin C Trait (AC):* Affected individuals are usually asymptomatic. The average concentration of the hemoglobin C in their blood is 35% (range: 28-44%). Their peripheral blood smears may show slight hypochromia and a definite increase in target cells (3-33%).
3. *Hemoglobin D Trait (AD):* The hemoglobin D content is usually less than 50% of the total hemoglobin. There are no significant hematologic or clinical abnormalities.
4. *Hemoglobin E Trait (AE):* Affected individuals are usually asymptomatic and the hematologic findings are often normal save

for occasional target cells (2%) in the blood smear. The hemoglobin E content is always above 20% and is frequently associated with thalassemia.

5. *Hemoglobin G Trait (AG):* The affected individuals are usually normal, showing no hematologic or clinical abnormalities. Schwartz and co-workers[31] have recently presented evidence suggesting that Hb-G may be a normal variant of hemoglobin rather than an abnormal type of hemoglobin.

6. *Hemoglobin H Trait (AH):* The reported cases showed hypochromic microcytic anemia refractory to iron therapy, reticulocytosis, increase in target cells, splenomegaly and decreased osmotic fragility of the red cells which often show inclusion bodies and shortened survival resulting in hemolytic anemia. The picture may resemble thalassemia minor. The hemoglobin H accounted 35 to 40% of the total hemoglobin. Fetal hemoglobin was slightly increased.

7. *Hemoglobin I Trait (AI):* The reported cases were asymptomatic and showed no hematolgic abnormalities save for slight increase in target cells (2% or less) and an unexplained lymphocytosis in one case. The Hb-I accounted 20% or less of the total hemoglobin.

8. *Hemoglobin J Trait (JA):* The reported cases in Negro family showed no clinical and hematologic abnormalities. The hemoglobin J accounted approximately 60% of the total hemoglobin. This feature is unique in view that other abnormal hemoglobins, unless associated with other erythrocytic abnormalities, rarely comprise even 50% of the total hemoglobin when in combination with hemoglobin A.

9. *Hemoglobin K Trait (AK):* Affected subjects may be asymptomatic or show hypochromic anemia. The incidence of this abnormal hemoglobin is very low.

10. *Hemoglobin L Trait (AL):* The subject reported in the original study of Ager and Lehmann[17] showed nothing remarkable in his blood picture excepting a slight eosinophilia. The osmotic fragility of his red cells is within normal limits. Twenty-eight per cent of his hemoglobin was found to be hemoglobin L.

11. *Hemoglobin M Trait (AM):* Affected subjects usually show familial cyanosis in the absence of increased amounts of reduced hemoglobin or methemoglobin. The Hb-M was found to comprise approximately 30% of the total hemoglobin in the recently reported case.[32]

12. *Memoglobin N Trait (AN):* The reported cases (20) were apparently asymptomatic and showed mild anemia with hemoglobin level between 10.4 gm% and 13.6 gm%. No cytologic abnormalities were noticed.

13. *Hemoglobin O Trait (AO):* The affected subjects[22,23] showed slight anemia, very slight anisopoikilocytosis, rare target cells and an increased resistance of the red cells to hypotonic saline. The abnormal hemoglobin was present in low concentration.

14. *Hemoglobin P Trait (AP):* The original case "MTu" reported by Schneider and Haggard[24] was a Negro obstetric patient who showed two major fractions in her hemoglobin—one fraction found to be identical with Hb-A and another fraction found to be overlapping with Hb-G and extending toward Hb-S (thus resembling Hb-L). The patient's clinical and hematological history is not contributory. Her son was found to possess hemoglobin of Galveston type.

15. *Hemoglobin Q Trait (AQ):* The case reported by Vella *et al*[25] is the mother of a young Chinese having Hb Q-H disease. She showed about 60% of Hb-A, about 40% of Hb-Q and a very small amount of Hb-F. There was slight to moderate degree of hypochromic anemia. The patient was asymptomatic.

B. Homozygous Abnormal Hemoglobin Combinations (Abnormal Hemoglobin Diseases)

1. *Hemoglobin S Disease (SS, Sickle Cell Anemia):* The picture of sickle-cell anemia is well known to medical profession. For comparison with hemoglobinopathies due to other abnormal hemoglobins the essential features of sickle-cell anemia are presented in Table II which represents a modification of the table in a previous presentation.[33]

2. *Hemoglobin C Disease (CC):* More than 24 cases have been reported, all in Negroes with but two exceptions in Caucasians. The important features are mild hemolytic anemia,

marked increase in target cells (40-100%) and the present of intraerythrocytic crystals.[34] The red cells are normocytic or slightly microcytic, slightly hypochromic and fail to show any sickling. They show a decreased osmotic fragility but a shortened survival. Splenomegaly (moderate or marked), elevated bilirubin and increased reticulocytes are commonly seen if anemia is severe enough. The prognosis is generally good.

3. *Hemoglobin D Disease (DD):* The patient reported by Chernoff *et al*[35] was a Negro with some white English and American ancestry. There was no anemia but the erythrocyte survival time was somewhat shortened. The patient also showed increase in target cells, slight hypochromia and microcytosis and moderate erythroid hyperplasia of the bone marrow.

4. *Hemoglobin E Disease (EE):* The reported cases showed a mild microcytic normochromic or hypochromic anemia, increased numbers of target cells (25-60%), decreased osmotic fragility and a normal or slightly hyperplastic bone marrow. There was no subjective evidence of increased erythrocyte hemolysis. Splenomegaly, arthralgia and easy fatigability were inconsistent findings. The red cells may contain increased amount of Mb-F (up to 6.4%).

5. *Hemoglobin G Disease (GG):* Affected subject is usually free from clinical and hematologic abnormalities.

6. Individuals with homozygous abnormal hemoglobin combinations other than those just discussed have not been reported or clearly studied.

C. Heterozygous Double Abnormal Hemoglobin Combinations

1. *Sickle-Cell-Hb-C Disease (SC, Hemoglobin CS Disease):* The patient usually presents a mild hemolytic syndrome. The red cells show sickling, increased number of target cells (20-85%) and some hypochromia. There is slowly progressive splenomegaly (moderate to marked degree). Excessive numbers of target cells in the blood smear of a patient with a mild form of sickle-cell anemia should arouse suspicion of the coexistence of hemoglobin C (ranging from 37-67% of the total hemoglobin). The disease is second in frequency, only next to the classical sickle-cell anemia among American Negroes.[36,37]

2. *Sickle-Cell-Hb-D Disease (SD, Hemoglobin SD Disease):* The reported cases[38] were either asymptomatic or showed a mild to moderate degree of hemolytic anemia with moderate splenomegaly, slow sickling, slight microcytosis, slight hypochromia and infrequent target cells. Up to 12% fetal hemoglobin has been found.

3. *Sickle-Cell-Hb-G Disease (SG, Hemoglobin SG Disease):* The reported cases[39] showed a picture similar to that of sickle-cell trait save for absence of target cells in the peripheral blood smear. There is frequent association with thalassemia in the same family.

4. *Hemoglobin J-D Disease (JD):* This combination of abnormal hemoglobins has been found by Cabannes and his co-workers.[40] The hematologic and clinical data have not been well defined.

5. *Hemoglobin Q-H Disease (QH):* The original case reported by Vella *et al*[25] was a young Chinese who showed moderate anemia of the hypochromic type resistant to iron therapy. The peripheral blood smear showed many target cells and inclusion bodies in about 95% of the red cells. Osmotic fragility of the cells was reduced. There was no sickling. Splenomegaly and jaundice were absent. X-ray of the skull and hands showed many small radiotranslucent areas. The blood was found to contain 20% of Hb-H and 80% of Hb-Q which has a electromigration between Hb-A and Hb-L. It is not resistant to alkali-denaturation.

D. Thalassemia and Thalassemia-Abnormal Hemoglobin Disease

1. *Thalassemia (AF & AA, Cooley's anemia & trait, Mediterranean anemia, hereditary leptocytosis):* The picture of thalassemia (major and minor) is well known to the medical profession and will not be discussed here. For comparison with other hemoglobinopathies the essential features of thalassemia are included in Table II.

2. *Sickle-Cell Thalassemia Disease (SAF):* The patient usually exhibits hematologic findings similar to those in thalassemia major, *i.e.*, moderately severe hemolytic anemia, spleno-

TABLE II

Essential Findings in Hemoglobinopathies*

Hemoglobinopathy	Severity	Splenomegaly	Target cells per cent	Sickling	Hypochromia	Microcytosis	Short RBC survival
A. Hb-S Trait	+	0	4	+	0	0	0
Hb-C Trait	0	0	3-33	0	+	0	0
Hb-D Trait	0	0	?	0	0	0	0
Hb-E Trait	0	0	2	0	0	0	0
Hb-G Trait	0	0	0	0	0	0	0
Hb-H Trait	++	++	+	0	+	+	++
Hb-I Trait	±	0	2	0	0	0	0
Hb-J Trait	0	0	0	0	0	0	0
Hb-K Trait	0 or +	0	±	0	0 or +	±	0
Hb-L Trait	0	0	0	0	0	0	0
Hb-M Trait	+	0	0	0	0	0	0
Hb-N Trait	+	0	0	0	0	0	0
Hb-O Trait	+	0	rare	0	0	0	0
Hb-P Trait	±	0	0	0	0	0	0
Hb-Q Trait	0	0	0	0	+	±	0
B. Hb-S Disease	++++	0	5-30	+++	0, +	0	++++
Hb-C Disease	++	++	40-100	0	+	±	++
Hb-D Disease	0 or +	0	few	0	+	+	+
Hb-E Disease	+	0 or +	25-60	0	0, +	++	+
Hb-G Disease	0	0	0	0	0	0	0
C. Hb-CS Disease	+	++	20-85	+	+	±	++
Hb-SD Disease	0 to ++	++	±	+	+	+	++
Hb-SG Disease	0 to +	0	0	0	0	0	0
Hb-QH Disease	++	0	many	0	++	0 to +	0
D. Thalassemia major	+++	++++	10-35	0	++	++	up to +++
Thalassemia minor	+	±	+	0	±	±	up to +
Sickle-cell-Thalassemia	++	++	20-40	+	+	+	++
Hemoglobin C-Thalassemia	0 to ++	0	20-60	0	+	+	up to +
Hemoglobin E-Thalassemia	+++ or ++	++	10-40	0	+	+	++
Hemoglobin G-Thalassemia	+	0	few	0	+	+	+
Hemoglobin H-Thalassemia	+	0	±	0	+	±	+
Hemoglobin CS-Thalassemia	+	0	many	0	±	+	+
Hemoglobin SG-Thalassemia	++	++	20-40	+	+	+	++

* The table represents a modification and expansion of the table previously presented by Loh.[33]

The degree of severity in each essential finding is graded from 0 to ++++.

megaly, microcytosis, hypochromia, significant numbers of target cells (20-40%), anisopoikilocytosis and occasionally nucleated red cells in peripheral blood. The usual tests for sickling are positive.

3. Hemoglobin C-Thalassemia Disease (CA): The reported cases[41-44] showed hematologic and clinical manifestations of widely varying degrees of severity. An average picture consists of a mild hemolytic anemia without splenomegaly, slight microcytosis, slight hypochromia and increased number of target cells (20-60%). The Hb-C content varies from 29 to 90% of the total hemoglobin.

Fetal hemoglobin is not elevated. The disease affects both Negroes and white persons.

4. *Hemoglobin E-Thalassemia Disease (EF):* The reported cases[45-49] exhibited rather marked manifestations which usually begin during childhood and may cause growth retardation. Clinically pallor and intermittent jaundice due to hemolytic anemia, cardiorespiratory symptoms, hepatosplenomegaly are usual findings. Hematologically the patients usually show a microcytic hypochromic anemia, polychromasia, reticulocytosis, increased number of target cells (10-40%), few nucleated red cells and spherocytes in the peripheral blood smear and decreased red cell survival. While osmotic fragility starts in more concentrated salt solutions, fragility is usually not complete until the lowest dilutions are reached. The Hb-E may amount to 60 to 80% of the total hemoglobin and Hb-F makes up the remainder.

5. *Hemoglobin G-Thalassemia Disease (GF):* A few reported cases[36,39] showed slight microcytic and hypochromic anemia, slight reticulocytosis, slight increase in target cells and shortened erythrocyte survival.

6. *Hemoglobin H-Thalassemia Disease (HA):* The two cases reported by Motulsky and coworkers[44] showed hypochromic anemia and shortened erythrocyte survival. Their hemoglobin consisted of Hb-A, Hb-H and a very small amount of Hb-F which was not abnormally increased.

7. *Hemoglobin CS-Thalassemia Disease (CSF):* Two cases have been reported by Brown, Sprague and Kloepfer.[50] The father of the subjects had thalassemia: Hb-C disease and the mother had sickle-cell trait. The two subjects showed mild anemia, microcytosis, numerous target cells and a mild hemolytic process. Their hemoglobin consisted of hemoglobin C, hemoglobin S and a normal amount of hemoglobin F, with hemoglobin C predominating.

8. *Hemoglobin SG-Thalassemia Disease (SG):* The subject reported by Schwartz and associates[31] showed manifestations identical to those resulting from thalassemia: Hb-S disease except that Hb-S comprised only 50% of the total hemoglobin.

E. Combined Spherocytosis Abnormal Hemoglobin Disease

Sickle-cell-Spherocytosis (SA): The picture represents a combination of sickle-cell trait and hereditary spherocytosis.

Diagnosis

A definitive diagnosis of hemoglobinopathy depends on the identification of abnormal hemoglobin or hemoglobins by one and usually more of the aforementioned methods. While the clinical manifestations of most of the hemoglobinopathies are not characteristic it is essential for a clinician to have a high index of suspicion concerning hemoglobinopathy and pursue pertinent laboratory studies to confirm his diagnosis.

Treatment

The treatment of hemoglobinopathies is still far from success. Measures applied have been largely symptomatic and supportive. The hypochromic anemia is usually resistant to iron therapy. Transfusions are used only when they are necessary. Multiple transfusions may result in isosensitization and other danger. Splenectomy may be of benefit only in well selected cases such as splenic infarction, hypersplenism or certain hemolytic reactions. Steroids are of only limited and temporary value in selected cases. It is beyond the scope of this presentation to discuss the genetic aspects of the diseases and the possible control of the diseases through the genetic combinations.

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Small Trailer Occupants Warned of Gas Heater Danger

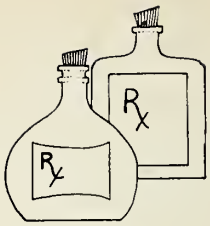
Indiana residents who own small trailer units of the type commonly used by sportsmen, and which are equipped with bottled gas heaters, have been warned by A. C. Offutt, M.D., State Health Commissioner, that "some heaters produced by the Thurm Manufacturing Company of Elkhart have proven to be defective, and should not be used until they are rendered safe for use. Those who have small type trailer units equipped with bottled gas heaters should contact the dealer who sold them the trailer, or the Thurm Manufacturing Company, for information as how to correct the defects."

Information obtained from the Michigan Department of Health indicates that eight deaths have resulted in that state, from gas released by such defective heaters. Four other persons are now in serious condition in a Michigan hospital as a result of a similar exposure.

The Indiana State Board of Health has already notified health officers in states outside of Indiana of dealers in their states who have purchased heaters, presumably for installation in the small type trailers.

Here in Indiana, approximately 30 companies received these heaters, and the majority of the companies are trailer manufacturers. State Board of Health personnel have been working with trailer manufacturers to get a complete list of the trailers which were equipped with Thurm 8M or Thurm 8MNS heaters, as well as a list of dealers to whom the trailer units were shipped.

Dr. Offutt asserted that State Board of Health staff members will work throughout the week-end to contact trailer dealers, so that they, in turn, may notify their customers of the dangers of the defective heaters. In addition, Dr. Offutt said he would ask the Indiana State Police to cooperate by stopping all automobiles pulling the small type trailer units, and advising occupants of the danger and the necessary steps to be taken to prevent illness or death.



The Case of the Upright Debauchee

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BACK in the twenties, as a young man just starting to practice medicine in the Hoosier town in which I had been reared, I was grateful for every patient trickling in even if most of them, at first, were the old chronics dissatisfied with their physicians and the habitual nonpayers of their bills. But the sight of Miss Frost marching into my little office brought me right to my feet.

Every town and even some cities of considerable size have THE recognized social leader, the bell-wether who sets the moral tone, the individual making the decisions as to which was the right side of the tracks. Miss Frost was the most durable institution of my little community. She was the daughter of a genuinely devoted divine who had fought Darwin up and down the line. His only daughter was reared in the sternest and most devout tradition of Puritan England. She had been a pillar of her church's Sunday school; she had been a staunch supporter of Frances Willard in the founding of the Women's Christian Temperance Union; she had approved of Carrie Nation wielding an axe on saloon bars; in fact, she was reputed to have done some pious labors along similar lines herself. Even the most hardened politicians blanched when they saw her bearing down into their offices; her word was gospel law in more ways than one.

She had known me since I was a little boy. I had always been overpowered by her angular, hard, positive personality. Even now, in 1925, as a grown man and physician, I still quailed—even if ever so slightly—at the very sight of that warship bearing down into my office.

She spoke to me first in that curious, clipped nasal twang of hers, "How are you, Arnold?" This was her way of reminding me that she had known me since my cradle and that now I had her permission to speak to her.

With the most deferential manner I possessed, I ushered her into my consultation room and seated her as comfortably as her bolt upright posture would permit. Having been born at the end of the Civil War, she was by that time a quite elderly spinster. Her straight face had almost veiled eyes set on each side of a thin, reddish nose that yet appeared slightly bulb tipped and had fine, rather prominent veins which I had never remembered seeing there before. The lips were a straight, uncompromising gash across her gaunt face; the hair was coiled in braids set in a bun characteristic of the Victorian Era; the neck was long, scrawny with the sagging folds of advancing years. The clothing she wore was most eminently and uncompromisingly late 19th century: obvious laced stays underneath a long cotton garment with long sleeves, high neckline and a hem almost reaching the floor. This in the era of skirts above the knees and Clara Bow dancing the Charleston!!

While she began unfolding her tale, I looked at her with a professional eye and observed that there was something quite sickly, almost cachectic about her whole being. She still looked the very image of the lady at the extreme left of the picture that Grant Wood was to paint in the next decade: The "Daughters of Revolution." But

The first of an intermittent series of case reports. Dr. Lieberman formerly practiced in Lake County, Indiana.

that was only the front, the outside shell of a decaying structure; the face was sallow, the eyes were suspiciously icteric, the voice was rather flat, the droning monotone sounded almost halting and she seemed unsure of herself seeming to search for words.

The story was superficially unexciting and vague. She had been developing gastro-intestinal symptoms chiefly. To her, everything beneath the chest was "stomach." She had been going "into a gradual decline." Her doctor had been the late Dr. Butterspout, a friend of her father's and a graduate of the old circuit riding days; a student disciple of a Civil War veteran surgeon. She had come to me because she had wanted to get the benefit of the latest medical teachings. She had become languid and absent minded; she had become "full" and had "pains in her stomach"; this, she had had regulated by pills Dr. Butterspout had given her but lately even these had become unavailing. She had been alarmed by bleeding that morning and so had come to see me. At the question "where?", a delicate flush mantled her cheeks and she pointed rather generally at the lower portion of her well concealed anatomy. Lately in addition to the fullness, some pain had been disturbing her sleep. Also, her feet had begun to swell somewhat making it difficult to get into her high-laced shoes.

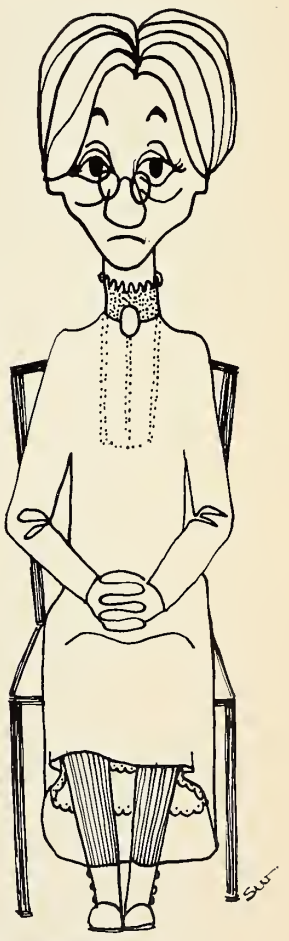
With all diffidence, I asked her to go with the nurse and disrobe. She would permit only taking off the garments above her waist and even then the examing robe was drawn tightly about her.

The nurse was able to get some additional past history. She had had typhoid and malaria in her youth; her periods had never bothered her and, besides, had ceased long ago; the bleeding now had been "from the other opening" and had been so profuse that she had almost fainted; the stools were hard, dry and she "felt lumps" when she "cleaned herself."

The blood pressure was low; the pulse quite rapid and rather feeble; the sclerae were unquestionably tinted yellowish; the hair was very scanty; the throat showed large tonsils of average appearance; the buccal mucous membranes were pale; the tongue was furred heavily; and the breath had a strong suggestion of "fetor hepaticus." The speech not only was slurred but had the rambling character and intonation so characteristic of those who have had either one too many or had had a "little stroke." The heart was small with just an insignificant hemic murmur audible at the apex only.

After much persuasion, Miss Frost permitted an examination of her abdomen. The liver edge definitely was palpable two fingers below the costal margin; it was slightly ridged and somewhat tender. The spleen could be percussed out and was questionably palpable. The abdomen was distended and there was a definite *Caput Medusae* around the navel. There was a vague sensation of an abdominal mass and ascites appeared to be present.

The suggestion of a rectal examination was beyond my courage; I definitely suspected a neoplasm and I knew that Miss Frost was very ill indeed. I desired to have some x-ray studies, blood counts, blood chemistries and, in addition, just plain old-fashioned observation seemed to be a must. After much diplomatic persuasion and vague insistence on possible dire consequences, the old spinster finally consented to enter our



". . . reared in the sternest and most devout tradition of Puritan England . . ."

hospital as a patient. She had outlived all her blood relatives but a staunch fellow cohort from the W.C.T.U. accompanied her the next morning as she was admitted by Sister Ursulina to the private pavilion.

The tests showed even more trouble than was expected; the bilirubin was high, there was gross blood in the stools and the anemia was alarmingly severe. Miss Frost consented to an abdominal tap; this showed clear fluid of low specific gravity. The blood chemistry revealed an azotemia; the urine had some albumin and casts, both hyaline and granular. Repeated enemas cleaned her out and also uncovered a whole nest of both internal and external hemorrhoids. I suspected esophageal varices; barium studies were suggestive; I did not quite dare the use of an esophagoscope.

The severity of the anemia led me to think of possible drug reactions; repeated and persistent questions elicited only the statement that she had not taken anything stronger than quinine for occasional "chills" several years previously. Repeated x-ray series of the gastro-intestinal tract showed nothing remarkable beyond a rather doubtful, incomplete filling of the cecum with a barium enema.

Just as more consultations loomed and a possible exploratory laparotomy was being considered—quite suddenly and dramatically, the whole case broke, descending at the same time from the esoteric stratosphere to the prosaic and mundane terra firma.

Several hours had been spent in x-ray looking at various films we had taken of Miss Frost's innards. That fuzzy cecum particularly gave us serious thought of exploring that region for a possible neoplasm. As I emerged from the room with all the view boxes, I encountered the Mother Superior. That fine old lady had known me for many years and now had been keeping her wise, cocked eye on my very first case to occupy the private wing.

"May I see you a minute, doctor?" she said to me quietly. Somewhat startled, I almost stammered an assent. We went to her private office and she pulled out of a drawer a gaudily labelled bottle of Triner's Bitter Wine.

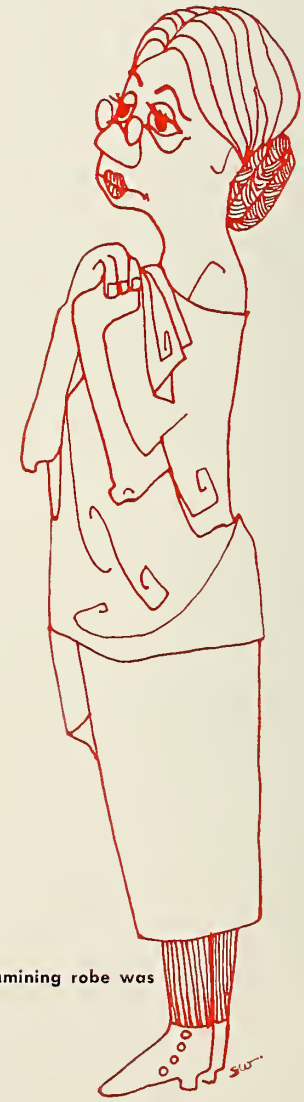
"Have you ever seen this?" she asked me—did I detect a gentle teasing in the voice of the Mother Superior?

Puzzled, I could say only that I had heard of them and that I had understood that this beverage had become enormously popular in these days of the Volstead Act; I knew that this tonic did not require a prescription but that I had never taken a close look at this medicine—much less ever recommended it.

Then I added the inevitable, "Why?"

"Well, Miss Frost has been upstairs only five days and she is on her third bottle of the—this tonic, shall we say. It is not being charted but it is being brought to her by her friend. Do you want to wait a minute while I get my glasses and we *both* read the label?"

The score or more of ingredients were printed in impressive large type. They were mostly old Galenicals and other outdated drugs of doubtful



". . . and even then the examining robe was drawn tightly about her."

value. The doses were shown in much smaller type and were so minuscule as to be truly homeopathic. Finally, in the tiniest type I have ever seen, there was printed the tiny phrase, "all dissolved in 44.6% alcohol by volume!!!"

I looked at Mother Superior mutely and then asked, almost with anguish, "Do you think she *knows* what she is taking?"

"Why not go up and ask?" We went together.

Miss Frost had just been nibbling at her supper; she appeared dull and distraught. When asked by me whether she had been taking any tonics, she answered in the negative. When shown the bottle of Triner's wine, a light of recognition shone in her face. "Oh, that! Why dear old Dr. Butterspout had told me 40 years ago to take it for scurvy; I was to take a teaspoonful of it with the juice of a lime and a little honey at bed-time."

"But, Miss Frost, why did you not tell us about it?"

"Oh, well! Dr. Butterspout distinctly told me it was not really a medicine or anything at all—still, I never *did* get scurvy. Funny thing, though; over the years, I have found that it gives me an appetite if I take it *before* meals; used to be only 50¢ a bottle and now it has gone up to $2.50 and the stuff nowadays does not taste nearly as good as when I first started buying it. I guess my taste buds are not as good as when I was younger; now I find I need a tumbler full to give me an appetite."

Miss Frost spoke as an ill woman but certainly not as one whose conscience was bothering her; both Mother Superior and I looked hard and long at her.

"One more question, Miss Frost. How many bottles of this—this scurvy preventative do you buy each week?"

"That is why I notice the price, young man; I find I need a whole bottle every third day."

This paragon of virtues, this scourge of sinners, this organizer of the W.C.T.U., this pillar of the church, this stanchion of morality, this living exemplar of primitive Puritanism was imbibing—in all innocence, it was true—but still downing a PINT of fiery liquor a day!!

Quietly, Mother Superior and I took our departures. The diagnosis, *OF COURSE,* was just, plain, prosaic Alcoholic Cirrhosis of the liver, the hall-mark of the drunkard; but who



"Do you think she *knows* what she is taking?"

was to break the news to this stern—even if badly buffeted—old Puritan? She would know on Judgment Day, yes, but who of the living mortals around her was so without sin as to dare pass judicial sentence on Miss Frost?

Mercifully, the decision did not have to be made. The next morning, she was coughing a bit and running a slight fever; in the afternoon, I could hear crepitant rales over both lung bases. The usual treatment available in those days was given but, in view of her physical enfeeblement, the result was really preordained. By the following morning, there was the typical hand flapping foretelling the hepatico-renal coma into which Miss Frost sank by noon. Osler's famous, "friend of the aged"—pneumonia—terminated the scene before the night was far advanced.

Only Mother Superior and I were aware of the Triner's Bitter Wine. Miss Frost was signed out by me as "pneumonia," which was true enough. As one of the honored pall-bearers, I can testify to her most impressive funeral. Miss Frost was buried from the church where her

father had preached and in which she had been reared.

"Everybody" who was anybody turned out; the eulogy was heart warming as her labors in various virtuous causes were extolled. In the absence of any surviving relatives, the Sunday school choir sang the several appropriate selections not forgetting "The Battle Hymn of the Republic" and "John Brown's Body." The W.C.T.U. chapter in the city (to which Miss Frost had bequeathed the half of her estate, the other going to her church's foreign missions) turned out in the full glory of its entire membership. Stores were closed along the route of the funeral cortege and schools were let out early so that children and their teachers could be present. There was not a single discordant note to detract in any remote way from the utter impressiveness and complete solemnity of the hushed service.

Miss Frost had died in an aura of total sanctity and her memory remained green for many years. However, by now those who knew her have in turn passed on one by one to their just rewards. With just a little ambiguity here and there to blur the exact locale, time and symptom —the story may be told in all safety.

A Generation of Eggheads!

In the broad area of education we need a new concept. I speak with some authority: I have seven kids in school and two at home of preschool age. I've been to dozens of PTA meetings, visited dozens of classrooms, looked at dozens of teachers. I have yet to see a poster urging scholastic excellence. I have yet to visit with a teacher whose emphasis is on excellence . . . I'd like to see every board of education and every PTA endorse a program with big posters on big bulletin boards which read something like: "It's patriotic to be an honor student," or "The cold war can be won if you get straight A's," or "If you don't aim for higher marks, you're not a good American." I say to hell with mediocrity, rock-and roll and the feeling of "belonging" by being average. Let's raise a generation of eggheads.

James F. Quinn
N. Y. advertising account exec.
Printer's Ink

The quality of man is determined by the manner in which he uses his leisure time. In our country and in our way of life, which allows for new leisure, we have a high standard of existence, but not of living. The difference between existence and life is the intelligent use of leisure.

Rev. Herman S. Hughes
John Carroll University
Quote

Report of a Case:

Benign Multiple Verbal Coincidosis

*JACK W. HICKMAN, M.D.**

Indianapolis

Report of a Case:

THE FOLLOWING case came to the attention of the author at Marion County General Hospital, and it seems to be worthy of at least passing notice. The author has made absolutely no attempt to find any previously reported cases in the medical literature, nor does he intend to.

Case Report

The patient, whose last name is WOLFE, a 64-year-old WHITE person was admitted to the hospital on February 6, 1959. Admitting diagnoses were generalized and cerebral arteriosclerosis, and PARKINSON'S disease. Physical examination, therapy, and course in the hospital are not pertinent to this report. The important finding was on the electrocardiogram, taken on April 3, 1959, which showed Wolff-Parkinson-White syndrome.

* Formerly Chief Resident in Internal Medicine, Marion County General Hospital. Resident Instructor in Internal Medicine, Indiana University School of Medicine, Indianapolis.

Discussion

Certainly physicians see an occasional case of singular verbal coincidosis. Examples of this would be a patient named Huntington who has chorea, and people who are named Graves who have hyperthyroidism, exopthalmos and goiters. Closely related to singular verbal coincidosis, but not to be confused with it are the people named Aschoff who develop rheumatic fever. Another similar group often mistaken is typified by a writer who has the arthritis, urethritis and conjunctivitis of Reiter's Syndrome.

Cases of double verbal coincidosis tend to occur less frequently. Etymologists would recognize the syndrome if our present patient had red hair and was found to have lupus erythematosis. The rarity of the present case, of course, hinges on the triple verbal coincidosis.

Summary

A case of multiple verbal coincidosis is reported, and some attention is drawn to this condition. It is hoped that no further interest is stimulated in this syndrome, since it would probably be a waste of time and lead nowhere.

625 E. 38th St.
Indianapolis

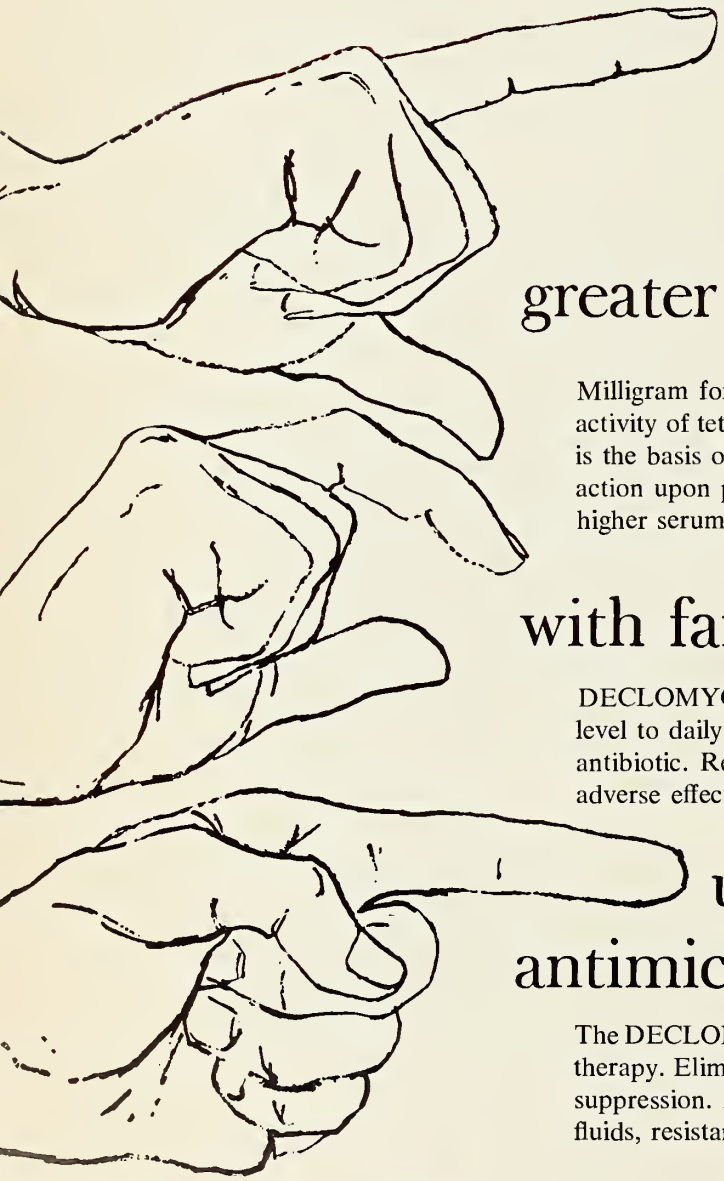
To Garner Peace of Mind

When anyone asked David Sarnoff what advice he would give to a young man just starting out on a career, the dynamic and brilliantly resourceful 68-year-old business leader and pioneer in the development of radio, television and electronics industry replied simply: "I would say to him to work and live in such a manner as to be able to serve others, to plan so as to be able to advance something, to achieve so as to leave the world a little better than he found it—and, finally, to garner for himself as much peace of mind, which is happiness, as he possibly can."

Alfred K. Allan
"The Faith of David Sarnoff"
Partners, Sept. 1959

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*Hirsch, H. A., and Finland, M.: *New England J. Med.* 260:1099 (May 28) 1959.

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A deformed colon in the new born is a remediable lesion—but must be diagnosed and treated early to insure survival.

Congenital Atresia of the Colon

ROBERT HALTER RANG, M.D.

Washington, Ind.

CONGENITAL atresia of the colon is an uncommon malformation which is rapidly fatal without successful surgical intervention. Few cases have survived, but there is hope of increasing success as the pathological principles peculiar to this condition are more widely known.

In a review of the literature of atresias of the gastrointestinal tract, Evans studied 1948 cases reported in 1353 articles. One hundred thirty nine of these were successfully treated, but only six of the successfully treated cases were in the colon. Although colonic atresia is essentially similar to ileal and jejunal atresia, the percentage of successful intervention is materially lower. Three factors contribute to these poor results:

a. A distal or low obstruction does not produce dramatic symptoms early, thus resulting in delayed diagnosis.

b. Atresia of the colon is multiple in a high percentage of cases and may be so extensive as to leave insufficient salvagable intestine for nutrition.

c. In colonic, or terminal ileal atresia there develops a distended, thick-walled, pouch which can lead to unsuccessful anastomosis if its physiological peculiaries are not recognized.

The developmental abnormalities leading to atresia occur between the 5th and 10th weeks of fetal life. During this time the formerly patent intestine goes through a solid stage and then reestablishes a lumen through coalescence of vacuoles. Atresia repesents a failure of this recanalization. The atresia may consist of a fibrous cord representing a considerable length of intestine or involve shorter segments down to a mere membranous diaphragm. Atresia is complete obstruction. If the process involves only narrowing, of whatever degree, it is called stenosis. The intestine proximal to the obstruction becomes dilated through swallowing of amniotic fluid and cellular debris. After birth swallowed air and food rapidly lead to further distension, ischemeia, necrosis and perforation. This may occur within three days. The average length of life of the untreated case is five days, and survival beyond a week is rare.

The symptoms of intestinal atresia are vomiting and abdominal distension. Vomiting in the newborn is too common to cause concern, but when vomitus contains bile and the abdomen is distended during the first day of life, the diagnosis should be considered to be intestinal obstruction due to an anomaly unless proved to the contrary. The most valuable diagnostic aid is the simple scout or plain film of the abdomen. With it the diagnosis of intestinal obstruction can be made with great accuracy. It is rarely necessary, or advisable, to use opaque medium. Farber's test for desquamated epithelial cells may be helpful, but may also be misleading if not carefully performed.

It is important to keep the infant in good fluid and electrolyte balance during the diagnostic study. The newborn infant has an amazing capacity to withstand extensive major surgical procedures. However, infants have limited reserves to maintain fluid and electrolyte balance when there is intestinal dysfunction. J. H. Lowe in reviewing 79 cases of intestinal atresia reported that the average age at operation was 5½ days, and the average survival without surgery was six days. Obviously earlier diagnosis and less procrastination will materially improve survival rates.

A statement is encountered in the literature that intestinal atresia is frequently associated with mental deficiency. R. H. Nixon, however, states that the association with mongolianism is in the duodenal atresias and not the ileal and jejunal. This is an important consideration, since the prospect of residual mongolianism might dampen a surgeon's enthusiasm.

The treatment of intestinal atresia is resection of the obstructed segment, and establishment of continuity between the dilated proximal and collapsed distal intestinal segments. The incision should be ample, and the exploration methodical. Side to side, end to side, wing, end to back, and Mikulicz types of anastomosis using one, two, or three layers of sutures have been recommended. The important factors are gentleness and accuracy, and the use of fine sutures on atraumatic needles.

In the duodenum and upper small intestine direct anastomosis gives a high percentage of success. In the distal ileum and colon one encounters a dilated, thick-walled, hypertrophic proximal pouch which does not function well when directly anastomosed to the distal collapsed segment. H. H. Nixon has demonstrated by ingenious experiments with rabbits that true peristalic waves are not present in such hypertrophic bowel until pressure is raised three times above normal values in the distal intestine. Gross has overcome this difficulty by using a Mikulicz procedure which gives the hypertrophic segment an opportunity to adjust itself. The problem may also be managed by excising the hypertrophic segment prior to direct anastomosis or by performing a proximal temporary tube ileostomy.

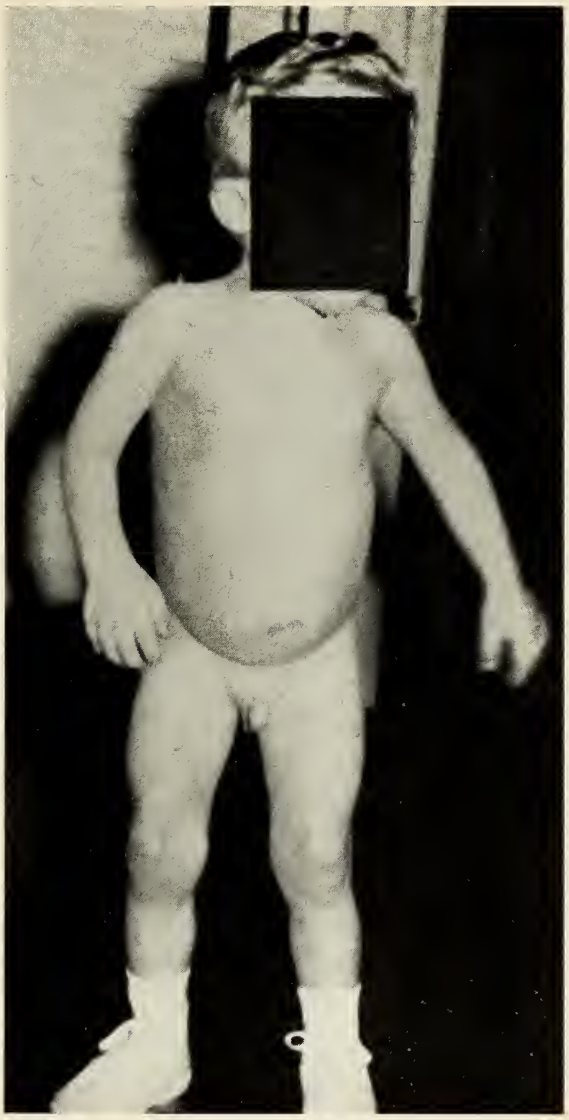


FIGURE 1

***Photograph* of case No. 1 at three years of age demonstrating good nutrition and abdominal tone.**

Case Reports

Case No. 1: Admitted to the Daviess County Hospital, Washington, Indiana on May 9, 1953.

The infant was approximately 1½ hours old and had been brought by ambulance a distance of 50 miles. The child had been born in the Obstetrical Department of the office of Doctor B. E. Sugarman of French Lick, Indiana, who observed that the intestines were on the outside. The intestines were covered with sterile towels, the baby wrapped in blankets and sent to the hospital. On arrival at the hospital, cautious examination of the intestines showed what appeared to be a congenital eventration through an umbilical defect approximately 1½ inches in diameter.

The child was taken to surgery, fastened to a circumcision board because of size, and anesthetized with open drop ether. The anus was found to be normal in appearance and to palpation by the inserted finger. Since the mesentery was so long that the intestines could fall between the legs, or onto the table at the side, they were held with sterile gloves while the abdomen and intestines were cleansed with S.T. 37, and sterile drapes were placed. A careful inspection was then made of the protruding intestines, which by this time showed a definite venous engorgement. It was discovered that the intestines were twisted through three complete anti-clockwise rotations on the mesentery, and after they were unwound the color improved markedly.

There was a congenital abdominal defect 6½



FIGURE 2

Colon x-ray of case No. 1 at age three years. The colon lacks posterior support and thus gravitates to the pelvis and lower abdomen. Several views taken at this time show complete colonic mobility.

cm in diameter below and to the right of the umbilical stump. The intestine ended blindly at the apex of the protruding mesentery, and there was a dilatation of gradually increasing diameter of approximately 30 cm of intestines which were outside the abdomen, and the last 15 cm of intestines had a diameter of approximately 5 cm. Distal to the blind end of the intestine was a fibrous cord approximately one millimeter in diameter and one centimeter long which appeared to represent that portion of the colon served by the superior mesenteric artery, for the intestine which could be identified as colon began beyond this fibrous cord and was entirely served by the inferior mesenteric artery. The colon was entirely lacking in its usual attachment to the posterior abdominal wall and hung as freely as did the small intestines, with the result that there was one continuous mesentery, and the most redundant portion of this, or the apex, served the very terminal part of the ileum and the proximal portion of the colon. The colon beyond the atresia had a diameter of approximately three millimeters, and the existence of a lumen appeared doubtful.

A hyperdermic needle was inserted into the colon and 20 cc of normal saline were introduced. This resulted in an increase in the diameter of the colon to approximately seven millimeters, and demonstrated that its lumen was patent throughout. Since respiratory embarrassment is notoriously a cause of death following the repair of large congenital umbilical hernias, and since the last 15 cm of ileum with diameter of 5 cm constituted a large part of the bulk of the extruded intestines and did not appear essential for digestion, 15 cm of the terminal ileum was excised, and the meconium was milked out of all the remaining small intestine.

An end to side ileo-colostomy was performed. The mucous membranes and submucosa were closed with a running suture of No. 000 chromic catgut on an atraumatic needle. Saline was then introduced into the ileum with a hypodermic needle until the ileum and colon between rubber clamps were distended, and it was demonstrated that the anastomosis was patent, adequate and water tight. The anastomosis was completed with a row of interrupted sero-muscular sutures of No. 0000 eye silk. The intestines were returned to the abdomen with only slight difficulty since they were of small diameter throughout following the removal of the meconium. The umbilical cord was excised, together with the margins of the umbilical defect, and a layer by layer closure of the abdomen was done. There was concern that the colon unsupported by retroperitoneal attachments would cause mechanical difficulty. Although x-rays (Figure 2) at the age of three years demonstrate continued complete colonic mobility, intestinal function is within normal limits. The child is presently alive and well at the age of five years.

Case Number 2

The infant was born in the hospital at Oakland City, Ind., two days prior to admission to the Daviess County Hospital on Feb. 16, 1957. Inspection had revealed a normal appearing anus. The absence of bowel movement and the presence of vomiting and distension led to a tentative diagnosis of intestinal obstruction. X-rays (Figure 3) combined with the demonstration of an anal pouch approximately four cm in depth led to a pre-operative diagnosis of high rectal atresia.

The child was brought to surgery and prepared in the lithotomy position anticipating an abdominal perineal procedure. A midline incision revealed a very large distended loop of blindly

ending intestine to which the appendix was attached. This was involved in a volvulus, as well as an obstruction, and was completely necrotic. This portion of the intestine was removed back to healthy ileum. The remaining small intestine was then explored and found to be rather short. All of the meconium was milked from it, and it was then possible to explore for the remaining portions of the colon. Apparently the part of the bowel which was excised represented that portion of the colon which was served by the superior mesenteric artery. Of the colon served by the inferior mesenteric artery there were only three vestigial remnants. One 2 cm x 1 mm segment appeared to represent the splenic and descending colon. Another apparently represented the sigmoid and was of the same diameter and 1 cm in length. There was in addition to that a rectal pouch extending from the perineum upward for approximately 1 cm. The two portions of colon were distended by introduction of a hypodermic needle and injection of saline solution.

It was possible in this manner to distend them to a diameter of approximately 4 mm. However, no attempt at anastomosis could be made because these portions of intestine were firmly bound against the posterior abdominal wall, had no mesentery whatsoever, and their arterial supply was extremely short. Therefore, the only action consistent with immediate preservation of life was to perform an ileostomy. The terminal portion of the ileum was brought out through the midline and the wound was closed around it.

To our amazement the child survived for three months, although it was obvious from the start that nutrition was insufficient. Shortly before death at the age of three months, the child had attained the weight of 7 pounds, 2 ounces, which was only four ounces above birth weight.

Dicussion

The evisceration in Case No. 1 was initially considered a hazardous complication; actually it contributed materially to the successful outcome of the case. In the first place it assured early diagnosis of the atresia. It also led to the resection of the dilated distal segment in order to avoid overcrowding the previously emptied abdomen. At the time we were not aware of the physiological reasons for resecting this hyperatrophied pouch even in an intact abdomen.



FIGURE 3

***The relationship* between opaque media in the short rectal pouch and gas in the intestine, with the child held feet up, led to a tentative diagnosis of high rectal atresia. Although this was incorrect, the scout film did show definite complete mechanical obstruction and led to early intervention.**

The second case represents an extreme degree of the multiplicity of lesions which is often present in colonic stenosis. It also emphasizes again the extreme importance of early diagnosis and the necessity to proceed as soon as a diagnosis of intestinal obstruction is made and the physiology of the infant adjusted.

Summary

Two cases of atresia of the colon have been presented. One of them represents successful surgical intervention; the other survived the immediate post-operative period, but there was insufficient residual intestine to support both nutrition and growth.

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The Journal of the Indiana State Medical Association

MEDICAL ESSAY CONTEST

for

Interns and Residents of Indiana Hospitals

During the intern and resident year of 1959-60 The Journal is sponsoring a medical essay contest open to interns and residents of hospitals in Indiana. The subject matter will be limited to clinical experience observed primarily in the teaching hospital of the author. Presentations may contain up to 4,000 words and preferably should be illustrated with clinical pictures, graphs or tables.

A first prize of $100.00, a second prize of $75.00 and a third prize of $50.00 will be awarded. All entries are eligible for consideration for publication in The Journal.

Manuscripts will be judged by a prize award committee selected by the Editorial Board of The Journal and by the Dean, Indiana University School of Medicine.

Manuscripts should be prepared in accordance with the specifications outlined on the masthead page of The Journal.

Entries must be submitted prior to May 1, 1960.

The manuscript itself is to be identified only by the title. The author's name must not appear in the manuscript. Instead, a special title page bearing the title and the author's name and address should accompany the paper. Mail entries to Mr. James A. Waggener, 1021 Hume Mansur Bldg., Indianapolis 4.

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS

Protein Electrophoresis

THE TERM protein electrophoresis as used in the clinical pathology laboratory refers to a test to separate the serum proteins into their various fractions. Instead of just two fractions as measured chemically by the usual albumin-globulin ratio, the albumin and at least four fractions of globulin called alpha-1, alpha-2, beta and gamma are demonstrated. In cases where abnormal proteins are present, these are usually separated as distinct additional fractions.

Since serum is used for the test, blood may be collected by the physician in his office with a dry syringe and needle and placed in a clean tube without anticoagulant as in collecting blood for a Wassermann test.

The separation is accomplished in the laboratory by applying the serum to a filter paper strip with a buffer solution to maintain a definite pH. The fractions are then separated by application of an electrical current which produces a migration of molecules dependent upon their various sizes and electrical charges.

After staining the separated proteins on the paper, the strips are placed on the patient's chart or are sent to the physician for examination. In some laboratories the strips are scanned by an integrator which automatically draws a graph measuring the quantity of each fraction. Interpretations can be made visually from the spots of stained protein directly or from the graph. There are several other methods of obtaining quantitative results, none of which appears to be necessary.

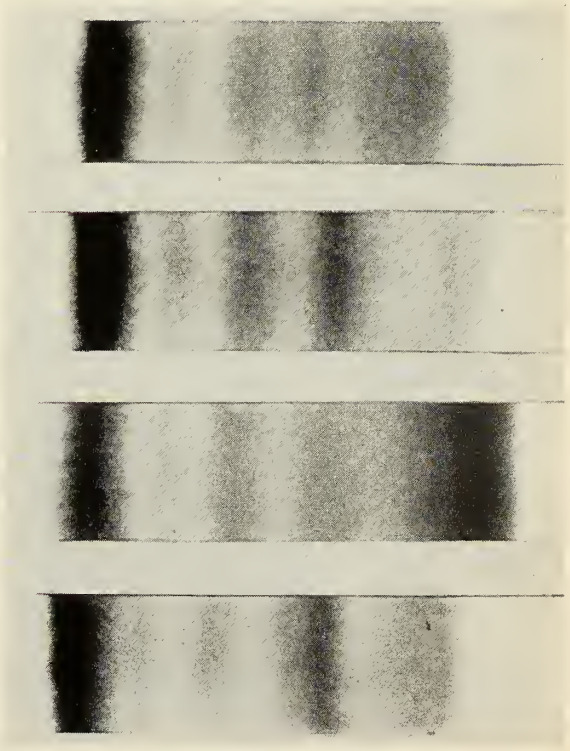
In patients with infectious diseases, the patterns usually exhibit an increase in the alpha and gamma globulins. Early in the disease, the increase is predominantly in the alpha fractions. In more chronic diseases there is an increase in the gamma fraction.

In virus hepatitis there is usually a decrease in albumin, an increase in gamma globulin and, at times, a decrease in the alpha globulins.

Cirrhosis usually has an associated decrease in albumin, an increase in gamma globulin and, occasionally, abnormal fractions in the beta or gamma globulin areas. These changes in cirrhosis are exaggerated in patients with ascites.

Cholelithiasis produces no change in the patterns unless there is associated liver damage. Jaundice does not interfere with the test.

Multiple myeloma often produces changes which are pathognomonic even though some-



STRIPS SHOW (reading from top to bottom): normal, hypogammaglobulinemia, hepatitis and multiple myeloma.

what variable. There is usually a heavy fraction in the gamma region or an abnormal fraction between the beta and gamma globulin zones. Non-specific changes are seen in some cases of other malignant neoplasms. Increase in the alpha-1 globulin is the most common.

Acute glomerulonephritis may produce an increase in the gamma globulin fraction. The other globulin fractions are gradually increased as the disease progresses. In lipoid nephrosis there is usually a marked increase in the alpha-1 and beta globulin fractions, a marked decrease in albumin, and at times, decrease in gamma globulin.

Many cases of lipemia, including lipemia of diabetes, have an elevation in the beta globulin.

The rare dysproteinoses including cryoglobulinemia and macroglobulinemia usually show characteristic patterns.

Some children, usually male, who are unusually susceptible to infectious diseases are found to have a decrease or even a complete absence of gamma globulin. There are also acquired cases of hypogammaglobulinemia in adults. These patients are sometimes helped by the parenteral administration of gamma globulin.

The test can be used as a screening procedure for many of the collagen diseases, since most of them show abnormalities in the later stages.

Protein electrophoresis is a simple, inexpensive test which can give valuable information in a wide variety of clinical entities, even though by itself, it is non-specific except when abnormal proteins are present. ◄

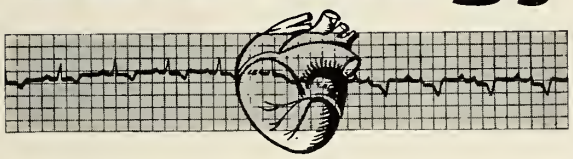
Henna Rinses and Student Problems

A colleague of mine remembers with affection a meeting of deans and deans of students which he attended a few years ago. For the better part of two days there was lively discussion of a wide range of problems: On what basis should campus parking permits be issued? How many automatic washing machines and hair dryers should there be in the women's residence halls? Should one require a special permit for henna rinses?

Finally, at 3:30 p.m. on Saturday, with the clock ticking inexorably toward a 4 o'clock adjournment, one man raised his hand tentatively and said, "I hate to change the subject, but do any of you people ever run into students who have trouble in getting their work done?"

Robert E. Streeter
"The Nature and Requirements of Learning"
Educational Record, Oct. 1959

Condensed Cardiology



Presented as a regular feature of The JOURNAL, Condensed Cardiology is a series of short talks on cardio-vascular diagnosis and treatment, edited by the staff of the Robert M. Moore Heart Clinic of the Marion County General Hospital, Indianapolis.

Use of Quinidine in the Treatment of Cardiac Arrhythmias

CHARLES FISCH, M.D.

Indianapolis

QUINIDINE is an extremely valuable antiarrhythmia drug and as such has been used extensively at the Marion County General Hospital. There are other useful antiarrhythmia drugs such as procaine amide derivatives, but by choice our experience has been limited almost entirely to quinidine. When dealing with a dangerous group of drugs there is a definite advantage in confining oneself to one representative agent and also to adhere, whenever possible, to a fixed dosage schedule. Such restriction allows for a more extensive experience with the agent in question and at the same time prevents or eliminates accidents due to improper use of such drug. Adherence to this policy, as far as quinidine is concerned, has prevented any serious complications despite the extensive use of this drug in our institution. This record is remarkable if one considers the number of house officers, some relatively inexperienced, who have administered quinidine in the past 10 years.

Pharmacologically quinidine is a myocardial depressant (protoplasmic poison). This depression manifests itself by slowing of conduction. In the atriae the flutter and fibrillation waves slow; in the ventricles the QRS Complex spreads, and if the drug is not stopped the classical sine wave appears with ultimate cardiac arrest (Figure 1). The depression of the myocardium may not be uniform and some of the less depressed foci may become "pacemakers" and the patient develops ventricular tachycardia and fibrillation.

From the Robert M. Moore Heart Clinic, Marion County General Hospital, Indianapolis, Indiana.

It is my personal feeling that many, if not all, of the so called "ventricular tachycardias" are rapid supraventricular rhythms with aberrant conduction through the ventricles (Figure 1, 2). Its effect on the vagus is atropine-like (vagolytic). By diminishing the vagal effect at the A-V node, the drug allows for an increased number of impulses to reach the ventricles.

Quinidine is administered in one of three ways. The intravenous route is used for termination of arrhythmias in critically ill patients, and the oral route either for conversion of arrhythmia to sinus rhythm or for maintenance of the sinus rhythm. The intravenous route is used almost exclusively for the management of ventricular tachycardia accompanied by signs of heart failure and/or shock. The drug (0.8 gm) is diluted in 150 cc of saline and given slowly over a period of 45 minutes. The procedure is monitored with an EKG and more recently with an oscilloscope. The patient is observed for signs of hypotension. The drug is discontinued if the duration of QRS increases by 50%. If conversion fails, the same procedure is repeated in two hours at which time the drug has reached peak level. In our hands this method has been most satisfactory (Figure 3).

With the exception of an occasional case of ventricular tachycardia without either heart failure or circulatory collapse, the oral route is used primarily for conversion of atrial arrhythmias to sinus rhythm. We begin by giving .3 gm of quinidine every two hours for five doses. On the next day the dose is increased to .4 gm every two

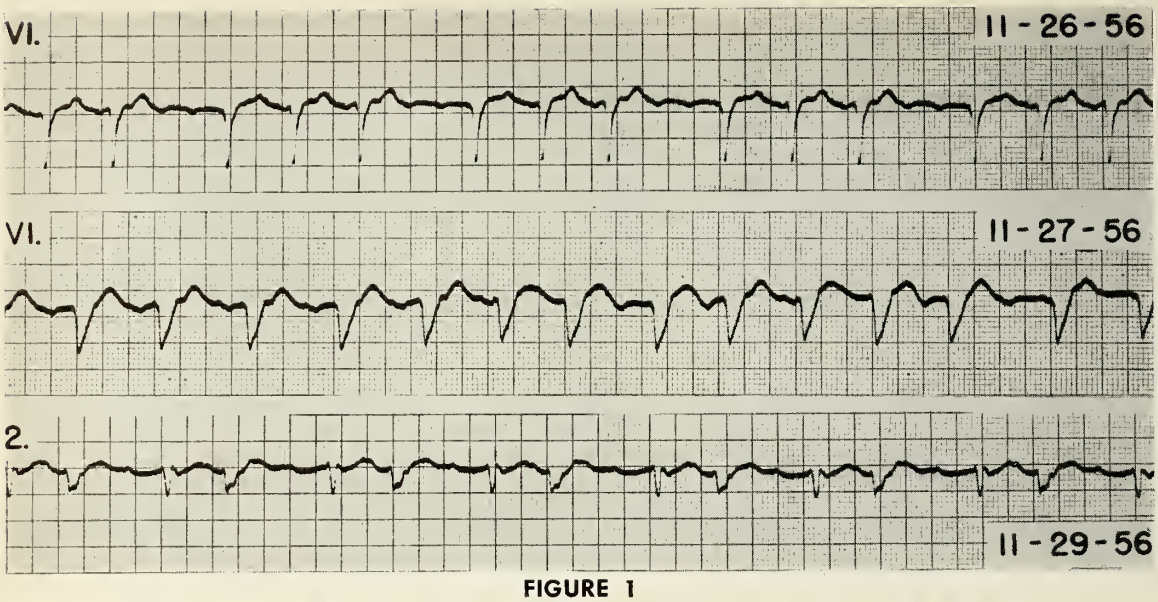


FIGURE 1

EKG DEMONSTRATES depression of conduction by quinidine with subsequent spread of the QRS.

Figure 1. This EKG demonstrates the depression of conduction by quinidine with subsequent spread of the QRS. The basic rhythm was an atrial tachycardia with a rate of 220 on 11-26-56 a varying 2:1 and 4:1 block and a normal intraventricular conduction (QRS). On 11-27-56 after quinidine was started, the atrial rate was slowed to 180 with a dominant 2:1 conduction. The depression of conduction became manifest by widening of the QRS. Had the atrio-ventricular response been 1:1 (e.g. the ventricular rate 180), a diagnosis of ventricular tachycardia due to quinidine suspected.

After quinidine was stopped (11-29-56), the atrial rate increased to 200 with a varying 2:1 and 3:1 block. At first glance the widened QRS in the third strip gave the appearance of ventricular premature beats, but actually these represent supraventricular beats with aberrant intraventricular spread.

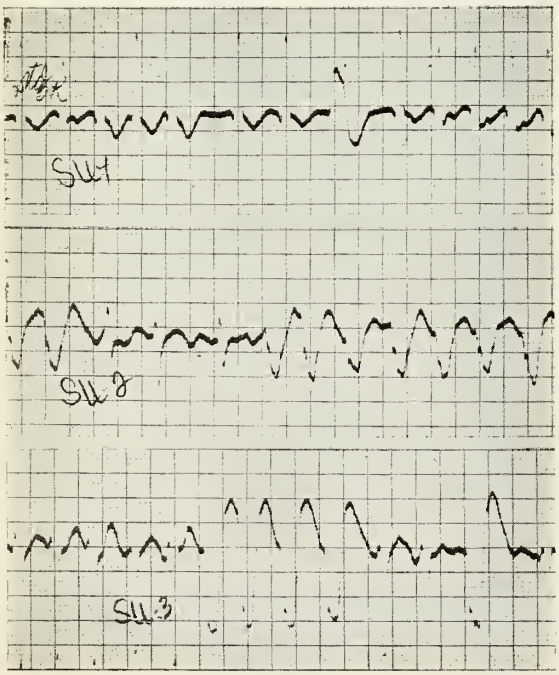


FIGURE 2

TRACING TAKEN after quinidine treatment was instituted for conversion of atrial fibrillation.

hours for five doses. This increment by .1 gm per dose on subsequent days is followed until the individual dose reaches .8 gm every two hours. It has been our experience, as well as that of others that the yield of satisfactory conversions when the individual dose had to exceed .6 gm is relatively small and the incidence of toxic side effects rises steeply. We are fortunate in being able to determine quinidine levels at the Lilly Laboratories. With such a guide, less attention need be paid the quantity of drug administered

Figure 2. This tracing was taken after quinidine treatment was instituted for conversion of atrial fibrillation. The control tracing (not shown) revealed normal intraventricular conduction. The quinidine, by depressing the ventricular conduction, resulted in broad, aberrant QRS complexes typical of what has been described in the literature as "ventricular tachycardia." A discussion of the many reasons why these changes are not ventricular tachycardia is beyond the scope of this paper.

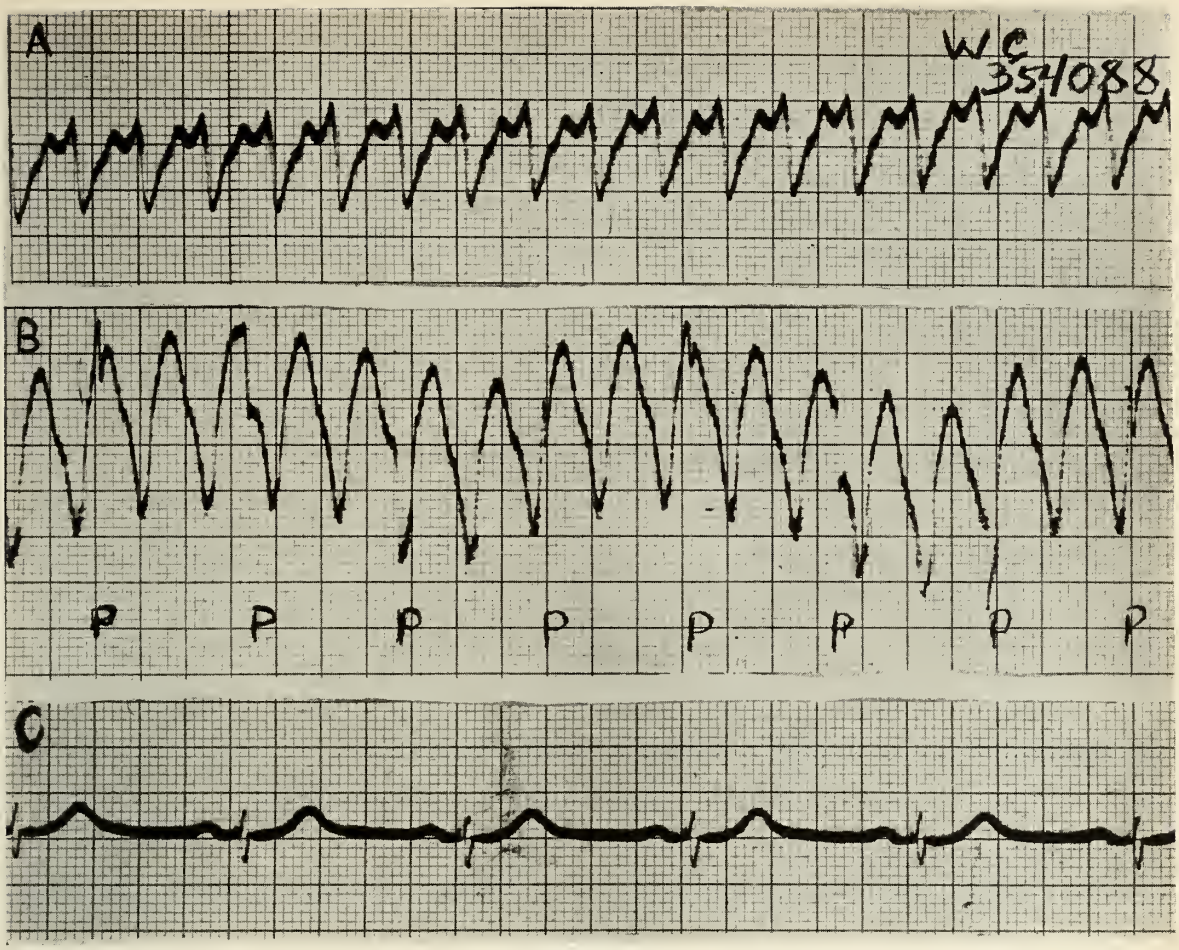


FIGURE 3

VENTRICULAR TACHYCARDIA converted to sinus rhythm with quinidine.

Figure 3. Ventricular tachycardia converted to sinus rhythm with quinidine. Strip A, lead II, shows a perfectly regular rhythm with aberrant conduction and a rate of 220. Because of the regularity, inability to identify P waves and the rate faster than average ventricular tachycardia, an esophageal lead was done (strip B). Here independent P waves were easily identified. Strip C shows reversion to sinus rhythm following administration of quinidine.

provided the therapeutic level of 6-12 mg % and occasionally 15 mg % is not exceeded. The reason for the use of 5 two-hourly doses is based on the fact that after the fifth dose the blood level is not raised unless the amount is increased or the same dose is given more frequently.

Maintenance therapy is used for prevention of arrhythmias or maintaining sinus rhythm following conversion. The starting dose is usually .3 gm given four times daily. On such a schedule, peak blood level is reached in about 72 hours and, at that time, the amount given may be raised or lowered depending on the patient's response to the treatment.

There is still some controversy about the dangers of simultaneous use of digitalis and quinidine. In our hospital quinidine is never used in treatment of atrial arrhythmias unless the patient is first fully digitalized. The reason for the combined use of drugs is, we believe, quite sound and the difficulties encountered in giving quinidine to patients whose A-V conduction is not depressed by digitalis may be on occasions disastrous. The slowing of the rate of atrial flutter combined with the vagolytic effect of drug may be sufficient to change the atrio-ventricular block from 2:1 or 4:1 to 1:1 with resultant rapid ventricular rate, usually over 200 beats per minute and such a rate in presence of heart disease may prove fatal.

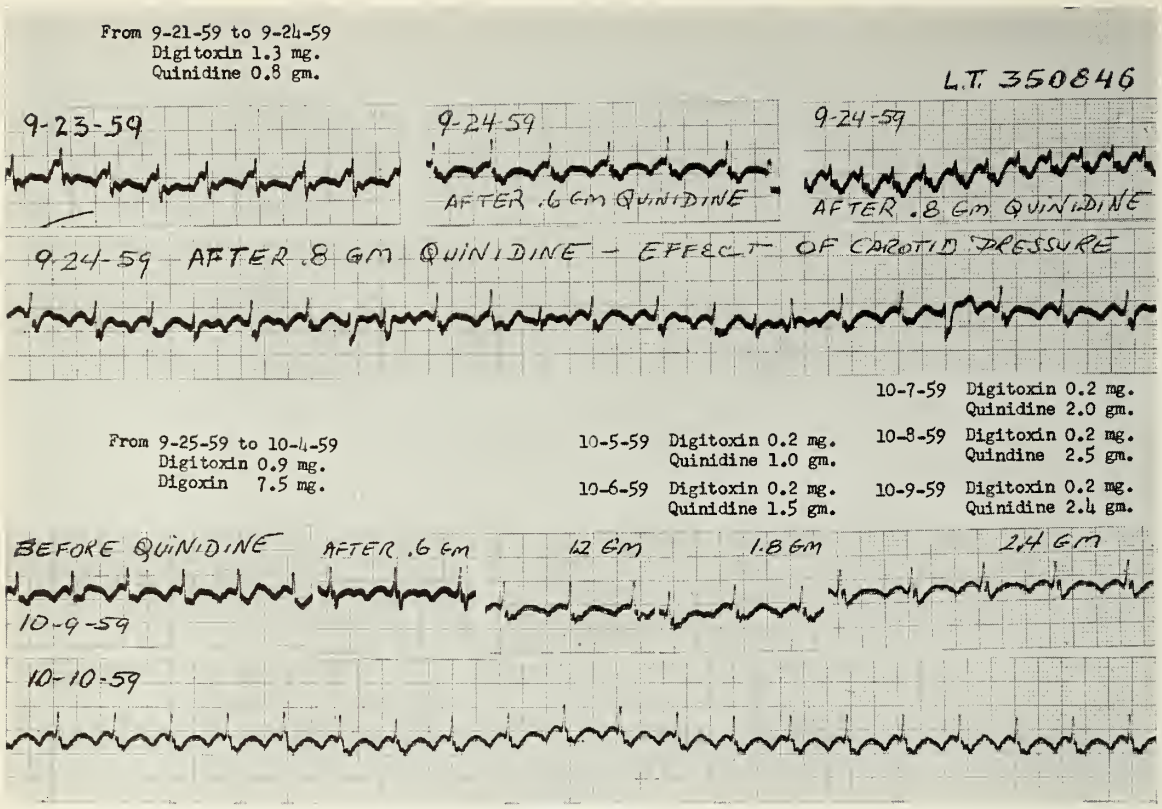


FIGURE 4

TRACINGS DEMONSTRATE difficulties through administration of quinidine to improperly digitalized patients with atrial flutter.

Figure 4. This set of tracings demonstrates the difficulties one may get into by administering quinidine to improperly digitalized patients with atrial fluter. Control tracing on 9-23-56 was taken after 1.3 mg of digitoxin was administered during preceding two days. The basic rhythm is an atrial flutter with an atrial rate of 300 and a 2:1 ventricular response. On 9-24-56, after .6 gm of quinidine, the atrial rate is 240 still with a 2:1 response and a ventricular rate of 120. After .8 gm of quinidine was given the atrial rate slowed to 214 but now with a 1:1 response and a ventricular rate of 214. This rate almost proved disastrous. With carotid pressure the block at the AV node was increased and the number of impulses reading the ventricles were also reduced. This strip shows how the two effects of quinidine (namely: slowing of the atrial rate and blocking of the vagus at AV junction) can combine to reduce the AV block and speed the ventricular rate.

Following further digitalization (10-9-59) and despite slowing of the atrial rate from 272 to 200, the effect of digitalis on the AV node maintained the 2:1 block and prevented speeding of ventricular rate such as occurred on 9-24-59. Please note that after 2.4 gm of quinidine was given, the QRS spread more than 50% and further administration of quinidine was stopped. On the following day (10-10-59) that atrial rate was 250, suggesting that a large portion of the quinidine was excreted.

Furthermore, not infrequently, flutter will first be changed to fibrillation before conversion to sinus rhythm. If the patient is poorly digitalized and at the same time the vagus is blocked by quinidine, the ventricular rate may become extremely rapid and deterioration of circulatory status ensues. Complication of quinidine therapy due to inadequate digitalization is presented in Figure 4.

It was our intention in this brief discussion to present a practical, safe and tried approach to the use of quinidine. We wish to emphasize that the use of quinidine for conversion of arrhythmias is a hospital procedure. The physician must monitor the intravenous injection at all times. If the two-hourly oral schedule is used, a short EKG strip is desirable before each dose. ◄

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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FORAND BILL—SOCIALIZED MEDICINE

SOCIALIZED MEDICINE in England has been the subject of myriads of reports and lectures. American doctors who visit England and English doctors who visit this country have all recorded their impressions of the system. The resulting mass of writing and speaking has, at least until recently, worn the subject out, and with repetition has deprived it of most of its original interest.

One of the factors concerned with lessening concern over the British type of socialized medicine may be that the United States has demonstrated very definitely that a system of compulsory government medical care is not wanted. If this is so, now is the time for everyone to renew interest in how the English scheme works and what kind of medical care it is providing.

When the Murray-Dingell plans were rejected the American people did so because they were sure that they did not want universal tax-supported medical coverage. At that time predictions were made that the socializers would not be discouraged by this defeat, but that they would attempt to introduce socialized medicine piecemeal.

One of their moves in the direction of establishing government medicine on the installment plan is the Forand Bill. The campaign in favor of this bill is long on emotion and short on facts. The need for a new method of caring for oldsters has been exaggerated, and the resources available under our present system have been minimized.

The forces in favor of the Forand Bill are dangerously strong and must be combatted by all means available. Organized medicine has made an intensive study of the medical needs of citizens over 65 years of age. The results show that the deficiencies in this segment of medical care are not nearly so large as represented by the social planners, and that the means for counteracting what deficiencies there are, are improving steadily.

Meanwhile, it is interesting and of practical value to review the mess that England calls a

medical care system. The California Academy of General Practice recently published an interview with Dr. Alastair J. Marshall of Luton, England, who was visiting the United States at that time.

Dr. Marshall has a full list of 3600 patients, each one of whom he sees on demand either in his office or at the patient's request by way of a house call. Dr. Marshall stated that his usual average number of patients per day prior to socialization was 35. Now it varies between 120 and 140. He is paid not for what he does but on the basis of the number of people on his list.

He estimates that most general practitioners have a gross income of about $10,000. Expenses of practicing usually lower this figure to a net of $5,000 or $6,000. The government can fine him if his office is not maintained according to standards or if he is rude to a patient.

General practitioners do not have any hospital privileges. They are able to have patients needing emergency operations admitted for care by specialists promptly. Elective operations such as tonsillectomy, cholecystectomy or gastrectomy have a waiting time of between two and three years.

There is a government approved list of drugs which may be prescribed. The list is limited. The newer drugs are not added to the list for a considerable period of time. If a doctor prescribes a non-approved drug he may have the cost assessed against him.

Fewer and fewer young people are entering medical schools.

Hypochondrical patients are so numerous as to create a tremendous problem. Apparently the health system has increased the number of neurotic patients. Psychiatric consultants are practically non-existent.

Before socialization only 17% of British doctors favored the scheme. After the government announced that it would proceed with the 17% and give them seniority and pension rights, and especially after the reimbursement by the government for the goodwill of the practices was limited to a short period, 47% of the doctors signed up.

The cost is now three times the maximum estimate. Dr. Marshall stated that the government obviously did not realize that so many people would take advantage of "free" medical care and take advantage of it so often!

LOW INTERNSHIP OCCUPANCY

THE RECENT (Oct. 10) report in the *Journal of the AMA* on approved internships and residencies contains many statistical tables. One of these is of special interest to Hoosiers. It has to do with "Number of Internships, by Census Region and State, 1958-1959," and it shows not only how many internships were then available, but also the number of these that were not filled.

Some, of course, were vacant. This allows determination of the occupancy rate. Indiana is one of the four states having the lowest rates. Ours was 53%, Montana being the only one lower with 50%. The figure for the grand total of all states, territories, possessions and the Canal Zone is 83% occupancy (including the four states below 60%).

Regardless of what these figures really mean, they offer food for thought. Perish the thought that Indiana's internships are not considered attractive—but such is possible. On the other hand, there are apparently more such positions available than there are men to fill them.

Still, we have not explained 53% vs. the overall 83% There is a possibility that someone has calculated, or reported, an erroneous number in counting the *available* internships in our fair state, and such number should be checked.

We suggest that this matter would fall in the domain of our State Association's Commission on Medical Education and Licensure, and that the pursuit of an explanation of the 53% occupancy (or alleged occupancy) of internships in Indiana is bound to be enlightening and ultimately beneficial. (A. W. C.)

PERSONAL PHYSICIAN

PARADOXICAL as it may sound, there is some truth in the statement that as the practice of medicine becomes more efficacious, people are less satisfied with it.

One of the criticisms of the medical profession seen in public print is that doctors today are too impersonal. There are frequent nostalgic yearnings for the "old fashioned" family doctor. Memories are revived of the kindly and sympathetic family counselor who knew the patient's family and medical history, and who, no matter how busy he was, always had time to explain everything and soothe away the fears.

The reason for the contrast between physicians of 50 years ago and those of today may be in part that the doctors of the days of long ago had little to offer the patient except friendliness and kind consideration. The kindly old doctor was limited in diagnostic aids to his stethoscope and he could carry all the potent and specific drugs of that time in one pocket. All the kindliness and compassion which are a common attribute of physicians of all time and of today, also, were highlighted and emphasized because of the meagerness of everything else that medicine had to offer.

Today, methods of diagnosis and facilities for treatment have multiplied and improved to almost a fantastic degree. The practice of medicine has become complex, time consuming and demanding at times of technical and exact niceties akin to an engineering problem.

It is easy to understand why in such circumstances the patient may be studied and diagnosed with an accuracy impossible 50 years ago, and may be treated and regain health in a short time, and in the process may miss the manifestation of the personal interest which is an indispensable factor of the entire procedure.

The older doctor was kindly and showed an intense personal interest in the patient because he was obliged to. If he lacked these things he was a failure, since the other things he had to offer were so ineffective. The longer ago he practiced the more this was true.

Today there is a tendency to underestimate the importance of the personal factor in the practice of medicine. It was the keystone and principal stock in trade of the older physicians. In spite of present day marvels of diagnosis and treatment it is still the keystone and principal stock in trade. Despite our high level of technical excellence, patients are still worried and frightened when they come to us for advice. Calming their fears by sympathetic consideration is the indispensable factor in their treatment upon which the scientifically marvelous advances may be added, but without which scientific medicine is strangely ineffective.

A paraphrase of a statement by an English clinician illustrates this principal. Given a choice, most patients would actually rather die under the care of a kindly and sympathetic but scientifically inept doctor than they would to recover with a coldly impersonal and unfriendly but scientifically perfect practitioner.

A HARD MASTER

FIRES in the United States in the year 1958 were a little less common and destroyed a little less property than was the case in 1957. However, the National Fire Protection Association considers this amount of improvement to be strictly "nothing to shout about." Slightly over one billion dollars worth of damage occurred in building fires. Since the Association considers building fires to be almost entirely preventable, a decrease of one million in damage is not much improvement. The decrease should have been one billion.

Hospitals and other institutions shared in the slight gain. Such fires in 1958 totaled 1600, down 100 from the previous year. The property loss was $2,040,000.

The principal causes of fires in buildings of all types were defective heating and cooking equipment, and careless smoking. This statistic applies to homes, hospitals, office buildings and factories alike. Correct defective equipment and eliminate careless smoking and most of the fires in buildings would never occur. Hospitals, especially, are deserving of extreme precautions. ◄

President's Page

The question of relative values being utilized in the economics of medical practice is before us. Relative value implies that an index price relationship exists between the various procedures in the practice of medicine. The postulation is to the effect that some basic unit, such as an office call, is conceived to be the value of a single unit; then other procedures are evaluated in relationship with that unit. For instance, if an office call is worth one unit, an appendectomy would be worth approximately 30 units. The people requesting such unit value scales are largely the third parties in medicine — Medicare, insurance companies and the government.

It has been said that if medicine doesn't fix its own unit values this will be done for medicine by someone else. It has also been said that unless we fix these values the consideration given will not be as fair as it should be.

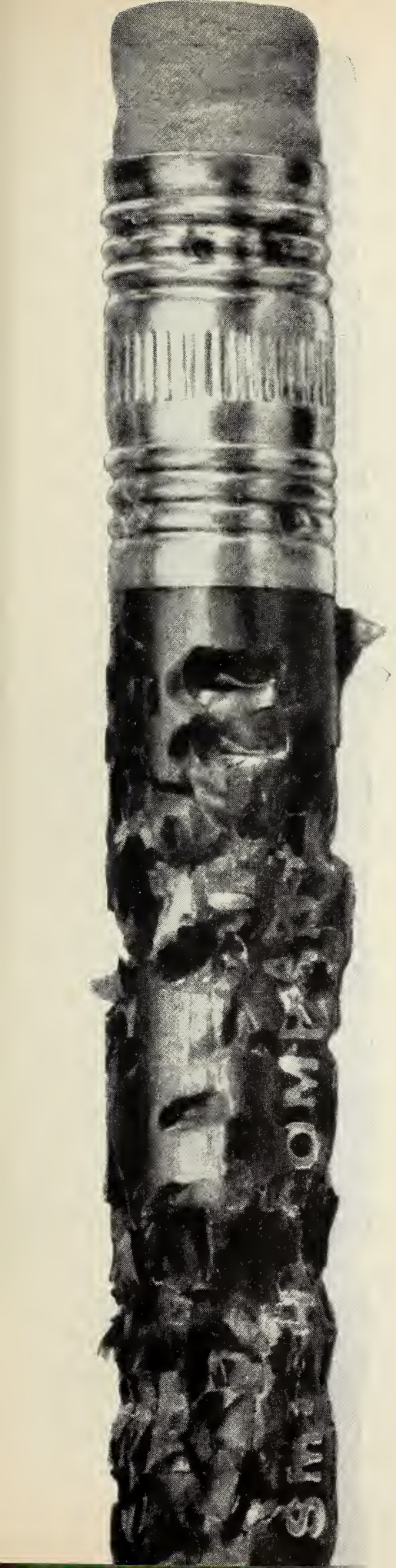
Recently I had the experience of listening to a discussion of relative unit values for a day and during that day I heard equally intelligent people discuss both sides of this question. One group was for the acceptance of this unit value schedule believing it would save medicine. The other group, equally emphatic, equally emotional and equally intelligent, felt that such a procedure would ruin medicine.

Some states have already adopted this plan and California particularly reports successful operation of the plan. In Indiana, however, sentiment is not crystallized as yet to this plan and some people are viewing it with suspicion. In this state we do not accept things quickly nor do we ever accept something that is not in keeping with freedom of medicine. For instance, many cities in our state have held fund raising campaigns to build hospitals so as to avoid acceptance of federal money in this needed situation and almost entirely these have been successfully conducted. This experience indicates that we do not give up any freedom quickly here. We believe if the federal government invests money in any project, the government will some time utilize some control over it.

There are those who believe the unit value schedule becomes a fee schedule once a fee schedule is written. Once posted, other people may have something to say about the relative unit value expressed in money. Certainly it is well that we study this in our deliberations in our forthcoming meetings and that adequate study be given to it. Never let us be accused of selling out any of our freedom for a security that might be very very short in endurance. Also, never let us be so negligent in meeting approaching situations that we do not take advantage of everything to the welfare of our patients as well as to ourselves.

The relative unit value consideration will perhaps be decided in the next few months and whatever our decision may be, I am certain it will be to the best for medicine in Indiana.

Earle W Bennett M.D.



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Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. *80*:481 (Oct.) 1958. 2. Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 3. Mathews, F. P.: Am. J. Psychiat. *114*:1034 (May) 1958.

SEARLE

The Woman's Auxiliary

REPORTS TO I.S.M.A.



THIS YEAR'S AUXILIARY officers to ISMA are, as shown, (frant, l ta r): Mesdames Jack Shields, carrespanding secretary; Paul Merrell, 4th V. P.; Jaseph Black, president; Edward L. Rigley, president-elect; Burtan Kintner, 1st V. P., and Gearge Waganer, recarding sec'y. Back raw: Mesdames R. Case Hammand, 2nd V. P.; P. T. Holland, historian; Kenneth Brawn, treasurer; M. O. Scamaharn, Dis. Caun. chairman, and William R. Tindall, parliamentarian. (Nat available far the picture was Mrs. Richard Gripe, 3rd V. P.)

Dear Doctors:

Your Auxiliary Officers and every Auxiliary member wish to you, our husbands, a Very Merry Christmas. We pray that the Spirit of Christmas will abide with you and bring you happiness and peace throughout the New Year.



Sincerely,

Mary Annette Black

Mary Black, President

President's Address

Delivered October 8, 1959
Murat Theater—Indianapolis

KENNETH L. OLSON, M.D.

South Bend

AS my year of service as your president draws to a close. I must turn to reflect upon what has happened during the year and give a report to you tonight. I will present some ideas about medicine which have come to my mind in preparing this address.

First, I wish to thank every one of the doctors who has helped me during the year, and I wish especially to recognize the commission chairmen and members, especially Dr. Wood, Dr. Edwards and Dr. Lamb, chairmen of the Commissions on Legislation, Insurance and Medical Economics, and Public Health respectively. The amount of study and work these three groups undertook, and the fine results accomplished were outstanding and I believe deserve special recognition.

I realize that other groups, including our special committees and the work horses of the organization called the Executive Committee, also contributed much to the association. I wish to thank the headquarters staff so ably directed by Mr. Waggener, who gave me efficient and helpful service. Mr. Waggener is doing an excellent job for the association and I hope he will serve us for many years.

Since I am presenting bouquets, I would like to commend you loyal doctors, wives and friends who are here tonight to give your support to our excellent association. In the last several years there has been talk of abolishing this part of the program and believe me, you would all be better off tonight if this had been accomplished.



KENNETH L. OLSON, M.D.
President, 1958-59

Constitution Still Guides Us

One year ago I presented my plan of a program to the House of Delegates for the ensuing year. This program was based upon the purposes of the Indiana State Medical Association as outlined in the constitution adopted by our association 110 years ago. It is remarkable that our objectives, aims and purposes remain as important today as they did when written, and that our predecessors, so long ago, had the wisdom and foresight to set a course and pattern for the medical profession that still guides us.

The basic philosophy of medical practice and patient care has not changed. We are as dedicated to our profession today as our predecessors were, and if we are not, then we need some reawakening to our responsibilities to the people and to society. There is sometimes expressed and believed by uniformed people the idea that doctors protect each other, inferring that we do not police our members. On the contrary, we as a group have as many, if not more, checks on each other than any other group of people.

President's Address

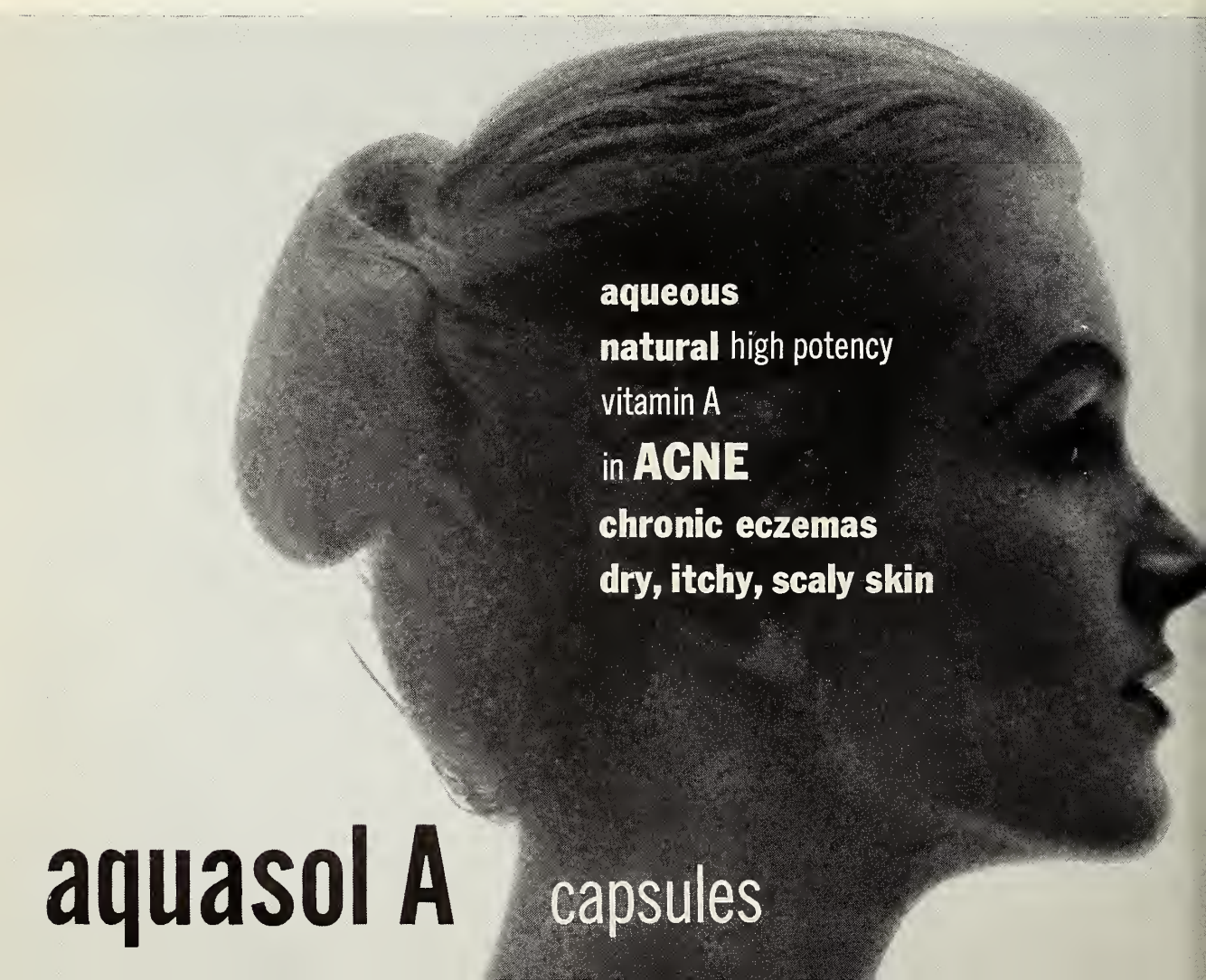
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To be able to study to be a doctor, there is a great deal of investigation of each applicant as to his mental ability, aptitudes in regard to medical practice and moral character. Once accepted, he must maintain his standards or be dropped from school and this happens to about 10% of those accepted. After graduation, he again goes through a selection method for obtaining an internship. When he has completed all requirements, then he must prove to the state that he is qualified to care for patients by passing a test for licensure.

He is now ready to practice, but again he is given scrutiny by his county medical society and the hospital staff of the hospital to which he desires to bring his patients. The county medical society instructs the young doctor as to maintaining good character, medical practice and ethics during his years of practice. The medical staffs of hospitals are constantly checking the quality of work of every doctor, through tissue committees and subsections of the medical staffs which meet each month. A doctor has, throughout his life of medical practice, constant surveillance by his fellow practitioner; and this is as it should be, to maintain the high standards of quality and ethics, for the betterment of the health of the people by a free society of men. And last but not least, he is subject to public scrutiny of his abilities and his ethics.

Primary Responsibility

Our primary responsibility is to care for the sick no matter who he is and the quality of care does not depend on ability to pay. In spite of the many safeguards, we would be silly and blind not to realize that there are exceptions, but generally these are few and minor and probably becoming less each year. We must continue to try to correct any wrong that we can. The over-all principles of ethics are followed naturally by any doctor worth his salt. We must realize that although the basic philosophy of medical practice remains the same, many other things relating to medical practice, like everything else,



have changed and are continuing to change more rapidly at the present time.

It is these changes that are taking place in medical science, medical practice, patient care and economics that I now wish to discuss. We now have a growing, vast reservoir of knowledge with which to treat our patients. The old horse and buggy medical practice is gone and replaced with a far superior understanding of the patient and his illnesses. The knowledge about diagnosis and treatment of disease has multiplied tremendously, so that it is to everyone's advantage that we have the family doctor or generalist and also that certain doctors specialize their practice to a certain area. This does not mean that any one group is better or superior to another for we all are physicians.

Since I have mentioned the changes going on in medicine I want to point out that we are constantly hard at work formulating plans for adjusting ourselves and our practice in such a manner that we are reasonably sure the changes will produce benefits for all. We must consider the results in our deliberations so that we do not make matters worse, similar to the old adage in medical practice that it is better to do nothing, to wait and observe rather than give some treatment that will make the patient worse than he was without treatment.

Consequently, we may at times move slowly in making changes, but this too can have its merits. If a person has many troubles and what seems to be unsurmountable problems, the quickest way to get rid of them is to commit suicide, for then that person has ended his problems on earth. A dictator can solve problems in a hurry, too; for instance, if his country is short on food, he can order a certain number of people killed or withhold food from as many as desired until they die. We in our society do not believe in these methods, nor do we believe that any means justifies the end result. The changes in medical science have been legion with numerous valuable drugs for the curing of disease and the correction and support of the body functions that become out of control and inadequate for normal activity and life.

Continued on page 2182

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1. Davidson, D. D. and Sobel, A. E.: J. Invest. Derm. 12:221, 1949.

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1. Kuge, T.: To be published.

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President's Address

Continued from page 2179

Medical Team Enlarged

Great strides have been made in understanding the effects of disease on the body and means of correction. Surgery has become safer and more rapid and complete recovery from illnesses and surgery is becoming more and more important. As a result of the advances in the scientiffc diagnosis and therapy of disease, changes in the activities of patient care are occurring. Not too long ago the doctor and the nurse were the only people involved in patient care, but now with the team enlarged to include other ancillary specialists ready to give aid, patient care has become very complex.

This field alone requires study and understanding by all the people involved in taking care of the sick so that improved care can be obtained. We should use methods of aiding in speedier recovery with less psychological shock and better adaptation of the patient to his surroundings and environment during his period of illness and his return to normal or as near normal activity as possible. I hope and know we can make great strides in this field to keep up with the progressive scientific and socio-economic improvements. There are studies going on in this state at the present time specifically experimenting with and studying the various methods and ideas of patient care.

We must be sure that we maintain the personal touch with our patients and not let any group or other persons interfere between the patient and his doctor. In these and other studies the result should always be that the doctor, who is the only qualified and trained person, is the captain of the team of people aiding him in the care of the patient. This refers to individuals, various groups as business organizations, labor unions or government.

A Patient A Whole Person

The patient is now being considered more and more as a whole person with the doctor being concerned about the effects of a certain illness on the body as a whole. It is imperative that we return the ill person to his normal environment and activities as soon as possible. The disruption of family associations and economic factors are very important to the patient and his family. The doctor must assume a broader role of cap-

Continued on page 2186



he deserves

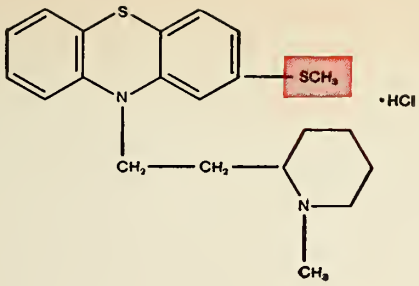
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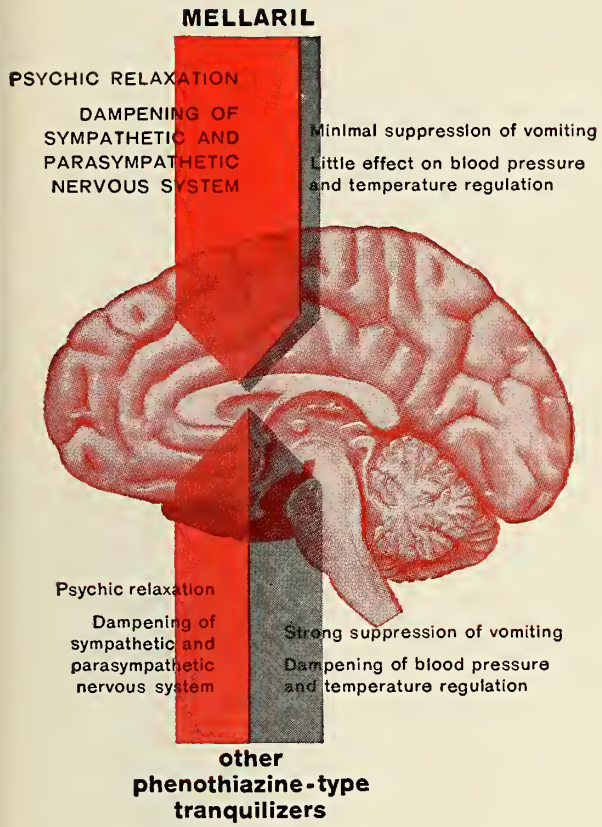
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*Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959

SANDOZ

President's Address

Continued from page 2182

tain of a team of allied groups of nurses, technicians and therapists to permit more rapid and more complete curing of the illness and rehabilitation of the person. We must not permit any person to become crippled if it can be prevented. A rehabilitated handicapped person can support himself and, instead of being a recipient of taxpayers' funds, he becomes a taxpayer to benefit of all society.

Demands made on the physician today have caused doctors to make a number of changes including even their location of offices from the congested traffic areas in the center of larger cities to the neighborhood areas, most often in buildings of their own or with one or more other doctors. The change in facility and location of our association headquarters has been ably studied by Dr. Kintner's committee this year and approved by vote of the membership. As you know, your association has been exploring and planning quarters of its own to meet its needs and I hope this will be accomplished in the near future.

More doctors are also joining in office sharing and changes are going on in their relationships with each other and with their patients. Two, three or more doctors in the present era of practice arrange to care for each other's patients while away on vacation or medical meetings. This permits more freedom to relax and also to acquire newer information about medical practice. I remember the day when a doctor would be afraid to have a colleague care for his patients, while he was away for fear of losing his patients. Many doctors, therefore, seldom took vacations or attended medical meetings.

I recently received a letter from a doctor who has retired who would like to have the Indiana State Medical Association organize a home for retired doctors who need help in a suitable facility to enjoy the companionship of persons with similar interests. The association might investigate this matter further and may be able to accomplish this by methods of financing that would not even cost the membership anything.

Economic Changes

The changes that are occurring also affect the economics of medicine. The procedures of diagnosis and treatment, including surgery, have increased the cost of illness but have resulted in shorter recovery periods and a more complete return toward normal. This increase in cost has become of increasing concern to the physician and to the public. It is necessary for us more than ever to prevent any unnecessary utilization of laboratory and x-ray procedures, surgery, therapy or hospitalization. The public should be informed and the doctor reminded that a patient should only be admitted to a hospital on a basis of medical need and not because the patient has hospital insurance. It is well known and recently accentuated by the increase in staphylococcus infections that infants and children have less danger of becoming infected from another person if cared for during an illness at home. It is the hospitalization costs that add so greatly to the expense of medical care.

We must be the leaders in reducing the cost, even possibly to originate newer ideas of patient care with less supervision when possible as in ambulatory wards of a sort of self-service area. We must use our influence and judgment in regard to informing the public to try to reduce over-utilization of hospitals for diagnostic tests which could be done in offices of doctors. To add the cost of 1, 2 or 3 hospital days at about $25 a

Continued

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President's Address

Continued

day to diagnostic laboratory and x-ray examinations is certainly a contributor to higher medical costs. Insurance companies have unwittingly contributed to this practice by paying for these examinations only if the patient was in a hospital. In order for this to be corrected, insurance should pay for these services in a doctor's office; but here again, overutilization can raise the cost too high. Some doctors who have their own laboratory and x-ray equipment may use these procedures more often because of being handy.

In some areas in this country, the overutilization of laboratory and x-ray procedures in doctors offices has been reduced by only paying for cases referred to another qualified doctor for this service. One other hazard of overutilization of diagnostic x-ray service is the radiation exposure to the patient. This leads to the problem of radiation hazards which, with todays knowledge, should always be of concern and no one should be using any x-ray equipment or fluoroscope unless it has been checked by a physicist to reduce the exposure to an absolute minimum.

Health Insurance Changes

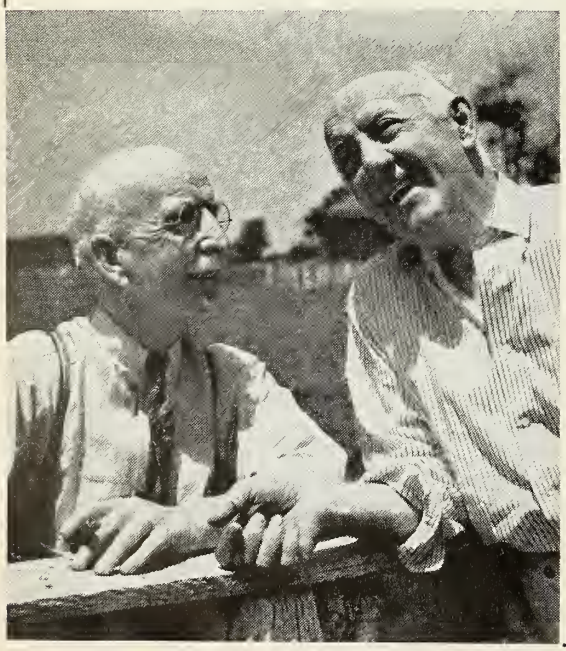
The whole problem of health insurance is undergoing changes in the types of policies offered. It was felt in the early days of development of health insurance that it was necessary to have the patient pay part of the bill to reduce overutilization of the doctor and hospital. Then the service full coverage plans in certain parts of this country became popular. Now there is a greater interest shown in co-insurance or deductible insurance to reduce the cost and lower the premiums. The advocates of the deductible insurance say that nearly everyone can afford to pay from $25 to $100 medical expense a year and if so, then the insurance coverage of the illness beyond this can be more adequately covered to a larger amount at a cheaper rate.

We physicians have been interested in improving health insurance and the success of this type of insurance is proportional to the interest of the individual members of the profession. We doctors in Indiana through our state association started Blue Shield and we have been interested ever since. The plan was so successful that it has had rapid growth, but now with the changes

Continued

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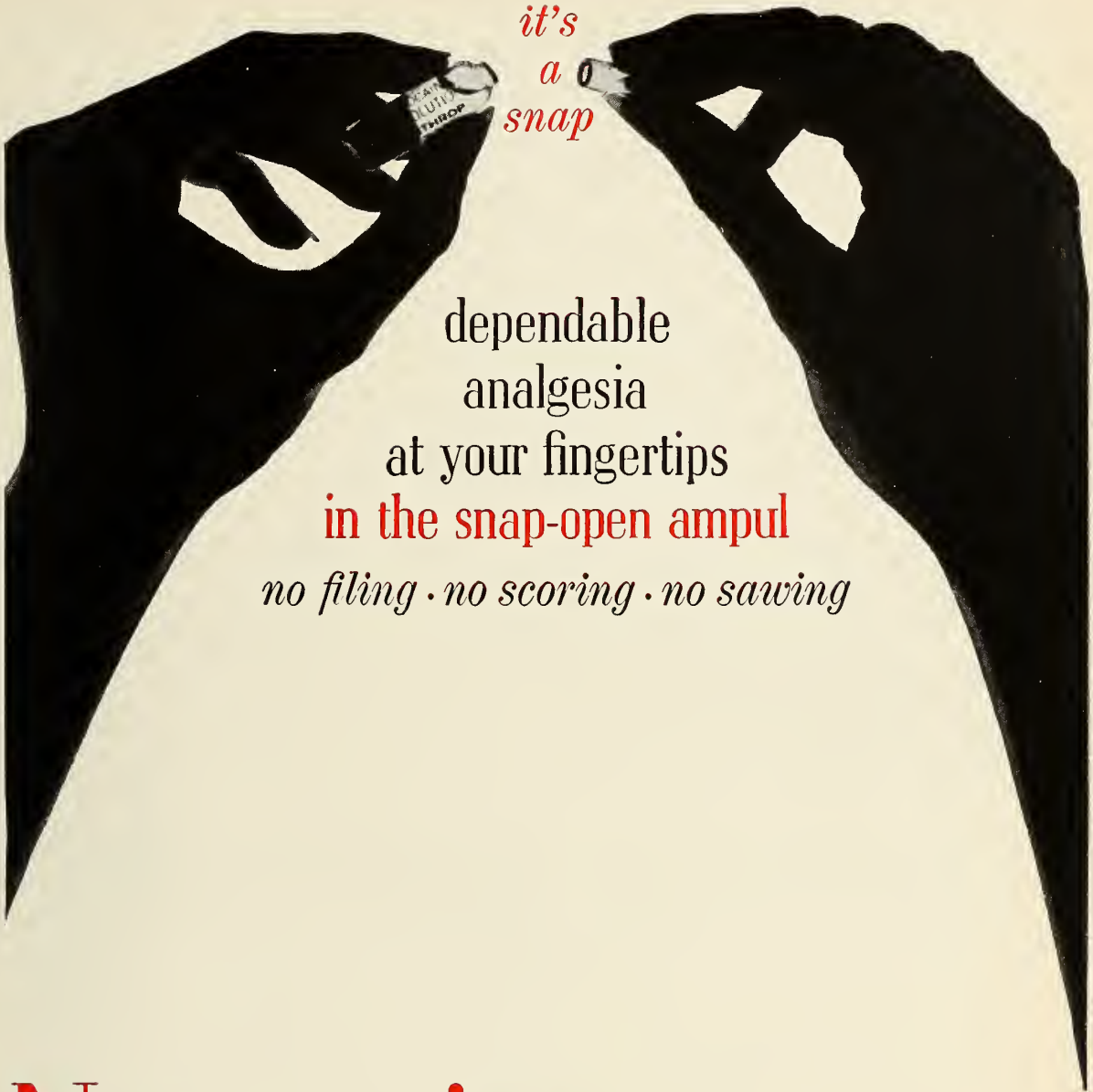
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President's Address

Continued

in medical care and the increase in cost of medical and especially hospital care, we have had a revival of more active interest in Blue Shield. I should point out that the increase in cost of medical care by physicians has been much less than other segments of our economy.

Our commission on insurance and our Council have been working together with officers of Blue Shield to bring about a better understanding of the activities and aims of Blue Shield insurance to the members of the Indiana State Medical Association. This year the president of Blue Shield, Dr. Howard, has made a report to the membership of the activities of this organization and a panel has been available to explain and answer any questions. I hope that this activity will be continued and improved in future years.

Voluntary Way Encourages

Then I believe that more physicians will become more active in aiding and presenting new ideas to help improve and expand the coverage of illness by insurance. It is possible one of you may bring a new idea for developing a different more popular type of policy than now offered. The more people who are interested, the less likely the government will be able to control the practice of medicine. The voluntary way encourages experimentation to increase the value of insurance. The phenomenal growth of voluntary health insurance the past 15 years has increased its coverage from 32 million people in 1945 to 123 million in 1958, or from 1 in 3 in 1945 to 3 of 4 people in 1958. This growth of voluntary insurance leads on to reiterate that it is the best means for prepaying the cost of illness of every citizen including the aged as opposed to governmental interference in the lives of the elder citizen.

We must resist with all our effort the spreading control and gradual growth of centralized federal government that would permit the eventual gaining of power of a dictator. The present proposed legislation in Congress to give certain health services for social security beneficiaries over 65 years of age, known as the Forand Bill, is dangerous legislation designed to try to attract voter appeal but which in reality will further increase taxes to pay for something at a greater cost than the voluntary method. Along with the

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President's Address

Continued

increase in taxes, there will also be an accompanying regimentation and issued directives from the federal government. It will not improve the care now given, but will make doctors, nurses, hospitals, allied groups and patients subservient to the federal government.

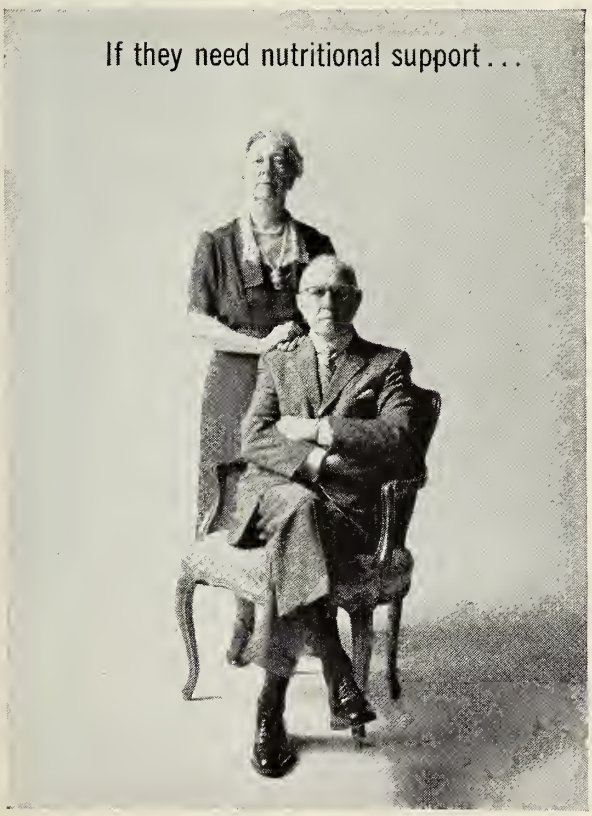
I hope that all of us may continue to live in a free society and that the medical profession be also a part of the free society. This type of legislation will be, and is intended to be, the entering wedge for complete socialization of medicine for surely with each succeeding Congress, attempts will be made to lower the age limit from 65 and everyone will be included. We must choose between the concept of the state being supreme and the concept of liberty of the individual where government is secondary to the individual and his spiritual values.

A Total Approach

Medical care is just part of the problem facing the aged. Inflation, retirement, community misunderstanding, housing, recreation, economic and sociological factors are major contributors to the problems. Because of the many factors involved, no politically motivated federal plan will ever provide a sound solution. There must be a total approach and not a hit or miss approach.

Federal government intervention at this point would completely undo and destroy all the progress that has been made by voluntary insurance, increased family responsibility and scores of community and state programs which have been moving forward in an encouraging manner. It would curb community incentive to support hospitals and the many health programs and activities locally. It would curb the freedom of experiment with new technics for aiding the elderly in homes and other activities. It would discourage the individual approach to the patient and would interfere with the professional relationships between the patient and the doctor. The elderly are individuals and the only thing they have in common is being over a certain age. Physicians apply the test of personal experience with their patients and we do not believe that governmental control will solve the problem as well as the voluntary methods.

These elderly people should be treated as individuals and not herded together to try to give uniform lists of their wants and needs. Government medicine equalizes individuals and stand-



they deserve

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President's Address

Continued

ardizes conditions of care. There can never be legislation that can be effective for loneliness, rejection or lack of useful things to do, but each one emphatically affects the over-all health of these people. They do not want to lose their dignity by being wards of anyone. They want and deserve sympathetic care and understanding that can only be given by private medicine. Any costly impersonal program of production-line government medicine would further complicate rather than solve the problem.

Physicians Should Lead

Since medicine and its related fields are largely responsible for the expanded longevity, it is fitting that physicians take the lead in efforts to help the elderly. This we have done and are now doing through our national, state and county societies. We are trying to solve the problems locally where they are best known at a minimum of expense. Many physicians are now working on committees and more should, for each of us must play a part in the story of the healing art and science to bring about better and healthier individuals for our society. Every one of us must become an emissary to enlighten our congressmen, senators and the public. We must get public opinion behind us and be as effective as the opinion that forced labor legislation.

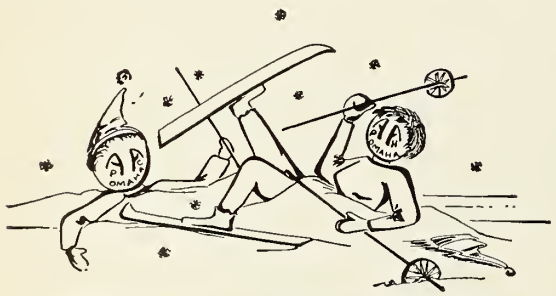
We must not let our medical societies become static, especially in view of all the changes going on about us in all phases of the medical field. All levels of organizations should be re-examined by their officers and members to be sure they are doing the job we want them to do. One of the large problems of any organization is communication and the effectiveness of that group depends on the communication skills that coordinate the efforts. As in patient care, not many years ago the relationship between the doctor and the patient was simple, but has been getting more complex, so it is with our association that the simple person-to-person relationship is gone. We now use many measures of communication which become a larger and more important factor in the organization.

One of the most effective means of enhancing our communication effort is being carried on by our field secretaries, and they are doing a bigger and better job as they realize the potentials of their position. They were very effective this year in helping to get the type of health legislation passed at our state legislature that was best for the people.

Importance of Communications

Communication is so important in getting enough doctors to understand the various problems confronting us. I believe that the importance and proper interpretation of the relative value schedules would be acceptable to the society members if properly informed for I have observed that those in our association who have studied this the most, finally are convinced that it is a good thing. We must learn to convey our ideas to other persons in such a way as to be properly understood. I am sure all of us wish we could express our ideas better than we do.

We must promote new ideas and approaches to the many problems we now have and that will arise in the future. Our state society has been active in trying to help solve the problems of automobile accidents. We have had exhibits and lectures and panel discussions on traffic safety, but we must continue and increase our efforts as long as our emergency rooms of hospitals and doctors' offices throughout the state are busy re-



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pairing the injured and trying to prevent death. This has become an increasingly important health problem and we physicians are in intimate contact with its victims. We must be interested not only in giving proper medical care, but should be active in efforts to prevent accidents. This effort for prevention may include the decision as to who is and who is not fit to drive, and also safety features of cars themselves and safety features of cars themselves and safety features of the highways. There are obstacles for the medical association to become too effective in prevention of accidents, but we may help by informing the public and the leaders of society of the importance of the problem, and may aid in suggestions for reduction in severity, numbers of injuries and death.

Rabies Threat

Another problem that involves the health of our patients indirectly is the threat of rabies in this state for we have by far the highest number of dogs infected with rabies of any state. Although there was only one human death in 1959, a number of people were bitten by animals with rabies and had to be subjected to the required long series of injections. We should use our influence to see that more effective means are instituted to reduce rabies infection in animals.

During the past year we have tried to instill more interest in immunization of all kinds for all people of Indiana. I hope that the day will come when doctors will become more aggressive in selling their patients the need of immunization, especially for the infant and later in life. If every infant is immunized, it will be done in the doctor's office where this procedure can be better done and at a time best for that child and family. We must not feel that there is anything wrong in promoting the health of our own patients.

I wish to compliment the University Medical School officials for their foresight in expansion of its facilities for more students to take care of the increase in the population. They are also to be complimented in regard to the new experiment in teaching a group of students in a two-year program who will be acceptable to go the last two years in a regular school.

I cannot tell you of all the activities that went on during the past year. These are being reported and submitted for study during this session of the House of Delegates. We have had a busy year with extra activities in the legislative field



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President's Address

Continued

and in the insurance field. The study and findings of the special committee for a state medical office building has been thorough and expertly handled. You answered the questionnaire in sufficient numbers to convince the committee and the officers of this society and I am sure that the new officers will give us what we want at a reasonable cost. I wish to compliment everyone for their tremendous untiring efforts to arrive at a proper decision for your society. The survey of our state association by a management consultant firm was done and a number of suggestions for improving the efficiency and activities were recommended and put into effect. I believe we have greatly benefited by this effort.

Loan to Students

As you know, the Indiana State Medical Association has a student loan fund, so ably handled by Dr. Ross, which has lent money to students. This loan bears no interest until after the student is in practice. Thirty-six students have been granted loans since the origin of this fund in 1956, three years ago. I believe we should seek means to increase the amount of money available for loans for there is certainly a need. We might consider publicizing this fund to our members with the idea that some doctors might want to contribute to this worthy project. We must never permit some capable student to drop out of school because of lack of finances if we can help him. Let each one of us give special thought about giving our efforts and financial help to this fund.

Now I believe I have covered what appeared to me to be important enough for your consideration. I hope I have stimulated thoughts and ideas for future and greater achievements of this wonderful association. You have all been very kind to and cooperative with me and I hope that some good has been accomplished for the Indiana State Medical Association that I love so well. ◄

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The Traditions



In Mexico

In Mexico, Christmas is marked by great gaiety. One of the most colorful customs is the breaking of the pinata by children. The pinata is a bright earthernware bowl that usually is made up to resemble the features of some animal. It is filled with fruit, peanuts, candies and other goodies.



Santa Claus

Santa Claus, the name beloved by children, comes actually from a German-Dutch derivation of the name of Saint Nicholas, who lived in the fourth century. The legend goes that the good saint heard of the plight of three maidens who were without suitors because their father was too poor to supply the dowry. Saint Nicholas came by their humble home at night, tossed three bags of coins into their room. Shortly thereafter suitors came for the maidens and they all lived happily ever after. "San Niklaus" from the German, became "Sinteklass" of the Dutch, who settled in New York. There the name wound up as Santa Claus.

In Japan

In Japan, Christmas is the signal for much merrymaking after church services. Dance halls are open 24 hours a day during the Christmas and New Year season and there is extensive dining. Gifts are exchanged and trees decorated as in other lands. Nearly everyone has rice and cakes and red-eye fish for the holidays.



of Christmas



Mistletoe

The Druids first used mistletoe because they believed it had curative powers. The Saxons gave it its name. It has become a symbol of peace and friendship and is hung over the entrance door. All who stand beneath it are entitled to a kiss.

In Sweden

In Sweden it is considered an omen of good luck if all Christmas candles burn brightly on Christmas Eve.



Yule Log

The Yule Log is wreathed in superstition and mystery. Some people believe it must not be handled or even lighted except by one with clean hands. Pine, ash, oak or olive wood is preferred for the Log. In some countries the Yule Log is gaily decorated with paper flowers and bright colored ribbons. Every year a branch is saved to rekindle the Christmas fire for the following year. Legend says that a half-burned Yule Log stored in the home serves as protection against lightning. According to some customs families who are separated by long distances will send each other Logs. At Christmas Eve both Logs are lighted and the families are together in memory.

Christmas Tree

The tree is deeply rooted in old legends. One of these is that the evergreen protected Joseph, Mary and the Infant from Herod's soldiers. Another story is that God sent his heavenly messengers to earth to find a tree "as high as Faith, as eternal as Hope, and as wide spread as Love," which would symbolize the birth of the Christ Child. The angels chose the balsam fir, according to the legend, since it had all these qualities and "bore many crosses on each branch." The tree stands as a symbol of Christ—the top pointing to the heavens, the lights depicting the Light of the World, and the presents heaped around it indicating that all good things come from above.



President-Elect's Message

Given Before the House of Delegates, Oct. 6, 1959, Indianapolis

EARL W. MERICLE, M.D.

President, ISMA 1959-60

I APPRECIATE the confidence this House of Delegates placed in me last year by electing me president-elect. Be assured my services will be the best I can give, and also be assured that the desires of this body, which is the governing body of the association will be followed.

Today, medicine finds itself in the midst of social change. We cannot be unwilling to change, nor can we too avidly accept changes without careful scrutiny of effects those changes bring. The deliberations of this House and the actions of its officers this year are perhaps as important as any that have occurred in the past, for today we are confronted with pressures never before experienced.

First, is the health of our people a responsibility of medicine?—or is health a responsibility of government? If health is a responsibility of government, where does medicine fit into the total picture? If health is a responsibility of medicine, then the freedom that goes with responsibility must reside in medicine. There is constantly some legislation before the Congress of the U.S.A. that would limit our freedom and interefere with free enterprise in medicine—also the legislation at state level is not devoid of such purposes. What is our action to be in this matter?

Another problem concerning organized medicine is that of the care of the aging population. At present, there are plans to consider reducing fees for medical care to those past 65 years of age—already one state has attempted such and the results are not all good. At present, there is no concrete knowledge of how extensive this need is. No one knows how many people past 65 need consideration of this kind. As yet, there is no breakdown of information as to the amount of senior citizens with insurance, private means, veterans care or responsible relatives who would not require this care. The Indiana State Medical Association is now engaged in such a study, which is perhaps the first of its kind.

One Congressman from Indiana remarked that he could always be elected if he had the votes of all those over 65. This certainly reveals the political side of this question.

One must consider two facts in considering this problem: (1) Can any type practice maintain the high standards now being maintained on a reduced fee basis? (2) Will this concession of fees be a lever to other groups to demand the same financial consideration? The long history of medicine caring for those unable to pay is a part of the doctor's responsibility and thereby removes one of medicine's finest traditions.

How do we approach this problem?

Another problem following organized medicine is that of insurance. As is well known, Blue Cross was established for the hospital needs; Blue Shield was established for the doctors. The Blue Shield was established to take the economic shock of catastrophic illness from the patient. As it has developed, more and more is expected of Blue Shield by both doctors and patients. Can the profession continue to demand more of Blue Shield and evade a service plan? If a service is established, fixed fee schedules are a reality. Presently, unit fee schedules are being considered by the AMA in meetings all over the U.S.A. Insurance companies would welcome such a schedule, as it would eliminate the problems now encountered in indemnity schedules. At present, there are 71 Blue Shield plans covering 42,575,256 people—of this total 57 are operating on a service basis covering 32,-

142,002 people, which indicates 75% of all members of Blue Shield are covered by a service plan. There are 14 indemnity programs. Indiana has such a plan, and has not seen fit to change its plan.

Organized labor wants a service plan, and in some areas of the state this voice is most compelling.

When one considers the Blue Plans as they exist today, it seems the emphasis has been to send patients to hospitals, rather than to doctors' offices. Perhaps, the medical dollar might be better utilized if some procedures once done in offices could be returned there again.

This, again, is offered for your consideration.

Another factor in our deliberations will include the changing of medical practice. No longer is our membership made up almost exclusively of private practitioners of medicine. More and more physicians are finding careers in federal positions, state positions, group practice, industrial practice and teaching medicine has now almost become a career aside from private practice. Consideration to the needs of these physicians must be given, as they are a part of our organization. These types of practice have proven themselves necessary in our social scene, and as such they will stay unless social change reduces their need. This does point out a change in our own ranks, which could be a source of splintering our unified efforts to the detriment of all.

Another feature of changing practice has been noted in the number of patients who circumvent the physician and go directly to a hospital. This tendency, perhaps, can be laid at our own door, as in the past it has been very easy to refer someone to a hospital for care because ones busy schedule doesn't permit this patient's inclusion. Another factor is the demand of the accrediting bodies that out patient care be a part of the total training program. This training could be done by the physicians, themselves, if they were willing to have residents in their offices in order to meet the criterion of seeing ambulatory patients.

The problem of relation of hospital staff societies to the county medical society is one of present significance. The president of the Marion County Society has indicated the functions of scientific meetings are lost to the county society because of lack of attendance at county society meetings. This type of meeting, he feels, is taken over by the staff societies of the hospitals, where attendance at meetings is mandatory to preserve one's privilege of membership.

Is the local society, which represents all doctors, to lose this prerogative entirely? Has specialization reached the point where only information regarding the specialties is desired? Is there no common meeting ground for scientific discussion for all medical disciplines? Is the county society to be a social, political organization only? This is for your consideration also.

Finally, the building—a home for our state organization must be mentioned. By mandate of 1,237 members against 383 the state association is to construct a home for the association. The House of Delegates is to decide: Are we going to build? Where are we to build? How much money are we to spend? How will the House of Delegates implement this mandate? This is for consideration too.

I would recommend that when these questions are answered that either the House of Delegates or the president appoint a committee of five men to do the job. This should not be a function of the Council nor the Executive Committee, as these bodies have more than adequate problems for their attention, and the problem of construction will require a great effort.

How can these questions be met, and what can be recommended for action?

1. To strengthen our association by closer liaison between the county societies—the districts—and the state office—the districts, particularly, to be recognized in the chain of relationship.

2. To begin now to take positive positions in which we are willing to stand and be counted when our position is right.

3. To rededicate ourselves, today, to the principles that are our heritage, and to justly and honestly pursue this policy.

This policy includes the care of all patients who present themselves for help.

We must continue our responsibilty to our patients, and in so doing, demand and keep the freedom that is necessary for, not only our survival as free men, but the freedom for our patients to select the doctor of their choice when the need arises. ◄

Medical socialization threat of Forand Bill calls for prompt and effective preventive action.

Uncle Sam with a Stethoscope

LOUIS M. ORR, M.D.
President
American Medical Association

MOST OF YOU know, I am sure, that the Forand Bill—which was first introduced in 1957—is being considered by the 86th Congress. This legislation would provide certain hospital, surgical, nursing home and dental benefits to persons receiving Social Security retirement and survivorship payments. The same idea, with numerous variations in benefits and eligibility, will be appearing in many other bills and amendments.

The real issue is not the specific provisions of the Forand Bill, but rather the basic principle involved. Any Forand-type legislation would raise the same danger. It would add service benefits to a Social Security program which so far has been limited to cash payments based on the "floor-of-protection" concept.

This new principle, as you know, would alter the nature of the Social Security program. It would pave the way for evolution of a system of tax-paid health care for the entire population. Every two years—in the even years of federal elections—the push for amendment and expansion would be under way. The continuing trend would first undermine, and eventually destroy, our system of voluntary health insurance and the private practice of medicine.

Top Priority in '60

No action was taken on the Forand proposal during the first session of the 86th Congress. However, it will carry over into the second session. And next year may be a different story. Because of its political appeal, this issue may very well assume "top priority" status in the presidential election year of 1960.

From the defensive standpoint, we must be alert to the strategy and tactics which probably will be employed next year by backers of the Forand Bill. For example, we should keep in mind these possibilities:

They will be ready to accept compromises that will water down the bill.

They are chiefly interested in establishing a precedent, no matter how small, for government-financed health care of the aged.

By using the tactics of "divide and conquer," they will try to prevent the American Medical Association from establishing a united front with the insurance industry, the Blue Plans and the American Hospital Association.

To disarm physicians, and lessen the intensity of their opposition, the bill may be amended to cover only hospital and nursing home care.

Every effort will be made to dilute the plan so as to make it more palatable to the hospitals. This strategy may include the suggestion that Blue Cross serve as the fiscal agent for any Social Security hospitalization plan.

To disarm those who are concerned over the potential cost of the Forand Bill, the age of eligibility may be raised to 70 as a starter.

* * * * *

This different approach will be more dangerous than any outright attempt to pass the Forand Bill as it now stands. A compromise proposal would

Continued

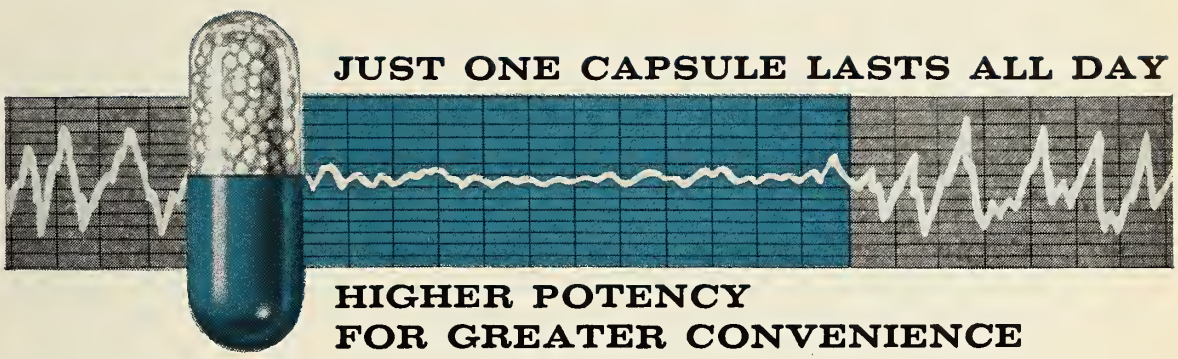
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Uncle Sam

Continued

appear to be harmless, and would not open the gate quite so wide right at the start, but it would lead to the same eventualities.

Establish United Front

To counter this approach, we must establish and maintain a united front of physicians, hospitals, insurance companies, Blue Cross, Blue Shield and all other groups that would be affected by such legislation. It is especially important for hospital administrators and trustees to realize that any kind of government subsidy — either direct from Washington or indirect through a fiscal agent—would simply be the first step toward federal controls.

However, we must do much more than just organize a good defense. We have to show that medicine and insurance have a better answer than the kind offered by Forand-type legislation. Our objective is not simply to beat an undesirable bill in Congress. Our major goal is to help solve a problem. And this particular problem gives us an opportunity for practical action—a challenge to produce dramatic progress in the growth and development of health insurance coverage for older people.

Of course, definite progress already had been made before Mr. Forand emerged on the scene with his version of an old idea. As of 1958, some 43% of the people over 65 had some form of health insurance protection. Many encouraging activities and trends have been taking shape during the past few years.

Not Pushed Hard Enough

For example, the number of persons over 65 covered by voluntary health insurance has been increasing at a greater rate than the total number of persons reaching age 65.

Coverage for persons now over 65 has been more widely available than generally recognized, but until recently it has not been "pushed" hard enough by most insurance companies and prepayment plans.

Continuation after retirement of coverage carried during working years is extending rapidly.

The principle of paid-up policies at 65 is still in the experimental stage, but despite the problems there are several possible ways in which this might be accomplished.

For the past year or more, both the Blue Shield Plans and the Health Insurance Association of America have had special committees actively studying means of expanding coverage for older persons. The latter organization, as most of you know, has been urging member companies to offer policies that are guaranteed renewable for life, individual and family coverage for persons already over 65, group coverage that will continue after retirement, and group contracts providing the right to convert to individual coverage when employment is terminated.

To help stimulate all these developments, the House of Delegates of the American Medical Association last December adopted a proposal which applies specifically to the population group over 65 with very modest resources or low family income. For medical services rendered to this particular group, physicians are urged to accept a level of compensation that will permit the development of insurance and prepayment plans at a reduced premium rate.

Adjust Fees with Vigor

Needless to say, the AMA is urging all state and county medical societies to implement that policy of adjusted fees with the utmost speed and

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vigor. And early this year the Blue Shield Plans developed a model insurance contract for persons over 65, incorporating the principle of the AMA policy action.

By August, when we testified before the Senate Sub-Committee on Problems of Aged and Aging, we were able to report that 25 Blue Shield plans in 23 states now enrolled persons over 65. In practically all of the other states, medical societies and Blue Shield plans are working out special new programs for the aged. It also was reported that all Blue Shield plans now permit those over 65 to continue their coverage.

In addition, the commercial insurance companies have been making excellent progress during the past year. An increasing number of companies—including many of you represented here today—either have announced new, specially tailored policies for the aged, or you have extended existing policies to more and more states.

We can say with truth and confidence that health insurance coverage for the aged will grow at an accelerated pace in the months ahead. In a conservative estimate based on trends of the recent past, the Health Insurance Association of America predicted earlier this year that 60% of the senior citizens who want it or need it will

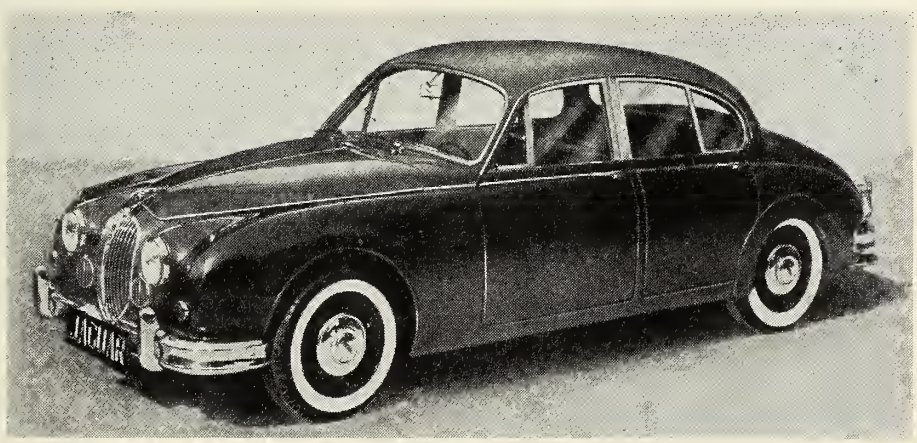


have protection by the end of 1960. Their further estimates are 75% by 1965 and 90% by 1970. Actually, however, because of the intense interest and activity now centering on this problem, the rate of growth might far exceed those conservative predictions—if medicine and insurance will cooperate in a valiant, all-out effort.

Most Urgent Field

During the next nine months or so, many people, including the members of Congress, will be paying close attention to the over-all problems of aging and the aged. And while health insurance coverage for older people is only one phase of this broad subject, it is—from a timely, practical standpoint—the most urgent field of activity.

In my opinion, the medical profession, the pre-



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Indiana State Board of Health

DIVISION OF COMMUNICABLE DISEASE CONTROL

MONTHLY REPORT - October, 1959

Disease	OCT. 1959	Sept. 1959	Aug. 1959	Oct. 1958	Oct. 1957
Animal Bites	435	601	618	784	300
Chickenpox	40	36	7	104	189
Conjunctivitis	38	91	59	41	23
Diphtheria	0	1	0	4	1
Dysentery, Unspecified	16	14	15	14	48
Impetigo	112	302	99	175	71
Infectious Hepatitis	18	12	20	17	14
Infectious Mononucleosis	12	5	4	19	7
Influenza	411	375	150	753	35672
Measles (Rubeola-Rubella)	35	79	64	171	59
Meningitis, Meningococcal	1	1	2	4	8
Meningitis, Other	23	49	25	15	14
Mumps	41	40	11	87	157
Pertussis	40	81	56	147	47
Pneumonia	76	112	61	138	129
Poliomyelitis	20	55	40	39	32
Streptococcal Infections	135	182	150	372	80
Tinea Capitis	7	21	3	7	4



Uncle Sam

Continued

payment plans and the insurance companies must concentrate, in the months ahead, on the development of voluntary coverage for the aged. We must promote, advertise and publicize new plans and policies. And we must be able to go before the Congressional committee hearings next spring with a real story to tell—a story of dramatic growth in coverage, new ideas and approaches, and hopeful outlook for future progress.

If we make that kind of effort—and if we can present a convincing case to Congress next year —I think we may be able to beat back the advocates of government action. If we do not make that effort, I would hesitate to predict the long-range future of medicine and voluntary health insurance. ◄

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INDIANA'S POISON PREVENTION PROGRAM

Hoosier household poison registration law and poison control centers are invaluable aids to physicians in poison treatment; but physicians must help through educating patients in use and storage of toxic materials.

T. E. SULLIVAN

Indianapolis

WHILE many infectious and communicable diseases are happily declining, it is an unfortunate fact that the number of accidental poisonings in the home is steadily increasing. In the majority of cases, small children are the unfortunate victims of poisoning accidents because, as a rule, the small child will put anything within reach into his mouth and swallow it.

On a national scale, statistics now show that more than 500 children under 5 years of age are killed each year by household poisons, and an additional 600,000 nonfatal poisonings occur in children annually. A recent study of 4,000 cases of accidental poisoning by the Public Health Service, United States Department of Health, Education, and Welfare, revealed that 86% of the cases studied occurred in children under 5 years of age—the largest number being in the 1- to 2-year age group. The study also showed that 85% of the children were under the supervision of a parent at the time the poisoning occurred, 10% were being cared for by other adults and only 5% had been left under the care of other children.

Death certificates submitted to the Indiana State Board of Health during 1958 show that 2 small children died from swallowing household lye, 4 died from ingestion of fuel oil and household products containing petroleum distillates, 2 died from ingestion of rat and mouse poisons, and several children's deaths were attributed to overdoses of medicines and drugs, particularly aspirin. In Indianapolis alone, hospitals reported treating 363 persons for poisoning from January 1 through November, 1957. During this period of time, 2 small Indianapolis children died by poisoning, one by chewing lead paint from a window sill and the other from an overdose of caffeine tablets.

* Director, Division of Food and Drugs, Indiana State Board of Health.

250,000 Toxic Products!

The American Medical Association has estimated there are approximately 250,000 toxic or potentially toxic consumer products on today's retail market. Many of these products bear labels identifying the hazardous ingredients, such as the labels of drugs, pesticides and caustics which have been regulated by federal laws. However, a multitude of other chemical specialty products sold to the householder have never been regulated by either federal or state legislation. As a consequence, most of these products fail to bear any information on the label to identify the hazardous ingredients or to caution the purchaser to keep them out of the reach of children.

The principal problem confronting the pediatrician and general practitioner has been the difficulty in obtaining, without delay, authentic information on the type and percentage of hazardous ingredients in products involved in home accidents. Frequently, it is impossible to get this information from the manufacturer, even when his identity is known. Many poisoning

Continued

Poison Prevention

Continued

accidents occur during night hours or on week ends and holidays when informed company personnel cannot be located. In some cases, manufacturers have been reluctant to disclose sufficient information on which to base adequate medical treatment, on the premise that formulation data on their products are "trade secrets."

Poison Control Centers

The physician, although well informed on the toxic effects of most medicinal agents, cannot be expected to be familiar with the infinite number of trade name products available on the retail market. To meet the need for a reliable source of up-to-the-minute information on the toxic nature of trade name products and hazardous substances, the idea of a poison control center was developed by the American Academy of Pediatrics. The first poison control center in the United States was established in Chicago in 1953. By 1957, 130 local poison control centers were in operation, and today there are 260 poison centers operating in 42 states and the District of Columbia.

Poison control centers have developed along two basic patterns, (1) as a poison treatment center where facilities are maintained for emergency treatment of all types of poisoning accidents, and (2) as a poison information center which provides toxicity information on trade name products and substances to physicians and hospitals on a 24-hour-a-day, 7-day-a-week basis. Many communities have developed a combination of these services into a single poison treatment-information center.

In recognition of the need for a central agency to coordinate the efforts of local poison centers in collecting information on new products, the Public Health Service, U. S. Department of Health, Education, and Welfare, established a National Clearinghouse for Poison Control Centers in 1957. Since there is no law requiring manufacturers to report ingredient data on hazardous products to the National Clearinghouse, a voluntary arrangement was worked out with more than 200 major manufacturers of drugs and household products to obtain information on hazardous products and antidotes for them. The National Clearinghouse supplies these data to all established poison centers in the

Continued on page 2116



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Riboflavin (B_2)	5 mg.
Niacinamide	15 mg.
Folic Acid	1 mg.
Pyridoxine HCl (B_6)	0.5 mg.
Ca Pantothenate	5 mg.
Choline Bitartrate	50 mg.
Inositol	50 mg.
Ascorbic Acid (C)	50 mg.
Vitamin E (as tocopheryl acetates)	10 I.U.
l-Lysine Monohydrochloride	25 mg.
Rutin	25 mg.
Ferrous Fumarate	30 mg.
Iron (as Fumarate)	10 mg.
Iodine (as KI)	0.1 mg.
Calcium (as $CaHPO_4$)	157 mg.
Phosphorus (as $CaHPO_4$)	122 mg.
Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF_2)	0.1 mg.
Manganese (as MnO_2)	1 mg.
Magnesium (as MgO)	1 mg.
Potassium (as K_2SO_4)	5 mg.
Zinc (as ZnO)	0.5 mg.

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1. Bodi, T., and Levy, H.: Clinical report, cited with permission. 2. Wetzler, R. A., and Phillips, R. M.: Clinical report, cited with permission. 3. Prigot, A.: Clinical report, cited with permission. 4. Gosline, E., *et al.*: *Am. J. Psychiat.* 115:939 (April) 1959. 5. Turvey, S. E. C.: Clinical report, cited with permission.

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Poison Prevention

Continued from page 2212

United States, which is the chief source for such information.

Indiana Sets Precedence

In 1957, Indiana led the states by enacting the Indiana Household Poison Registration Act, a precedent-setting state law requiring manufacturers, distributors or sellers of poisonous household products to, (1) label the product to identify each poisonous ingredient by chemical name, and (2) register the formulation with the Indiana State Board of Health. In order to insure up-to-date information in the State Board of Health files, the law further required reregistration of any poisonous household product if the trade name, chemical formula or the manufacturer be changed after the initial registration. This legislation was sponsored by the Indiana State Medical Association for the purpose of providing the Indiana physician and emergency treatment hospital with an authentic source of information on the toxic nature of household products through the medium of product labeling and the establishment of a central repository of information at the State Board of Health.

Following Indiana's lead, the states of Connecticut, Kansas and Texas enacted similar legislation to require labeling of hazardous household products. Colorado recently enacted a hazardous substance law which takes effect Jan. 1, 1960. Within the last few months, Ohio and Illinois have enacted similar state laws. Several other states are reported to be considering such legislation. Two bills were introduced in the 86th Congress for the purpose of establishing federal legislation on the subject. It now appears that when Congress reconvenes, legislative action will be taken to establish a Federal Hazardous Substance Act which will supersede the antiquated Federal Caustic Act of 1927.

Information Around-the-clock

Up to the present time, Indiana's requirement for registration of hazardous household product formulas has remained unique among the various state laws. The value of Indiana's registration program is particularly evident in emergencies where the physician does not have access to a labeled container of the

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causative agent. Information on the hazardous ingredients of any registered product can be obtained by any Indiana physician or hospital by calling the State Board of Health at any time—day or night, seven days a week. For the protection of manufacturers' interests, the Indiana law permits disclosure of only the hazardous ingredients by chemical name and percentage. The confidentiality of information on nonhazardous ingredients is preserved.

The Indiana Act provided an exemption for drugs labeled in compliance with the Indiana Food, Drug, and Cosmetic Act and for household products registered under the Federal Insecticide, Fungicide, and Rodenticide Act as these laws require labeling of active ingredients. Products for agricultural or industrial use only were also exempted.

As the 1957 Indiana Act was pioneering legislation, several problems were encountered in drafting the bill and later in administering the law. The principal problem in preparing the legislation was that of properly defining the hazard which concerned the physician. The term "poison" was finally chosen as most descriptive of the hazard of products which cause serious human injury or death through accidental misuse. In order to provide industry with a criteria to use in evaluating products, the LD 50 toxicity testing standards of the Manufacturing Chemists' Association were included in the Act as a part of the definition of a poison. A provision was added to give precedence to human experience over test results obtained on laboratory animals in determining if a product qualified as a poison.

Some Manufacturers Reluctant

In administering the law, it was found that some manufacturers were reluctant to register and label their products under a poison definition, and certain elements of industry contended that the human experience provision of the Act was legally restricted to experience with the concentrations outlined in the LD 50 animal tests. It also became apparent that many chemical ingredients of household products are not amenable to the LD 50 tests although capable of causing serious human injury or death. For example, carbon tetrachloride, ethylene glycol and petroleum distillates do not classify as technical poisons. The toxicity of these substances to small children is, of course, generally recognized. In the interest of consumer protection, many manufacturers voluntarily registered and labeled their products under the 1957 Indiana law even though many products did not technically classify as a poison under the LD 50 definition.

The need for additional precautionary information on labels of hazardous household products was also recognized since many chemicals might not be interpreted as dangerous to children by the householder.

In order to resolve the problems with industry in administering the original law and to provide more extensive protection to the householder, a bill for a new and broader law was drafted for consideration by the 1959 Indiana General Assembly under the sponsorship of the Indiana State Medical Association. The Chemical Specialties Manufacturers Association, Manufacturing Chemists' Association and individual representatives of the various chemical industries took an active part in the drafting of the new legislation. Most of the suggestions by industry were incorporated in the bill for the purpose of

Continued



Poison Prevention

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establishing uniform definitions of hazard and labeling requirements in line with similar legislation in other states and the proposals for federal legislation.

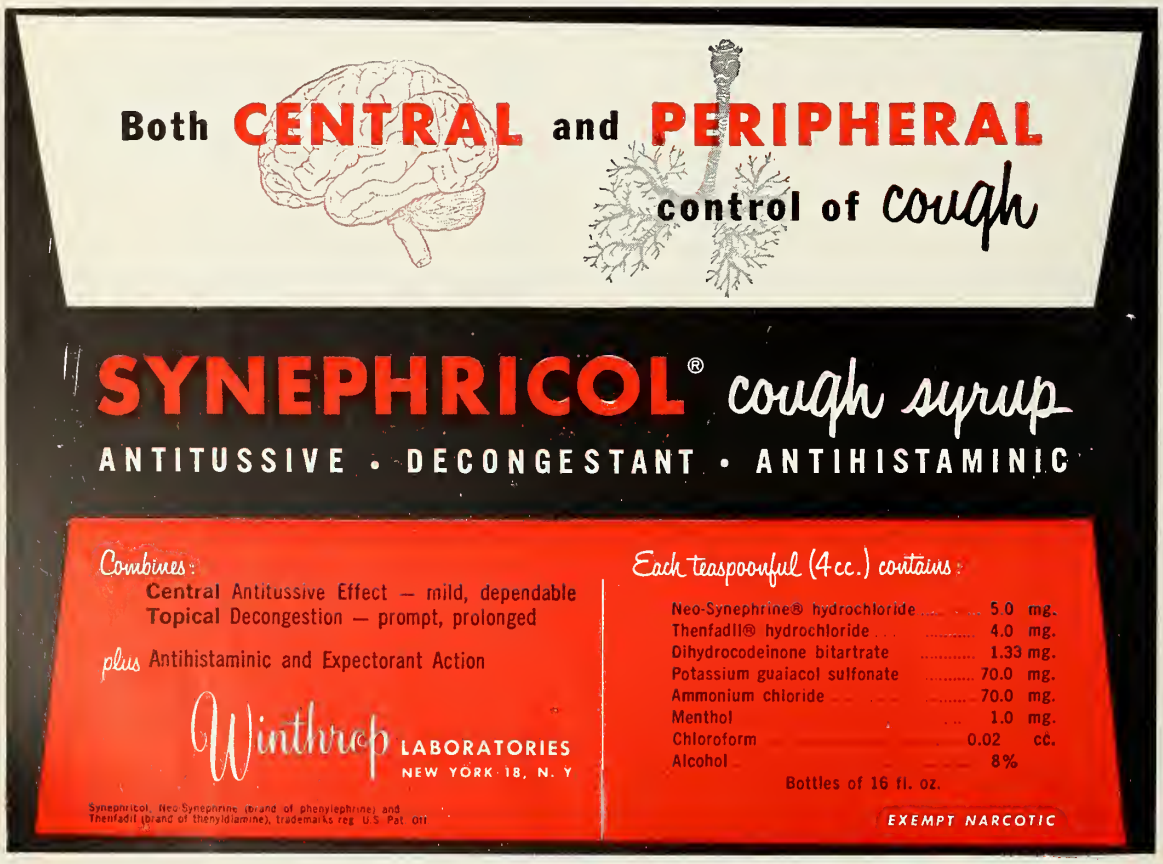
Indiana's New Law

The 1959 General Assembly enacted the proposed new legislation into law as the Indiana Hazardous Household Product Act, which becomes effective Jan. 1, 1960, to replace the 1957 Act. The new law defines a hazardous household product as one capable of causing serious human injury or death by reason of its being, (1) a poison, (2) toxic, (3) corrosive, (4) an irritant, (5) flammable, (6) radioactive or (7) capable of generating pressure through decomposition, heat or other means. In the new law, the LD 50 test for determining a technical poison was modified to require a 14-day test rather than the 48-hour test required in the 1957 Act. This change may result in a number of additional products being classified as a poison.

Under the new law, manufacturers and distributors will be required to show the following information on labels of hazardous household products:

(1) the name and place of business of the manufacturer, packer or distributor.
(2) the common or usual name, the chemical name or the recognized generic name (not the trade name only) of each ingredient which contributes substantially to the hazardous quality of the product.
(3) one of the signal words: "Danger," "Warning" or "Caution."
(4) an affirmative statement of the hazard, when necessary, for the protection of the user, such as "Flammable," "Vapor Harmful," "Causes Burns," et cetera.
(5) precautionary measures describing the action to be followed or avoided.
(6) instructions, when necessary, for first-aid treatment.
(7) the word "Poison" for any product which is a poison, as defined by the act.
(8) instructions for handling and storage of packages which require special handling or storage.

Continued



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VARIDASE is not an anti-infective, but by increasing the permeability of the fibrin wall, it eases penetration of natural regenerative factors and fosters healthy tissue growth, making infection less likely.

VARIDASE Buccal Tablets contain: 10,000 Units Streptokinase and 2,500 Units Streptodornase.

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Poison Prevention

Continued

(9) the statement, "Keep out of the reach of children," or its practical equivalent.

The exemption of hazardous household products registered under the Federal Insecticide Act was modified under the new law to require manufacturers to file the formulas with the State Board of Health in order that physicians' inquiries concerning such products can be answered. The change was also made in view of the fact that some toxic solvents used in insecticides, fungicides and the like may be included under the term "inert ingredients" on labels registered under the Federal Insecticide Act.

Product registrations completed under the 1957 law are preserved so long as there is no change in the product trade name, chemical formula, or the manufacturer's or distributor's name shown on the label. However, all hazardous household products must be labeled in accordance with requirements of the new law after Jan. 1, 1960.

Locate Centers Strategically

In conjunction with administering the Indiana legislation on hazardous household products, the State Board of Health is interested in developing a program to establish poison information centers at strategic locations in the state to expedite the prompt transmittal of toxicity data to physicians and hospitals in emergencies. A plan is now being studied to establish several such centers in order to eliminate the present need for a call to Indianapolis in each emergency.

At the present time, Indiana has 11 operating poison information and/or treatment centers.

Continued

TABLE 1

Poison Information and/or Treatment Centers in Indiana

CITY	NAME AND ADDRESS	TELEPHONE	DIRECTOR
Anderson	St. Johns Hickey Memorial Hospital 127 West 19th Street	3-3391 Ext. 82	Sister Mary, Administrator
East Chicago	St. Catherine Hospital 4321 Fir Street	Export 7-3080	Jack Troy, M.D.
Elkhart	Elkhart General Hospital 600 East Blvd.	3-5350 Ext. 224	C. Richard Yoder, M.D.
Evansville	Welborn Memorial Baptist Hospital, Inc. 412 S. E. Fourth Street	Harrison 3-3103	R. K. Glenn Chief Pharmacist
Gary	Methodist Hospital 1600 West 6th Avenue	Turner 3-0491	Glen T. Dreher, R.N.
Hammond	St. Margaret Hospital 25 Douglas Street	Westmore 2-2300	Herbert I. Arbeiter, M.D.
Indianapolis	Marion County General Hospital 960 Locke Street	Melrose 6-6331 Ext. 211 or 212	Richard W. Dyke, M.D.
	Methodist Hospital (Emergency Room) 1604 North Capitol Avenue	Walnut 4-6411	Merle Bacastow, M.D.
	Poison Information Center		
	Indiana State Board of Health 1330 West Michigan Street	Melrose 4-8433 Ext. 226	
Marion	Marion General Hospital Wabash and Euclid Avenue	North 4-2313 Ext. 44 or 45	A. B. Snowhite, M.D.
Whiting	Whiting Clinic 1900 Indianapolis Blvd.	Whiting 2075	Jack M. Troy, M.D.

Although Indiana is in an enviable position to obtain and distribute toxicity information on trade name household products to physicians and hospitals, it is recognized that labeling and registration is only a partial solution to the problem of accidental poisoning of children in the home. Many manufacturers of drugs and medicaments are developing safety closure containers which are difficult for the small child to open. Educational programs are needed to make the public aware of parental responsibility to keep all potentially harmful products out of the reach of children. The efforts of manufacturers to properly label hazardous products will be of little avail if the householder fails to read the label, or, having read it, fails to handle, store and use the article as directed.

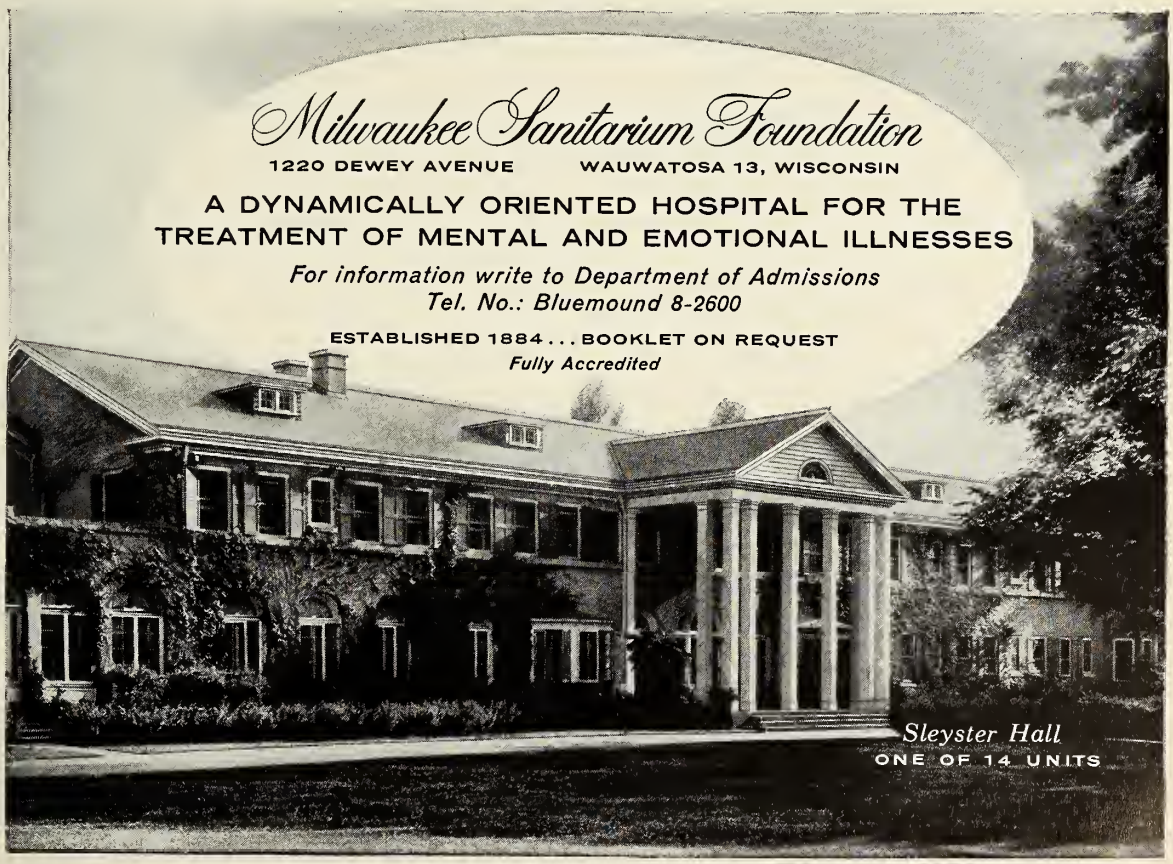
The pharmacist can play an important role in poison prevention by attaching labels printed with the statement "Keep out of the reach of children" to all legend drugs he dispenses.

Physician Can Assist

The physician can assist materially in preventing many accidental poisonings in the home which involve prescription drugs and medicines if he will make a special effort to instruct each patient in the use of prescribed medicaments, including written warnings where necessary, such as "For external use only," "Do not use near the eyes", "Keep out of the reach of children", et cetera. The pediatrician, in particular, has many excellent opportunities to drop home safety hints to parents regarding the dangers of careless storage of any potentially hazardous substance within the reach of small children.

Protecting children from accidental poisoning must become a matter of concern for everybody—the manufacturer, the distributor, the householder, the physician, the teacher—if it is to be effective. Mandatory provisions of the Indiana law, supplemented by a state-wide poison intelligence network, must be complemented by an educational program directed to parents and guardians if the number of accidents involving children is to be reduced materially. ◄

Automobile-bicycle collisions during 1958 injured 59,300 persons.



Why Business Should Take More Interest In Politics and Legislation

GEORGE W. McDERMOTT

State Senator

THE 91st Indiana General Assembly will long be remembered by those who were in close touch with its deliberations and you people from business and industry should take warning from those individuals who fought your battles with the radical labor bosses.

Never before in Indiana legislative history have such forces been organized and directed toward the complete subjugation of the free enterprise system in Indiana. With a House of Representatives completely dominated by big labor, radical labor legislation flowed rampant. Even to the extent of having an imported Chicago labor lawyer writing a weak labor reform bill for the majority party in the house.

The people of Indiana can thank their lucky stars for a State Senate that had the intestinal fortitude to stand up and fight off the onslaughts of big labor.

In terms of unfettered power, big labor is the strongest single center in our American economy today. Big labor today is in a position of unrestricted monopoly power. There can be no question that big labor is politically powerful and effective. Certainly the results of the last election can leave no doubt in your mind. A good look at the recent political triumphs in California, Michigan, Ohio and Indiana will show you the results of all-out participation in politics by the whole union organization.

For this reason the big labor unions with their economic-monopoly power, their political influence, their methods and motivating philosophies, demand the most serious scrutiny by all thoughtful Americans, liberals and conservatives, Democrats and Republicans who are seriously concerned about preserving important basic fundamental values of our economic and political system.

You may not like what I am about to say—but as chairman of the Senate Labor Committee—along with many of my fellow Senators who lived and fought for 61 days fighting for your rights, we believe that we have earned the privilege of telling business and industry what you are going to have to do—if you want to stay in business and remain free. I have never been more serious in my life as I direct these remarks to you. I do not want to appear as an alarmist—but just give you the facts.

No longer can a handful of legislators and a few Chamber of Commerce research men hold the line against the very same issues that management bargains away to the big labor bosses at the conference table. I know of the great bitterness of conservative legislators who comprehend exactly what happened last November, and of what is likely to happen again. Time after time they have said to each other, "What's the use when management itself doesn't seem to give a dam?" A few of you business people came down to the Legislature, but the majority of you sent your wires and letters whenever you got excited about some issue, telling us to pass this bill or kill that one. Quite often you asked us to hold the line against certain issues that had passed many days previously. The plain fact is that you are missing the boat—in most cases you were wasting your time—because the basic voting alignment on the major issues you were concerned about was all decided on election day

* Presented before the Industrial Division of the Greater Lafayette Chamber of Commerce June 17, 1959, Lafayette.

and you business and industrial managers had very little to do with that.

As chairman of the Senate Labor Committee I received hundreds of letters and telegrams from you people asking me to hold the line on the Right-to-Work law and other important issues. I knew from personal contacts and other first-hand information that many of the writers of such letters had actively supported duly elected legislators that were fighting to repeal or pass the very same issues you were asking me to hold the line against. The logical answer is for business and industry to pay more attention to *who* gets sent to Indianapolis, or Washington, to write our laws.

No longer can business and industry sit on the side lines and expect a handful of legislators and chamber of commerce people to bleed and die figuratively for your rights in the halls of our State legislature and in the halls of the Federal Congress.

You people contribute dollars to the political parties of your own choice and that has been the extent of your efforts toward self preservation. A lot of you make the cardinal political sin of not voting in the primary, and that has led to the labor domination of one of our major political parties.

The time is now present, business and industry must become participants in our future political wars in order to maintain control of your own destiny. You are now going to have to put *your voice, your influence* and *your organizational know-how* where in the past you only put your dollars in party contributions.

I would like to stress at this point that I believe that it would be wrong for business and industry to get into politics just to be the counterpart of union political action.

I believe that a business-in-politics movement should be directed toward the maintenance of a free business system which is part of the basic fundamentals of a free society. The businessman's stake in government is co-extensive with government itself.

I am firmly convinced that unless you make politics an essential part of your business—you are going to find it increasingly difficult to do business at all. Right now our complete system of representative government is in danger.

The Constitution of these United States assures us that our government should belong to everyone. However, practical politics is rapidly changing that. In the final analysis—the government belongs to that segment of society which practices practical politics best—especially if others choose to ignore their own stake in political affairs.

Sadly enough—a large segment of American society, the people who make their living as employers and managers, have shunned politics and consequently have allowed groups that are hostile to business to have more than a proportionate share in formulating all legislation.

I am confident in predicting to you—that if the political trend of 1958 continues on into 1960—business and industry in this State and Nation is going to be well on its way to existence under the rules of a labor government.

Listen to me my friends—listen to what Labor plans for National VOTE-GETTING DRIVE.

From the March 9, 1959 issue of the *Indianapolis Star* comes the following AP release and I quote:

"Organized labor's top political directors yesterday announced plans for a coast-to-coast series of meetings to rally Union vote-getting forces for 1960 election campaigns.

Continued



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Business and Politics

Continued

"The first of 20 such rallies opens Wednesday at Huntington, West Virginia, for delegates from Kentucky and West Virginia. Other sectional gatherings will be held regularly week by week through June.

"James L. McDevitt, COPE director, said that last year's conferences were so successful in gearing up Union vote-getting task forces that the program is being tripled this year.

"The 1958 conferences were the most successful we have ever held, McDevitt said. Undoubtedly a major portion of our own accomplishment in the November elections can be attributed to them.

"McDevitt said the conferences give Union people of a given area an opportunity to exchange information on political tactics and strategy, and renew contacts with the Nation COPE staff.

"He said he was confident the coming meetings will give impetus in our efforts in the State and Municipal elections this year and the National and Congressional elections in 1960.

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SURGERY—
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Surgery of Colon & Rectum, One Week, November 30, January 25
General Surgery, Two Weeks, December 7
Blood Vessel Surgery, One Week, November 30

GYNECOLOGY & OBSTETRICS—
Vaginal Approach to Pelvic Surgery, One Week, February 1
Office & Operative Gynecology, Two Weeks, February 9
General & Surgical Obstetrics, Two Weeks, February 22

UROLOGY—
Two-Week Intensive Course, April 22
Ten-Day Practical Course in Cystoscopy, by appointment

RADIOLOGY—
Diagnostic Radiology, Two Weeks, November 30

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"The more elaborate set of sessions this year is a further indication of organized labor's determination to seek an even greater role and influence in City, State and National elections."

All over this country I read and I hear this cry—*POLITICS IS IN BUSINESS. Let's get business into politics.*

Despite all the talk about getting business into politics, there is a real timidity in the corporate world to get active politically. Many of our friends in the corporate world are not aware that the Wagner Act prohibition, now removed, against employers talking to employes about unionism, and by inference, about any political issues, can be used to the fullest extent under the banner of an educational program. Competent legal opinion holds that a business association or corporation may:

1. Compare its own views with those of the various political candidates.
2. Distribute information regarding political candidates and their positions on issues and circulate the voting records of legislators.
3. Sponsor committees for the purpose of getting business people to become more active in politics.

I am sure we all know that contributions to political parties are not deductible for federal income tax purposes. Competent legal opinion holds that it appears generally that business and industrial groups can engage in a wide range of political education activities not contrary to the Corrupt Practices Act without effecting their tax status. The Unions certainly have free rein in their political education activities and the lavish spending of Union dues for whatever purpose they see fit.

Such Corporations as Aerojet-General, Gulf Oil, General Electric, Ford, General Dynamics, Chrysler, Shell Oil, United States Steel and others have said publicly they favored efforts to educate businessmen in the area of electioneering.

I would like for a moment to draw your attention to what one great American industrialist, Henry Ford II, had to say regarding business in politics in an address given Feb. 19, 1959 to the student body of Yale University, and I quote:

"How business has failed in politics.

"While business has been politically active, it has not been effective because of its failure to generate broad participation by people in local politics. I suspect also that it has erred in identifying itself and its causes too exclusively with the extreme conservative political viewpoint.

"It spends most of its time trying to convert the faithful; it has notably failed to appeal effectively to the large mass of independent voters and has almost totally defaulted in the terms of making its influence felt within the most moderate elements in both political parties."

I will have to agree with Mr. Ford's analysis. My own personal observations and experiences in some 20 years' participation in practical politics leads me to believe that practical politics is a science unto itself.

Elihu Root, 1845-1937, lawyer and statesman once said, and I quote: "Politics is the practical exercise of the art of self-government, and somebody must attend to it if we are to have self-government, somebody must study it, and learn the art."

Business and industry going into political education need to think through carefully the relationship involved so they can get off on the right foot. I am firmly convinced that for business and industry to get politically active, then business and industry must draw upon the know-how of the practicing, practical politicians within their own organizations, or seek assistance from veterans of outside political world.

In the interest of saving time and money I would most seriously recommend that much thought be given to the selection of person or persons required to head up such an activity within a corporation. This assignment cannot be a job for just anybody, the un-initiated, or the naive. This will be a job that is going to require *leadership, know-how, tenacity, intestinal fortitude* and *salesmanship*. Just finding the vitality to match the political vitality of the union movement alone will be no easy job. Many of us found that out on the right-to-work issue.

The very facts of practical politics tells us that the majority of the voting public is not ranked in the employer and managerial group, and is very largely indifferent to industry.

The voting public generally does not recognize any personal stake in the welfare of business and industry and many of our simon-pure politicians are well aware of these political facts of life. The politician who considers every legislative vote cast in the legislature as a matter of political expediency, knows that the general public is fickle—its indignation is short lived. That is why so many of our legislators and congressmen vote 100% in favor of labor legislation and ignore the general public. Putting through laws to curb labor abuses may be popular with voters this year. But the unions will be around for a long time, and they would not soon forget. We need another powerful voice to remind these labor politicians that America is the home of many, many groups of voters who are entitled to a voice in government.

So, I again say to you that we must recognize all the facts of the political world if we are to become a strong force in the realm of active politics.

In my closing remarks I would like to present a few facts concerning our presently active political scene in America.

We have a new political alignment that is rapidly crystallizing in America today and this

Continued on page 2228



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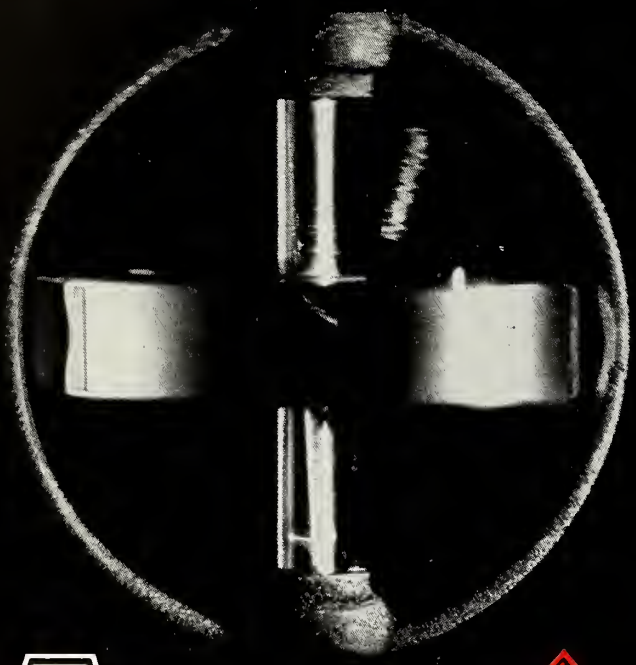
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References: 1. Feinberg, S.M., Feinberg, A.R., and Fisherman, E.W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J.I. and Sherwood, H.: *Connecticut Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S. and Friedlaender, A.S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M.S. and Duvenci, J.: *Bull. Tufts North East M. Center* 4:71 (April-June) 1958. 5. Segal, M.S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Sherwood, H. and Cooke, R.A.: *J. Allergy* 28:97 (Mar.) 1958. 7. Duke, C.J. and Oviedo, R.: *Antibiotic Med. & Clin. Ther.* 5:710 (Dec.) 1958. 8. McGavack, T.H.: *Clin. Med.* (June) 1958. 9. Freyberg, R.H.; Berntsen, C.A., and Hellman, L.: *Arthritis and Rheumatism* 1:215 (June) 1958. 10. Hartung, E.F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Hartung, E.F.: *J. Florida Acad. Gen. Pract.* 8:18, 1958. 12. Zuckner, J.; Ramsey, R.H.; Caciolo, C., and Gantner, G.E.: *Ann. Rheum. Dis.* 17:398 (Dec.) 1958. 13. Appel, B.; Tye, M.J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 14. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958. 15. Mullins, J.F., and Wilson, C.J.: *Texas State J. Med.* 54:648 (Sept.) 1958. 16. Shelley, W.B.; Harun, J.S., and Pillsbury, D.M.: *J.A.M.A.* 167:959 (June 21) 1958. 17. DuBois, E.F.: *J.A.M.A.* 167:1590 (July 26) 1958. 18. McGavack, T.H.; Kao, K.T.; Leake, D.A.; Bauer, H.G., and Berger, H.E.: *Am. J. Med. Sc.* 236:720 (Dec.) 1958. 19. Council on Drugs: *J.A.M.A.* 169:257 (Jan. 17) 1959. 20. Rein, C.R.; Fleischmajer, R., and Rosenthal, A.R.: *J.A.M.A.* 165:1821 (Dec. 7) 1957.

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Business and Politics

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alignment is causing a lot of us to do much serious, soul searching.

We have on the American political scene today—

1. A Democrat-Labor party—controlled body and soul by the big labor bosses of the northern States. Now I know that a lot of my good Jeffersonian Democrat friends will scream at me for making such a remark. However, the political facts of the past few years will bear out this analysis. Take a good look at the political and economical scene in the State of Michigan.

2. A Republican-Democracy Party—that is struggling for stability and waiting for real leadership. This alignment is composed of those Democrats who have no party to adhere to after the labor bosses take over in the primary election, and those Republicans who are tired of vacillation and me-too-ism. This Republican-Democracy party believes in financial solvency in government, State rights and representative government.

The time is at hand—right now, for much soul searching and serious reflective thinking.

Whether you like it or not, you are going to be compelled to take political action in self defense, or you can sit on your hands and the big labor bosses will dictate to a labor government how to regulate the American way of life. If we are to survive, big labor's political power must be opposed by a matching force, and there is no place in these United States where such a force can be generated except among the business and industrial corporations that make up American business.

In Indiana there is still time to turn about and reverse the trend. We can still make Indiana the pivot for an historic renaissance of political vigor, thus not only living up to the great traditions of freedom-living Hoosiers, but also serving as a beacon for other states to turn and regroup.

Believe me, the eyes of the nation are on Indiana now. We are debt-free. Our tax rate is among the lowest in the nation. Almost alone we



refused to raise taxes in the current legislative winter.

We were first among northern industrial states to legalize voluntary unionism. We have retained that law despite the fiercest of onslaughts by the labor bosses. Indiana looks like the land of milk and honey to all sorts of industries, which are now in the process of moving to our state, or are very seriously contemplating such a move. But all this will be only a mirage and a memory unless the management of the business enterprises already here gets behind the moderates, and goes all out for a resurgence of conservative political power regardless of political complexion.

Now anything worthwhile is worth fighting for. No American worth his salt ever folded up without a fight.

I know that each and everyone of you in this room represents a successful business enterprise. I am confident that there is an aroused business and industrial group in America. Politics will not be an inferior, or dirty business when worthy and substantial persons get into the American political scene. I am confident that you will organize, and you will fight for the continued self control of a free business, and a free America.

I would reiterate my previous remarks to the effect that it would be wrong for business and industry to get into politics just to be a counterpart of union political action. Don't let your participation be a one-shot-in-the-arm venture. Unless you are determined to remain politically active over the years, you will be wasting your time.

Don't wait until a few months before election. The time is very short and I confess that I am not sure but that it is almost too late. As for this moment, get active in politics and enlist in the fundamental struggle for individual freedom.

Your future, and the future of America is in your hands. ◄



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A Physician Looks at Education In Health and Fitness

*HERBERT T. WAGNER, M.D.**

New York, N. Y.

AS A PHYSICIAN, as a member of the Medical Society of the State of New York, which with fine state and city departments of Public Health has done so much for child health in the state of New York, and in particular as a Hoosier—born in Indianapolis and educated here at Indiana University—I am honored several-fold to be here. It was with pride and humility that I accepted the invitation of the Indiana State Medical Association and of the University. I sincerely hope that my presentation will fulfill their confidence, the desires of the faculty and your needs. To be the keynoter is to be responsible for much of your time, effort and investment in the seminars to follow. I shall try to meet that challenge but this course is your opportunity. My charge to you is to think unselfishly, to speak forthrightly, and to contribute generously toward conclusions which may, by your courage, become new programs in your professional and technical lives.

If I am to set the stage properly as I see it, then I must state now that the whole concept of education both in health and in fitness must be broadened. Indeed, it must be broadened across the entire spectrum of the vital fields of school and community health.

This, I submit, is the basic prerequisite for meeting the challenges that confront each of you today, and the new challenges that will confront you tomorrow, in this, the Age of the Atom and Space, the Age of Anxiety—the Age of the Question Mark.

If I can do no more here today than to convince each of you of this great need for broadening concept, I will be able to return home with a sense of accomplishment.

In order to have this concept of health and fitness, we must first have full realization of the meanings of these two terms. Health and fitness are very common terms. And simply because they are, there is a general tendency to use them loosely, as if they were synonymous. To all too many people, health, for instance, has come to mean merely physical well-being. We must not allow words to mean just what we want them to mean at a given time or situation.

What, then, are health and fitnesss? I believe they should be thought about in the terms with which the are described by literary authorities. Webster's International Dictionary defines health as the "State of being hale, sound or whole in body, mind or soul; well-being; especially the state of being free from physical disease or pain." The American Illustrated Medical Dictionary has this to say of our precious commodity: "A normal condition of body and mind; that is, with all parts functioning normally." According to the Preamble to the Charter of the World Health Organization, "Health is a state of complete physical, mental and social well-being and not the mere absence of disease or infirmity." Are any of these definitions practical and reasonably attainable under the one word, health, alone?

None of these three definitions includes the word fitness. What, then, is fitness? Is it something apart from health? Yes, the two terms are not synonymous, although a great deal of confusion certainly does arise in concept between them. Can you be healthy and not fit? Can you be fit and not healthy?

Dr. W. W. Bauer, distinguished physician and

Continued on page 2234

* Executive Director Medical Society of the State of New York, 750 Third Avenue, N. Y. 17.

Keynote address at the Indiana University Annual Workshop on School and Community Health, held at Bloomington. August 8, 1959.

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SUPPLIED: Bottles of 50 white coated 350 mg. tablets.
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A Physician Looks

Continued from page 2230

director of the department of health education of the American Medical Association, delivered an address in acceptance last year of the William A. Howe Award presented by the American School Health Association. Dr. Bauer's address, entitled "How Fit is Fit?," has been published by the American Medical Association. I believe his answer to our question constitutes one of the most accurate and interesting ways of describing the state of fitness. He said, "I do not believe that health by itself constitutes fitness. Health can either be something passive or something dynamic. One may be healthy in a languid sort of way, free from disease, suffering no pain, able to carry out a day's work and even to have a little fun if one's interest can be sufficiently stirred. There might even be in such a pallid type of good health a sufficient reserve to meet an emergency if one should be encountered. This is essentially the concept of good health which emerges from all the numerous definitions.

"Fitness, on the contrary, is something inherently dynamic. It is hard to imagine a passively fit individual. Physiology tells us, and so does common sense, that inactivity breeds deterioration.

"All physical educators know, of course," Dr. Bauer continued, "that training and conditioning improve performance. Muscle sizes increase, the heart action becomes stronger, deeper, slower and more steady; the nerves acquire special skills; endurance is increased, and the individual is converted from a sufficiently healthy but untrained specimen into a person eminently fit for a specific or a general program of activity.

"There can be no question," said the eminent doctor, "that good health contributes to fitness. Adequate rest and sleep; the ability to relax, and to recreate; a well adjusted outlook on life—all these help in the achievement of fitness; indeed they point up the broader concept of fitness which transcends mere physical activity. This is all-around fitness which embraces not only the physical but the mental, moral, spiritual and social fitness of the individual."

And then, having given his description of concept, with which I am in complete accord, Dr. Bauer came to one of the cardinal points. He said that in the current, widespread emphasis placed upon the physical, there is danger—and this is certainly the word for it — that these mental, moral, spiritual and social aspects of fitness will be overlooked. In point of fact, they are *being* overlooked all too often. While conceding the need for more effective activity, I maintain that there is urgent need to place far greater stress upon these equally vital aspects—the mental, the moral, the spiritual and the social. In fact—to what extent have the athletic activities in schools replaced academic achievement as the primary purpose and the area of popular recognition?

Further along in his exploration of fitness, Dr. Bauer came to the question of how fit is fit; can there be fitness in the absence of good health? In answer, he named a number of the many historic figures who, in the absence of good health, achieved great attainments. Alexander the Great, who died of gall bladder disease. Lord Byron was epileptic and clubfooted. Julius Caesar was a celebrated epileptic. Admiral Lord Nelson had only one arm and one eye. Florence Nightingale who, though sickly in the conventional feminine manner of her day, had the fitness nevertheless to convince the tough minded admirals at Scutari to do her bidding. The handicaps suffered by the tubercular Chopin and the deaf Beethoven did not deter them. The songs of Stephen Foster, an alcoholic, have become a part of the American tradition. Tuberculous Robert Louis Stevenson created exciting tales of adventure and poetry of rare charm.

Abraham Lincoln, with his black moods of depression, certainly did not qualify as a healthy individual. Franklin Roosevelt came to high achievement despite the lack of perfect health. And today we have in the Presidency of the United States Dwight Eisenhower, a gentleman who has had the fitness to rise above serious illnesses and perform the exacting duties of the highest office in the world. It can be accurately said that such great names as these belong to individuals who had, or have, not only physical limitations but also equipment of some extraordinary kind with which to overcome disease and defeat, and to arrive at the heights. They exhibit an indefinable quality, a something which makes for the ability to succeed. This, as Dr. Bauer said, is the unknown, the priceless ingredient in fitness, and it is an ingredient of which all elements cannot be measured.

As you are aware, insistent demands have

come from certain quarters for a series of exercise and achievement tests to measure the physical fitness of an individual. I number among the many who doubt seriously whether such tests can be so constructed as to constitute a true measure of fitness.

I seriously question that real fitness is to be measured only by the physical education department on performance of athletic skills. As I watched the development of my own children, my wonder increased when I first noted that a skill was measured without prior teaching or coaching in that skill. Does it really measure fitness to send a boy to the track and to be told to run a mile within a given time? Without teaching him some of the elements of running, without knowledge of the individual's limitations, and without adherence to medical direction, such measurements are not of fitness and do constitute a hazard to health. My wonder is further amplified when I note the same test of skill given categorically to all members of a given school grade without adaptation to the physical characteristics of the individuals. Can you honestly say that the same test measures fitness in the rangy, well developed six footer and in the puffing glob of an adolescent five footer?

There must be reasonable integration and practical application of adaptive technics based *upon the individual* if we are to measure physical fitness.

Physical capacities and performance capabilities can be measured, of course. In fact, tests for this purpose have been devised by physical educators and research scientists. Some have met with considerable approval in their practical application. I submit, however, that it would be fallacious in the extreme, to assume that such a measurement of physical strength, endurance and agility can be the criterion of an individual's total physical fitness to meet the challenge of living.

I trust that in defining health and fitness, and in drawing a heavy line between these two terms, I have brought renewed realization of their true meaning, and with it, the cognizance which is a key to the broadening of concept.

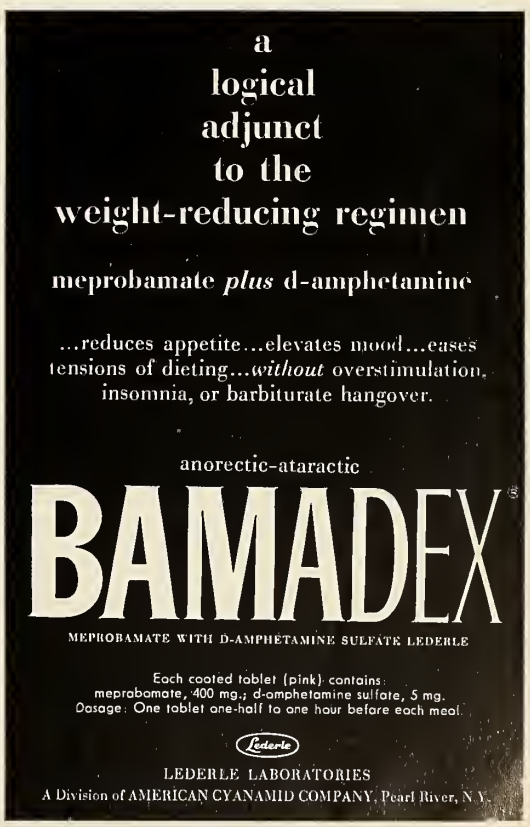
Good health is the responsibility of the individual. However, for his benefit and that of society, it is essential that he utilize the advice and the services of his physician. Do not forget that even though the school physician, and/or others, may need to promote a child's being seen by a family physician or another medical consultant, these are the ones who must direct and be medically responsible for that child's health. There should be—in fact there must be—well used channels of communication between the private physician and the school doctor. The school health and fitness program must carry out the basic health program of the child's physician. The private physician should be an excellent outside resource to call upon in the school health program.

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Unfortunately, too few medical people are really interested in preventive medicine and health maintenance. I deplore the truth in the cynacism of a medical leader who remarked that any second year medical student gets easily interested in a case of pernicious anemia but it takes an excellent doctor to be interested in the normal person. Perhaps it is you, and your colleagues, interested in school and community health, who must help develop the interest and participation of physicians, individually and collectively.

Another dependable resource and important liaison is with organized county and state medi-

Continued



A Physician Looks

Continued

cal societies. These groups usually have committees of interested physicians who can be materially helpful. I would certainly recommend that school authorities—particularly the school physician—ask for appointment of a school health committee of local physicians to review and to consult on school health and fitness policies and programs. The school physician and the nurse teacher have the prime responsibility for school health but they are dependent upon several others for assistance.

In this connection, I emphasize that, in my opinion, the activities of health programs should be conducted under a health and medical administration by physicians *and* professionally trained health educators, rather than under an educational department directed by laymen and educators with non-medical related degrees.

One challenge to each of you is your dual role. On the one hand you are a specialist in a given field in which you alone may be responsible. On the other hand you are an assistant to physicians in preventive health or health maintenance, or even, perhaps, in some program of therapy. But it must be remembered, and it must be maintained, that in matters of health and health education, you are assistants to well qualified physicians.

In *fitness,* each person in the audience may have his primary and independent role, whether he or she be an academics teacher, a nurse teacher, a health educator, an athletic coach, a psychologist, a dietitian or other specialist. And yet your activities cannot, for the general good, be uniquely the one discipline of your particular talents, but must be, like good steel, tempered with other ingredients. In the tempering, remember the needs for those whose talents are particularly in the areas of moral and spiritual fitness. This tempering can be accomplished by cooperation among all of you as active members of what I like to think of as a partnership in education for healthy living. Ideally then, and to the greatest extent practical, a school system or a single school should have a specially trained individual to serve as health and fitness coordinator. I do not mean a physician. I do mean a trained health and fitness coordinator.

Merely by acceptance of the fact that you are whatever you may be in the field of health and fitness, you acknowledge that there is necessarily some "give and take," so that each discipline is a part of the whole, rather than an entity strictly unto itself. It is in this relation that I urge your unselfish thinking. In other words, physical-ed teachers, for example, cannot for the over-all good operate on a remote plateau where their sole purpose is to develop "the body beautiful" of superior development in a few, and necessarily accept the inevitable danger and damage to some who will fall by the wayside in the effort.

The danger and/or damage may be physical or emotional or in the grades you give a student which, obviously then, illustrates that more than just physical educators are concerned in the activities of health and fitness programs. In many schools today there are regular members of the staffs who are trained in psychology. I fear that they tend toward independent medical practice rather than to fit into their proper place as adjuncts to the physician and as advisor to others. This, then, indicates the need to formulate, institute and carry out a well conceived specific health and fitness education and activity curriculum.

A good seven point curriculum includes: Proper Medical Care; Nutrition; Dental Services; Exercise; Satisfying Work, Healthy Play and Recreation; Rest and Relaxation. These are the elements the American Medical Association calls, and very aptly, I think, the "Seven Paths to Fitness." In fact, the American Medical Association has published for the general public a very succinct folder under that name. The proper formulation and conduct of such a curriculum calls for consultations and staff planning with all related elements in the field being represented at all times; and whatever may be the particular curriculum or program in which you are involved, I urge you to see to it that there is a standard vocabulary used in all discussions, relevant papers and correspondence. If a conversation is medical, for instance, then it should be carried on in frank medical language which physicians can understand. If it concerns coaches, it needs to be in athletic terminology, and so on. Far too often have I heard supposedly informed educators who talked in pseudo-scientific jargons which meant nothing to their medical listeners.

As you can appreciate, the objective of a well

developed and organized program of school and community health goes beyond the attainment of immediate good health in its broadest sense. Its objective should be the development of strongly rooted habits of healthy living. These promote good health, avoid or prevent disease and promote fitness. For instance, visiting one's physician for periodic medical examinations and immunizations; developing habits of regular, moderate exercise; developing good food habits to avoid the danger of overweight on the one hand and nutritional deprivation on the other; developing the habit of not smoking.

This team or group approach I suggest, might be used to develop the health and fitness habit I mentioned previously in regard to exercise. There is, as you know, an increasing acceptance among progressive physical educators that the establishment of a regular habit of moderate exercise, through walking or well liked individual or group games, which can be pursued through the early and middle adult years. This is far more desirable than simply the attainment of some degree of immediate physical fitness in its narrower sense of superior physical conditioning.

This brings us directly to the first mention of the trained recreation director. All of us are not predestined to athletic achievement. In high school, college and later years we are more dependent upon physical recreation than upon physical competition. As a matter of fact, serious study and opinion exist today which recommend that interscholastic and competitive sports must be curtailed up to the senior high school ages. There are sincere and well founded school health authorities who today beg for less emphasis on competition and for more on recreation.

The emphasis on training and facilities for physical recreation will gain in importance and in urgency as one looks at health and fitness in the middle and senior years.

I am sure you are equally aware that there has been a certain amount of criticism of the amount of health services concentrated among children of school age, since this is the age period in which the least amount of serious illness occurs and in which there is proportionately more private medical attention. There is certain justification for this criticism if only the immediate health problems of the school aged child and adolescent are considered. It seems that the long-range implications of health services and health education during this period are important factors in assessing the value of concentration on this age group.

I mentioned development of good habits of nutrition. I know that you are in accord with me, that far more people must be informed as to the nature and importance of good nutrition. I have called this the Age of Anxiety. I think it could also be called the Age of the Desperate Dieter and of the Health Food Faddist. Today, we observe with alarm vast numbers of impatient people who, though otherwise of reasonable intelligence, ignore the advice and warnings of physicians or qualified dietitions and nutritionists, and cast about for "the easy way," for those nonexistent shortcuts to taking weight off or putting it on, or to "being healthy."

In doing so, many of these innocent and gullible people fall easy prey to quacks and charlatans who grow fat on "easy money" eagerly thrust at them by these hectic dieters. Each of you, as an individual and as a member of the great partnership, has a challenge to help protect these legions of the misguided and uninformed, to explain and illustrate with new and improved techniques what nutrition really is. Rest assured, that in this effort you will continue to have the active support, guidance and assistance of the medical members of the partnership; private physicians, the local and state medical societies, and the American Medical Association.

The American Medical Association has, as many of you know, what frustrated quacks and charlatans around the country have come to regard as a kind of medical "F.B.I." This is the Bureau of Investigation headed by Mr. Oliver Field at the American Medical Association headquarters in Chicago. You are fortunate that Mr. Field will speak to you next Thursday. Recently, for example, the Bureau of Investigation was responsible in large measure for the removal from the open market of tablets of compressed sea kelp. Sea kelp, the charlatans who sold it would have us believe, can perform virtual miracles for the purchaser. Sea kelp, alfalfa pills and such quackery must be exposed for what it is. However, such seed would not sprout on those properly and adequately taught the basics of good nutrition.

There is another urgent purpose in a good health education curriculum. This also provides

more fertile ground for another necessary service in the senior school group. Organized medicine has shared activity with others in efforts to develop programs in health careers. There is great need for personnel in many parts of the health field and there are real opportunities for successful careers. This orientation to health careers should be one element in health education.

Following this general orientation, good vocational guidance can direct those with determined interests and aptitudes into ethical fields of health service. One positive result would also be that by factual and honest information, you would be keeping sincere people out of so-called "schools" of cultism. How better could we rid our society of the dangers and evils of cultists than by drying up their primary source of enrollees?

It is obvious that there are many purposes for which a health education program for *all* of the schooling years needs to be developed. I would like to suggest for your study, one newly recognized purpose which I think may be a new concept in school health and fitness education. This has to do with the rapidly expanding senior citizen population and its problems. Today, because the focus is on people of sixty years of age and up, many of us tend to forget that aging, both mental and physical, begins at birth and processes us through life's various stages. The babe in arms to the crawler, the crawler to the toddler, the walker to the runner, the infant to the child, the child to the adolescent, the adolescent to the adult.

If, in our entire experience in school, including college, and in our community health programs reaching young and middle age adults, we have a well integrated, well coordinated, continuing program of health education, instituted and conducted in the broadest concept possible, and with physicians, nurses, coaches, educators and teachers in all subjects having an active part to play, we will have established, both among children and adults, a much better understanding of the growth and development, or aging process and all of its various effects and problems.

Progress in the art and science of medicine, technological progress in industry, and socio-economic reforms are giving Americans a steadily increasing amount of free time. We should use this invaluable dividend of progress productively, healthily, relaxingly and entertainingly. Will the present school lessons and experience in physical recreation carry over into this new found free time and to the aging years, and be found applicable? This is a new challenge to recreationists for health and fitness in leisure time activity in the post-school years. Our physical and occupational activities should be patterned so as to learn what we can do when we are elderly, at which point in life we will have an even greater amount of leisure time and a great need for activity to maintain physical and emotional fitness. We should learn today, and teach more and more activities that can be adapted and used at the various stages of the aging process. All of us are interested and concerned one way or another with the problem, and we should work toward this objective in a well balanced, systematized and coordinated way.

The assigned focus today is to provoke in you speculation, discussion and hypothecating on group teaching responsibilities, or better, perhaps, opportunities in health and fitness education. I hope that I may stretch your minds so that new concepts and new technics may be produced and related to some of the physical and emotional needs of our senior citizens.

We recognize that there are certain areas of immediate need for those in the older age group. These are the programs I choose to consider as remedial or curative. In contrast however, the greater and enduring good will result from broad preventive programs among those of young and middle years.

There are many facets in a total preventive program. The fundamental technic in prevention is education. The purpose of education is, of course, not knowledge, *per se,* but knowledge and wisdom to make possible understanding of life's problems, freedom of choice of alternative routes toward solutions, and then definitive action. Therefore, I recommend that, wherever it is applicable, education administrators establish the health and fitness program in the curricula, and that physicians, nurses, academic teachers and other health educators, teach and indoctrinate the young with good health understanding and habits.

I know that you are in accord with me that health education must become a way of life. A continuing health education program in *all* schooling years will establish the base upon which the young, the teens and the middle years adult, will obtain a good health level and a standard of fitness for maintenance in the senior years.

Physical and emotional health maintenance are as important in our understanding and practice today, as are jet travel, economics, batting averages and blood pressure. Only through good health education and by personal experience will individuals and society at large understand the growth and development aspects of senior citizens.

Who has not at some time said such as, "How gracefully she has aged!" The facility with which one adjusts to senior age is much influenced by earlier learning and experience. Many groups may and should contribute to a continuing health education, of which, one principal purpose would be an understanding of the aging process. Through such a program, human beings stand a better chance to grow gracefully, not to deteriorate drastically, into old age.

Such an educational program as I envision, should give youngsters and young adults a factual basis for understanding and adjustment to physical and emotional changes in themselves and in others. This will help toward an adoption of mature attitudes toward changes in the social structure of family and community as it is affected by conditions of the aging process. Wherever it has not already been done, let us start teaching about the aging process throughout the entire period of formal schooling. Human beings must learn to fit into their environments. Again, we must develop in youngsters from four to forty the need of preparation for the time when they will be "old." One of the needs is to realize that only by developing a wide range of interests while young, can they hope to keep themselves busy mentally and physically as they grow older. The more personal resources they possess the easier it will be to maintain their zest for living. Many disciplines and groups can contribute in the development of activities and specific interests to fill leisure time profitably.

It may well be a problem of society, at community level, to organize and to provide necessary recreational facilities. We have each seen senior citizens with the complaint of "nothing to do." What an individual and collective tragedy—this unoccupied, this wasted time! This is one of the problems requiring immediate curative action as well as long range preventive planning and action. This is still another of the challenges to you, as individuals and as members of the partnership in education for living.

To each one of you present, to the sponsors and to the directors of this workshop, I voice the sincere hope that I have provoked open recognition of old and unresolved problems as well as to have suggested for your attack, new areas of potentially greater usefulness of your individual and collective talents. Dedicate yourselves to an unselfish professional attitude within a broad concept of education toward health and fitness and then stretch your own minds, plan and work courageously.

To each of you I extend every good wish for your successful attack on these problems. Keep always in mind that the purpose of education is intelligent choice of action. Effective action requires promotion. Look at that word—two-thirds of it is motion. . . . Be on the move. ◄

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NEWS NOTES—from State and Nation

I. U. Announces Plans for New Two-Year Family Practice Program

The Indiana University School of Medicine announced last month that it will initiate a new 2-year program for the preparation of family practice, as a separate entity from the regular internship and residency programs.

In accordance with recommendations of the AMA and the American Academy of General Practice, administration for the training aspects of the program will fall within the Department of Medicine.

The training period will consist of three divisions, the first of which is familiarization with and experience in the emergency room, medicine, pediatric, psychiatric, and obstetrical and gynecological services.

Advanced experience in medicine and pediatrics fall in the second division of the program. Trainees will practice out-patient medicine and see both scheduled and emergency patients. They will follow patients through the various consultative services, including psychiatry, and into the hospital, if they are admitted.

Trainees, while on pediatrics, will serve as residents in both in-patient and out-patient divisions.

Elective work will comprise the third division of the program. The Medical Center anticipates that in a majority of cases, it will be spent in office gynecology and non-operative obstetrics. The division could also consist of added work in pediatrics, medicine, psychiatry or emergency services.

Stipends are $2400 for the first year and $2700 for the second year of the program. Trainees are to have all privileges extended to other members of the house staff. Plans call for three appointments each year, with the selection being made through the regular procedure of the intern matching program.

Additional information and applications are to be directed to the Office of the Medical Director, Indiana University Medical Center, 1100 West Michigan, Indianapolis 7.

"Hospital Sepsis" Manual Available to Administrators

A discussion manual supplementing the much in demand professional motion picture—"Hospital Sepsis: A Communicable Disease"—is now ready for professional use.

A copy of the manual will be made available to hospital administrators with a limited supply further available gratuitously to all hospital administrators requesting it.

The film on Hospital Sepsis was prepared under the auspices of the American Medical Association, the American College of Surgeons and the American Hospital Association. The film and manual are available as a professional service through the support of Johnson & Johnson.

The manual is 44 pages, contains 93 questions and answers, 29 illustrations, charts and pictures, and is in color. To help the hospital personnel speedily find their answers, a two-page comprehensive index covering 76 major categories with detailed sub-heads is included.

Dr. Marc J. Musser, a native of Terre Haute, has recently been appointed by the Veterans Administration to the post of director of medical research. Dr. Musser will coordinate a nationwide program of some 6000 studies from his office in Washington, D. C. He was formerly director of professional services at the Houston V. A. Hospital, and professor of medicine at Baylor University College of Medicine.

American Medical Assistants Convention Features Several Hoosiers on Program

Twenty-three Indiana members attended the third annual convention of the American Association of Medical Assistants held Oct. 16-19 in Philadelphia.

Program for the 3-day session included workshops, seminars, panel discussions, and meetings of the general assembly and House of Delegates.

Bettye J. Fisher of Evansville presided over one part of the program, a Medical-Technical panel discussion. *Robert Allyn Royster, M.D., also of Evansville,* participated on the panel. Speakers included *Rice Kello, Evansville,* "Bends or Breaks;" Robert G. Ravdin, M.D., Philadelphia, "Advances in Cancer Diagnosis and Treatment," and William V. McDonnell, M.D., Philadelphia, "The Rh Factor."

Also on the same program were Fred Alexander, M.D., Philadelphia, "New Medicines," and Donald Levitt, M.D., also Philadelphia, "The Practical Application of Hypnosis in Modern Medicine."

The first annual Leadership Seminar, established through an educational grant from Lakeside Laboratories, was moderated by Steward H. Smith, M.D., San Diego, an AAMA advisor. Speakers included John E. Eichenlaub, M.D., New York, on "Leadership in Medicine;" Leonard Berry, St. Louis, "Magic with Words," and High Brenneman, Michigan, "Leadership in Public Relations."

Two banquets highlighted the session with Mrs. Marian Little of Cedar Rapids, Iowa, AAMA president-elect, presiding over the first.

After greetings from AMA's President Louis M. Orr, M.D., the feature speech was presented by Robert J. Samp, M.D., Madison, Wisc.

Wyeth Laboratories showed a film, "The First Contact," a story of a young girl attending an AAMA convention and relating the aims and objectives of the association to her physician-employer.

AAMA President Lucille Swearingen presided over the second banquet. Feature speaker was Frank A. Elliott, M.D., whose subject was "Changing Patterns in Medicine."

Charters were presented to New York, Georgia, Massachusetts and Alabama.

AAMA officers installed in a candlelight ceremony were, Mrs. Marian Little, Iowa, president; Mrs. Lillie Woods, California, vice-president; Mrs. Virginia Dougherty, Pennsylvania, president-elect; *J. Marie Theobald, Indianapolis,* recording secretary, and Hallie Cummins, Michigan, treasurer.

Tours of Philadelphia and vicinity were highlighted by a tour of Pennsylvania Hospital, one of the oldest in the United States.

Richmond, Ind., has been selected for next year's Indiana State Association of Medical Assistants' convention. Plans are now being formulated for the program to be held April 30-May 1, 1960.

The film shown at the national convention is available to medical assistants associations and medical societies through Wyeth Laboratories, AMA and AAMA.

Cookbook for Diabetics

"Cookbook for Diabetics" is 176 pages of low calorie, low carbohydrate recipes and menus, together with exchange tables, advice on counting calories, and instructions for computing weighed diets. The recipes are from the "ADA Forecast" and have been assembled, together with appropriate supplemental information, in book form for the first time.

The book is noteworthy for its advice on seasonings, and for hints on the preparation of small amounts and single servings.

Published by the American Diabetes Association, 1 E. 45th St., New York 17, New York, the book is $1 per copy, postage prepaid (discounts for quantity orders).


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References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) (Jan. 26) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 1958. 6. Pfleger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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Science for the World's Well-Being

SAMA Announces Plans for Scientific Exhibit Competition

Medical students, residents and interns have been invited to prepare scientific exhibits to display at the 10th annual convention of the Student American Medical Association in Los Angeles May 4-8, 1960.

The three exhibits judged most outstanding in both the students and resident-intern categories will win SAMA-Lakeside Awards. Top exhibits in each category will be featured at the scientific exhibit assembly of the American Medical Association during the annual AMA convention in Miami Beach in June 1960.

In addition to a prize of $500, and an award certificate, the top winners will receive an expense-free trip to the AMA convention. Second and third prize winners will receive $250 and $100, respectively, and an award citation.

The SAMA-Lakeside Awards program was initiated three years ago to stimulate interest among medical students and resident-interns in the use of the scientific exhibit as a primary method of communicating important research information within the medical profession.

Applications for the 1960 SAMA-Lakeside Awards should be sent to the Executive Director, SAMA, 430 North Michigan Ave., Chicago 11, Ill. Deadline for applications is Jan. 1, 1960. Notification of accepted exhibits will be made Feb. 1, 1960.

Applications should contain the title of the exhibit, a brief description of its physical dimensions and a 250-300 word report explaining its purpose. Applicants are advised to first check their subject matter with a faculty member or chief.

This program is sponsored by the Student American Medical Association with the cooperation of Lakeside Laboratories, Inc., Milwaukee, Wisc.

Surgeons Sectional Meeting Slated for January 21 to 23

Surgeons and related medical personnel are invited to attend the three-day sectional meeting of the American College of Surgeons in Louisville Jan. 21 to 23. Headquarters will be the Brown Hotel.

In addition to a general surgery program of particular interest to gynecologists, thoracic surgeons, vascular surgeons and urologists, the program includes a two-day opthalmic surgery program, a two-day program for otolaryngologists, and a cancer workshop program for medical directors of approved cancer programs at Louisville General Hospital.

Cystic Fibrosis Film Available For Sales, Rental

A medical training film on *cystic fibrosis,* produced by the University of California Extension, is now available for sales and rentals.

Designed to establish a fundamental background of patho-physiological information with clinical aspects, the 16mm sound and color film summarizes in lecture form the history, clinical aspects, pathology and treatment of the disease.

Roentgenological and pathological presentations are also included in the film, which runs 28 minutes.

Script and technical direction is by Henry B. Bruyn, M.D., associate professor of pediatrics at the University of California Medical School. Pathological studies are by Jackson T. Crane, associate professor of pathology, and the roentgen presentation is by Howard L. Steinbach, M.D., associate professor of radiology.

Sales information is available from the Department of Visual Communication, University Extension, University of California, Los Angeles 24.

Rental information may be obtained from the Department of Visual Instruction, University of California Extension, 2272 Union Street, Berkeley 4, Calif.

Marcus H. Flinter, Col. M.C., U. S. Army, was recently named commander of the U. S. Army Hospital at Fort Jay, Governors Island, New York. Col. Flinter received his license to practice in Indiana after taking his residency at the Methodist Hospital in Gary.

Dr. Kenneth L. Craft, Indianapolis, was moderator of a panel discussion on Nasal Polyps which was presented at the annual meeting of the American Academy of Ophthalmology and Otolaryngology at Chicago in October.



"See if you can get that guy in the maternity waiting room to stop pacing around . . . he's driving me nuts!"

Nuclear Medicine Journal To be Published in January

The Society of Nuclear Medicine announced recently that the first issue of its official organ, *The Journal of Nuclear Medicine*, will appear during January, 1960.

Editorial contents of the new journal will be directed toward those interested in the diagnostic and therapeutic application of radioisotopes and in human radiobiology.

The editor is Dr. George E. Thoma, Southwest Medical Center, 3915 Watson Road, Saint Louis 9. Subscription requests should be directed to the publisher, Samuel N. Turiel & Associates, Inc., 430 N. Michigan Ave., Chicago 11, Ill.

A little girl did not want to go to bed because she "had some thinking to do." Her mother understandingly told her to finish her thinking. Later the mother asked, "What were you thinking about, dear?"

The little girl confided, "I was thinking about gravity, Mother, and I decided that gravity is God right at the center of the world that keeps people right side up when the world is upside down."—*Eric Butterworth, Good Business.*

A new idea is delicate. It can be killed by a sneer or a yawn, it can be stabbed to death by a quip and worried to death by a frown.—*Brower, quoted in Phoenix Flame.*

Loneliness is a prison that can be opened only from inside. —*Annabelle, Zurich* (Quote translation).

Former Hoosier Named Director of Research

Mead Johnson & Company recently announced the appointment of Dr. Richard T. Arnold of New York City as director of Research. Dr. Arnold has been administrator of the basic science program for the Sloan Foundation since 1955. He is a native of Indianapolis.

Dr. James M. Tuholski has been promoted to director of Product Development, and Dr. George W. Brown to the post of clinical research director. Dr. Willard Nicholl will replace Dr. Brown as associate director of Clinical Research.

Dr. John Phillips, Bluffton, will become an assistant professor at the University of Kansas City Medical Center in January.

Dr. David Joe Smith, medical director for L. S. Ayres & Co. in Indianapolis, has accepted a position as medical director of the Edgar Thompson Works of the United States Steel Corp. at Pittsburgh, Pa.

Dr. Henry G. Nester, Marion County public health director, was named president-elect of the American Association of Public Health Physicians at a recent convention in Atlantic City. He will take office in October, 1960.



"Ordinarily we wouldn't open you up again, old man, but (Heh, heh) my wallet happens to be missing!"

Add 1

The Spirit of Christmas - - the Year Around; New Year Resolutions; Gifts to the Staff

by corki

Writ in November

And a merry Christmas to all!

As stated something like a year ago in this column, it's pretty hard to get the Christmas spirit more than a week before Thanksgiving. Before turning in last night, I told myself "Awaken with the Christmas spirit, old girl!" The weather man tried his best to help me out by bringing in a five degrees above zero cold sweep, but somehow bells aren't jingling, bobs aren't sledding and I'm just miserable with a cobe in my nobe.

Not much Christmas spirit to decorate the "Halls" *or* the December *Journal.*

But all of this takes me to a newspaper column before mentioned here which, to me anyhow, had something of the real "spirit" of Christmas without trying. It's Myrtie Barker's "My Window" in the *Indianapolis News* printed a month or so ago.

Isn't one of the main ingredients of Christmas "good will to men?" In this column Miss Barker did one of the most beautiful jobs I've ever seen of expressing friendship (and how many writers, great or unknown, have tried to express this bond between people which draws them close and gives some of the greatest pleasures of life?).



With Miss Barker's kind permission, I'd like to quote a few paragraphs of her writing, her impressions of friendship . . . for it also expresses, to me, a great deal of what Christmas is.

Myrtie Barker on Friendship

"Friendship is a fragile something marked 'Handle With Care'—yet as sturdy as dependability and as rugged as loyalty.

"It's softly tender like love, and forgiveness, and hope—yet as hard as truth and as firm as faith.

"Friendship is believing when all others doubt. It's remembering when all others have forgotten. It's rejoicing in another's good fortune; weeping for another's bad luck.

"It's the man on the road to Jericho, who goes where another is—and supplies what is needed whether it's a word of encouragement or praise, or an invitation to come take a walk on a sunny autumn afternoon.

"Somehow a friend is intuitive and can sense a longing, and can come up with the right prescription to heal a headache or comfort a hurt heart. A friend is someone whose spirit is nourished by the identical food that feeds our own; someone with whom you can find companionship even in silence, or with whom you can share differing convictions in a kind of tolerant understanding.

"Because a friend looks on you with fondness and considers you something special—you put forth a mighty effort to live up to the



ideal. You try to do better, and are better—just because you have a friend."

That sort of reminds me of "putting Christ back into Christmas" *the year around.* For to me, one of the things Christ stands for is love for our fellow man; love, compassion, understanding, goodness (not a puritanical goodness—but warmth and a helping hand to others). And I think Myrtie captured this feeling in her beautiful wording.

So, not merely a merry Christmas to you all; but a Christmas of warmth in love and friendship . . . a New Year of health and happiness and the nearness of those you love.

. . . the mouths of babes

Christmas is an exciting adventure for the small fry and somehow seems to belong to them as far as Santa and his reindeer, Christmas trees and bobbles and gaily wrapped but mysterious gifts (the mistletoe belongs to their elders!).

The *Bankamerican* (San Francisco) tells about a small boy who went into one of Bank of America's branch offices to the teller window. Barely able to see over the counter, he told Teller Carolyn Knight, "I need a new school savings passbook for my baby brother and I want to take out $4."

Carolyn explained that she would have to have the mother's signature. "She's too busy to come in," the young one said. "But we do need her signature," Carolyn repeated. "Can't she come in for just a few minutes?"

The lad shook his head sadly and said, "You don't understand at all. She's awful busy 'cause she's got triplets!"

And a very Merry Christmas to mother, son *and* triplets!

Questing with Quote

In browsing through last December's copies of *Quote,* a few Christmas gems turned up that seem to reflect the Variety that people are made of.

"Over the ages Christmas has had no more implacable foes than those squares, the Puritans. They were violently opposed to caroling for fear somebody might enjoy it, and, in 1644, they declared Dec. 25 market day, forbade shopkeepers to close, and made it against the law to have mince pie or plumb puddings." *William J. Barker, Empire Magazine.*

"Christmas is a time for melody and memories, perhaps with a minor note of sadness, like poetry. No one can interpret the meaning of either for anyone else." *Ruth W. Stevens, "Don't You Hear Them Bells?" Music Journal, Oct. 12, 1958.*

"This is the time of year when every contract between child and parent has a Santa Claus in it." *Woodmen of the World Magazine.*

But most of all, I like this one:

"The challenge of simplicity is a magnet to the human spirit. Much of the beauty of Christmas lies in its challenge to look further, deeper, until we find its secret in the heart of God. *Dale Evans Rogers, Christmas Is Always (Fleming H. Revell).*

A Christmas Salute . . .

A Christmas column seems an appropriate place for this little item for it seems to me that the everyday living of the Kingsburys has been the embodiment of the Christmas spirit—the year around!



"MRS. DOCTOR"

Last month we did a pushing-the-deadline story on Indiana's Doctor of the Year, John Kingsbury, M.D. We were fortunate in getting a family picture at the convention banquet, but, unfortunately missed an important, very important, member of the Kingsbury team, Mrs. Kingsbury. With the help of a Kingsbury patient, fan and friend, I now present Mrs. Kingbury.

She has down through the years been his helpmate, his partner—his wife, the mother of their children. Always, as with physicians' wives,

she's worked her schedule around his busy medical practice and, I have a hunch, been there whenever he needed a pat on the back, encouragement, or even help with his patients in a non-medical way. So—my personal salute to the "Doctor's Wife of the Year." (I gave Slorine Kingsbury that title here, please note! But from reports from his patients, I think she can wear it well.)

The name Slorine, incidently, she says comes from being a sister among five boys. It was coined from several words—and as she said, "Has stuck with me ever since."

Incidently, while speaking of the good doctor and his wife, the *Journal* has reprinted a letter we received from one of his patients in the "To the Editor" department. It would be well worth your while to look it up—in this issue.

And On New Years

"Concerning Resolutions for the Bright New Year: First, resolve 'em, then dissolve 'em!" *Catherine Clark* in *Quote*.

It's really sticking my neck out, or dropping it under the verbal guillotine, to make New Years Resolutions in type. It always leaves room for some smart aleck to put the printed page under my nose and make me look cross-eyed at it when I break them one by one. But here goes.

I resolve not to gripe about the cold quite so much! (You figure out what "quite so much" means!)

I resolve to join all the organizations I want to join after I pay the dues to those I already belong to! (That's after I pay the bills induced by Christmas buying!!)

Come to think of it, I resolve to pay my Christmas bills some day!

I resolve not to gripe about the cold so much! (So, I already resolved that. But it will take a lot of resolving to reach a minimum of success!)

In line with the above, I resolve to chatter my teeth half as loud as usual and turn only half blue from the cold!

And pay my Christmas bills. (Creditors, please note!)

Aw, to heck with it!

Gifts from the Gabber

Better that I pass out a few verbal gifts to headquarters staff and then the Christmas bills won't be so high (and, come to second thought it, I might not even be around to pay them after the next few choice gifts!).

To the *Journal* boss (always think of your boss first) Dr. Frank Ramsey: lots and lots of scientific manuscripts from ISMA members during the coming year, a good red pencil, lots of popcorn, and a record of "Wabash Cannon Ball!"

To the Keeper-of-the-Journal-purse-strings and topman-on-the-office-totom-pole Jim Waggener: lots more money for *Journal* advertising, a huge gourmet cookbook and a big vote of thanx for his special recipes. Some popcorn, too!

To Mary Emory: more Medicare restrictions (less work!), a trip to Europe and a bottle of Rheine wine.

To Elsie Reid: a year of great pleasure on her new wheels (and no repair bills) and more stories about her nephews.

To Jackie Pierce: cough drops for her telephone voice, time to finish her mosaic tile table top, success with her taped version of the chipmunks and more respect for her elders (me!).

To Eleanor Chapple: More trips to Chicago, a year's supply of Pepsident to keep that sparkling smile going and a dictionary containing all the unusual words Jim Waggener dictates to her.

To Lucille Kribs: Roller skates so she can get around faster at the convention and an automatic weeder for her garden.

To Bob Amick: All the latest books on hypnosis (self-hypnosis!) and that camera he keeps pestering me to have fixed.

To Howard Grindstaff: A box of bow ties because he looks better in them, flashbulbs for the polaroid camera he's trying to use and a new pen so he can write out reports the Journal staff can read!

To Sally Mitten: A supply of vitamins so she'll come back to work with vim and vigor after the hectic haze of a formal wedding (the guy is aspiring young lawyer-to-be Bill Snyder and they'll hitch up right after Christmas), lots of serving trays to help decorate their new apartment and an office typewriter so she'll quit latching onto mine.

To myself: Like a trip to California, of course! What else?

And to all the very merriest of Christmases and happiest of New Years! ◄

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Deaths...

William E. Barnett, M.D.

A former Logansport physician, Dr. William E. Barnett, died at Dallas, Texas Nov. 2. He had practiced medicine in Logansport from 1933 to 1942, and was a 1933 graduate of the Indiana University Medical School.

E. Vernon Hahn, M.D.

Dr. E. Vernon Hahn, Indianapolis neurosurgeon and psychiatrist, died Oct. 16 in his home. He was 68.

Prominent in Indianapolis medical circles for more than 20 years, Dr. Hahn was a former president of the Marion County Medical Society and also of the Methodist Hospital medical staff. He was a former clinical professor of psychiatry at the Indiana University School of Medicine.

Dr. Hahn served on the board of examiners of both the American Psychiatric Association and the American College of Surgeons. He helped to establish and was an officer in the Central Neuropsychiatric Association.

Oscar D. Ludwig, M.D.

Dr. Oscar D. Ludwig, 79-year-old Indianapolis physician, died Oct. 13 at Noblesville. He had practiced in Indianapolis 48 years.

A 1910 graduate of the Indiana University School of Medicine, Dr. Ludwig was Marion County Health officer in 1933 and was a staff physician at St. Francis and Methodist hospitals.

Dr. Ludwig was a World War I veteran and a member of the American Legion and Masonic lodge.

James H. Stygall, M.D.

Dr. James H. Stygall, chief of staff at Flower Mission Hospital in Indianapolis, died Oct. 18 in Albuquerque, N. M.

The 72-year-old chest specialist was attending an annual convention of the American College of Chest Physicians. He had served as president of that organization in 1955-56.

Dr. Stygall came to Indianapolis in 1921 as director of the Indiana Tuburculosis Association, and was instrumental in setting up the first county clinics in Indiana.

A graduate of Buffalo (N.Y.) Medical School in 1910, Dr. Stygall was on the staff at the Indiana University School of Medicine in Indianapolis, and on the medical staffs of St. Vincent's and Methodist hospitals, Indianapolis. ◄

County Society Reports

Allen

The Allen County Medical Society met Nov. 3 in Fort Wayne for a scientific program on Chemotherapy of Carcinoma. There were 111 members in attendance.

Bartholomew-Brown

Twenty-eight members of the Bartholomew-Brown Medical Society met Oct. 14 at Columbus for a scientific program on hypnosis, presented by Dr. K. D. Schneider, of Nashville.

Cass

"Use of Oxytocin in Obstetrics" was the subject of the scientific program at the Cass County Medical Society meeting Oct. 5.

Dearborn-Ohio

Fifteen members of the Dearborn-Ohio Medical Society met Oct. 15 for a general business meeting and review of 1959 ISMA convention activities.

Delaware-Blackford

The Delaware-Blackford County Medical Society met Oct. 20 in Muncie to honor the new ISMA president-elect, Dr. Guy A. Owsley, and for a general business meeting.

Elkhart

Seventy-seven members of the Elkhart County Medical Society heard a scientific program on epilepsy, given by Dr. Ben Lichtenstein, Professor of Neurology at the University of Illinois, at their Nov. 5 meeting.

Fulton

Members of the Fulton County Medical Society met Nov. 6 at Rochester for a general business meeting. Eleven members attended.

Grant

"The Physician and Emotional Disturbances" was the subject of the scientific program given by Dr. John W. Southworth, Indianapolis, at

the Oct. 27 meeting of the Grant County Medical Society. Forty-two members were present.

Hancock

Twelve members of the Hancock County Medical Society met Oct. 26 at Greenfield for a business meeting.

Jackson-Jennings

Members of the Jackson-Jennings Medical Society heard a talk on insurance at their meeting Oct. 24, at Seymour.

Jefferson-Switzerland

Twenty-one members of the Jefferson-Switzerland Society met at Madison Nov. 3 for a general business meeting and a review of the 1959 House of Delegates sessions.

Knox

The Knox County Medical Society met Oct. 20 for a general business session and to discuss the 1959 House of Delegates actions.

LaPorte

"Changing Concepts in the Approach to Cancer" was the topic of Dr. Danely P. Slaughter's scientific paper, presented at the LaPorte County Medical Society meeting. Oct. 20 at Michigan City. The 38 members present also heard a report on the 1959 ISMA House of Delegates meetings.

Marion

Dr. Ernest Jokl, of the University of Kentucky, and physician for Olympic Games in Australia, was the principal speaker at an Oct. 22 coaches-physicians conference, sponsored jointly by the Marion County Medical Society and several other organizations.

Marshall

Twelve members of the Marshall County Medical Society met in Plymouth Nov. 4 for a general business meeting.

Morgan

The Morgan County Medical Society met in Martinsville Nov. 5 for a general business meeting. Eleven members were present.

Montgomery

Dr. Glenn W. Irwin, Jr., spoke on "Physical Findings in Endocrine Disorders" at the Oct. 15 meeting of the Montgomery County Medical Society. Twenty-six members attended.

Owen-Monroe

Thirty members of the Owen-Monroe Medical Society met for a discussion on medical education Oct. 22 in Bloomington.

Shelby

Fifteen members of the Shelby County Medical Society heard a discussion on "Canadian Medicine" by Dr. F. D. Travis at their Nov. 4 meeting at Shelbyville.

Steuben

Ten members of the Steuben County Medical Society met at Angola on Nov. 2 for a general business meeting.

Washington

Members of the Washington County Medical Society met Oct. 13 for a general business meeting. Ten doctors were present.

Wells

The Wells County Medical Society held their 12th annual fall Clinical Conference Sept. 23 in Bluffton. Dr. Lindon Seed of Chicago gave the evening lecture entitled "A Look at Radioactive Iodine and the Thyroid Gland" before 40 physicians from the area.

Fourteen members attended the Oct. 19 meeting for a discussion of the ISMA House of Delegates meetings and also a report on a Boy Scout explorer unit devoted to medical sciences, which the society sponsors.

Whitley

The special speaker at the Oct. 13 meeting of the Whitley County Medical Society was Rev. Dick Wolfe, who talked on "Hospital Ministry." Sixteen members attended.



"After the drinks were passed out at the company picnic, somebody mistook my nose for a hot dog and tried to roast it."

Association Reports

THE EXECUTIVE COMMITTEE

October 9, 1959

Meeting called to order at 12:30 p.m., following adjournment of the Council meeting, in the Ballroom of the Columbia Club.

Present: Don E. Wood, M.D., chairman; Wendell E. Covalt, M.D.; Earl W. Mericle, M.D.; Guy A. Owsley, M.D.; Maurice E. Glock, M.D., and O. W. Sicks, M.D.

Frank B. Ramsey, M.D., editor of *The Journal,* and James A. Waggener, executive secretary.

By ballot, Dr. Don E. Wood was elected chairman of the Executive Committee for the year 1959-60.

There being no further business, the meeting adjourned to meet again on November 11, 1959.

COUNCIL

October 5, 1959

The Council of the Indiana State Medical Association convened for its fall meeting at 3 p.m. (CDT), Monday, Oct. 5, 1959, in Parlors 1 and 2 of the Columbia Club, Indianapolis, Ind., with Dr. Guy A. Owsley, chairman, presiding.

Roll Call showed the following present:

William B. Challman, Mt. Vernon; J. H. Crowder, Sullivan; John M. Paris, New Albany; J. E. Dudding, Hope; Joe M. Black, Seymour; Robert K. Webster, Brazil; Harry P. Ross, Richmond; Ralph V. Everly, Indianapolis; Guy A. Owsley, Hartford City; Kenneth O. Neumann, Lafayette; James P. Vye, Gary; Max R. Adams, Flora; Maurice E. Glock, Fort Wayne; G. O. Larson, LaPorte; P. J. V. Corcoran, Evansville; V. Earle Wiseman, Greencastle; William R. Tindall, Shelbyville; Charles A. Jones, Franklin; Gordon B. Wilder, Anderson; A. E. Stouder, Kempton; Earl W. Bailey, Logansport; Raymond E. Nelson, Kenneth L. Olson, South Bend; Earl W. Mericle, Okla W. Sicks, Frank B. Ramsey, Indanapolis; Lall G. Montgomery, Muncie; Don E. Wood, Indianapolis; Wendell E. Covalt, Muncie; Gordon B. Wilder, Anderson; Wendell C. Stover, Boonville; Harold C. Ochsner, Indianapolis; Francis L. Land, Fort Wayne; George W. Willison, Evansville; Burton E. Kintner, Elkhart.

The minutes of the Council Meeting, held July 12, were approved, upon a motion of Dr. Dudding and Dr. Larson.

Reports of Councilors

The councilors gave brief reports on their districts.

Dr. Joe Black, Seymour, a new councilor from the Fourth District, was introduced.

Reports of Officers

Dr. Kenneth L. Olson, president. Dr. Olson reported that he had attended the Kentucky State Meeting and found that Indiana and Kentucky have many similar problems. He also reported on the AMA Regional Conference on Relative Values and a meeting of the Building Committee held September 12.

Dr. Olson urged the councilors to encourage all the physicians from their districts to attend the scientific sessions during the annual convention.

Dr. Earl W. Mericle, president-elect, gave no report.

Dr. Okla W. Sicks, treasurer, gave the treasurer's report.

Dr. Frank B. Ramsey, editor of the *Journal.* The chairman called attention to the splendid *Journal* and the Council, by consent, commended Dr. Ramsey for his work in the improvement of the *Journal.*

District Meetings

The First District reported the time and place for their 1960 Meeting had not been established.

The Second District—no date set.

The Third District—tentatively set for May 18, at French Lick.

The Fourth District—May 11, at Columbus.

The Fifth District—not definite.

The Sixth District—Shelbyville, May 11.

The Seventh District—not set.

The Eighth District—June 8, Anderson.

The Ninth District—May 18, Lafayette.

The Tenth District—Possibly, Second Wednesday in May (May 11) at Whiting.

The Eleventh District—Wabash, but date not set.

The Twelfth District—The First Tuesday in May (May 3) in Fort Wayne.

The Thirteenth District—South Bend, Nov. 18, 1959.

Unfinished Business

The chairman called attention to the scientific program and the sale of exhibit space, and by consent, the secretary was commended for his sale of exhibit space.

Student Loan Fund. Dr. Harry Ross stated there was no further report.

Building Committee. Dr. Burton Kintner gave a detailed report on the findings of the Building Committee of the House, and presented his report, which is also to be presented to the House of Delegates.

Liaison Committee between Council and Blue Shield, Dr. Challman stated he had no formal report to make, only a few remarks. Dr. Challman said that he would like for the Council to give consideration to the advisability of the president and president-elect automatically becoming members of the Board of Directors of the Blue Shield during the tenure of their office This was discussed by several and Dr. Glock suggested that it might be well to give this matter due consideration, and by consent, it was to be discussed at one of the breakfast meetings of the Council during the convention.

Nominations for Editorial Board. Dr. Franklin F. Premuda, Hammond, was elected and Dr. Samuel R. Mercer, Fort Wayne, was re-elected as members of the Editorial Board, each for a 3-year term, ending Dec. 31, 1962, upon motion by Dr. Challman and a second by Dr. Crowder.

Nominations for Members on Blue Shield Board for 3-year terms beginning March, 1960. The Chairman

announced this item would be held over until the January, 1960, meeting. It was also announced that since the last meeting of the Council, C. P. Fox, M.D., of Washington; John M. Paris, M.D., New Albany; W. U. Kennedy, M.D., Newcastle, and G. B. Bowers, M.D., Kokomo, were re-nominated by their respective districts as representatives on the Blue Shield Board of Directors.

Membership Problems

Remission of State Dues. Councilman Max R. Adams, M.D., Eleventh District, presented a request for the remission of dues of Edgar K. Black, M.D., of Wabash, due to disability. The request was approved, upon motion of Dr. Adams and seconded by Dr. Glock.

Letter from Lake County Medical Society. A letter from the Lake County Medical Society was read in which it was pointed out that Dr. J. F. Carlo, of Alamo, Texas, and Dr. George Holmes, of Chicago, had paid their 1959 non-resident membership fees to the Lake County Medical Society; further pointing out that Dr. Carlo is a member of the Texas State Medical Association and Dr. Holmes is a member of the Illinois State Medical Association. The Lake County Society questioned whether or not they could pay their county dues in one place and their state dues in another. It is pointed out that under the Constitution and Bylaws, a county society cannot grant membership within the society which does not include membership in the Indiana State Medical Association. On motion of Dr. Paris, and seconded by Dr. Neumann, it is voted that these men be dropped from the rolls.

Membership Report. The chairman read a membership report, which was approved by consent.

New Business

Letter from Dr. Lafe Ludwig. The Chairman read a letter from Dr. Lafe Ludwig, Chairman of the Council on Medical Service, of the American Medical Association, calling attention to the fine service contributed to the work of the Council by Dr. Wendell C. Stover. Upon motion of Dr. Paris, seconded by Dr. Vye, a standing commendation was given to Dr. Stover. The Council also instructed that the letter be read before the House of Delegates.

Matters Referred to the Council By the Executive Committee

Dr. Wood stated that he would like to report on legislative activities before giving the report of the Executive Committee, and informed the Council that Dr. Mericle, Dr. Owsley, Mr. Waggener, the executive secretary, and he, attended the AMA meeting in St. Louis, October 2 and 3, where they met with representatives of other states for the purpose of discussing legislative activities during the coming year.

Dr. Wood pointed out that one of the most pressing problems facing medicine during the coming year is the Forand Bill. Dr. Wood outlined some of the thinking of his commission on the activities they anticipated pursuing during the coming months regarding this particular issue. One of the suggestions which was made was that the Council propose a Resolution to the House of Delegates on the Forand Bill. This was approved, by consent, and a resolution was to be prepared for presentation to the House of Delegates the following morning (October 6).

Dr. Wood presented the following resolution for the consideration of the Council on the question of the establishment of outpatient departments for intern and resident training:

Resolution

WHEREAS, the staff of the Council on Medical Education and Hospitals the last few years have been placing increasing importance on the value of outpatient service for intern training, and

WHEREAS, this outpatient service is considered by the staff on the Council on Medical Education, is best obtained in the hospital outpatient department, which encourages the entering of hospitals in the practice of medicine, sociologically such clinics are considered not in the best interest of the patient who can better be served in his own Doctor's office, and

WHEREAS, this staff, or any staff of a hospital on medical education and the hospitals' prime interest is intern training without consideration of other phases of medical practices and ethics, and

WHEREAS, these efforts are tending to force the setting up of outpatient clinics and hospitals where it is not desired,

BE IT HEREBY RESOLVED, that a Committee of Private Practicing Physicians from the House of Delegates, which will include at least two members from cities between 100,000 and 200,000 people who have interns in their hospitals be appointed to study the value of outpatient service and to recommend the various methods that would be acceptable to give adequate service.

Dr. Vye reported that the Lake County Medical Society Council had worked out a similar resolution proposed to introduce to the House of Delegates on the same subject.

By consent, it was agreed that this resolution should be presented to the House of Delegates.

Resolution Concerning AMA Dues. The chairman stated the Executive Committee desired to call the attention of the Council to the Council proposed resolution making AMA dues mandatory for all members of the Indiana State Medical Association and its component county societies. The chairman stated the Executive Committee felt that the resolution might be softened by changing the "resolve" to read that the Indiana State Medical Association recommends to the county society that each member who pays county and state dues also pay dues to the AMA. Dr. Olson moved that the recommendation of the Executive Committee be adopted, there was considerable discussion on this question. For lack of a second, the resolution was to be presented to the House of Delegates in its original wording.

Better Business Bureau Membership for 1960. Upon motion of Dr. Ross, seconded by Dr. Paris, the association membership to the Better Business Bureau, in 1960, in the amount of one hundred and fifty dollars was approved.

Retired Physicians Home. A letter from Dr. M. A. Austin, concerning the problem of phyisicans who are forced to retire in old peoples' homes was read by the chairman. Following considerable discussion, upon motion duly made and seconded, it was voted a resolution be presented to the AMA asking the AMA to investigate the possibility of establishing a home for retired physicians.

Election of Editor and Four Associate Editors for the Journal, 1960. Upon motion duly made and seconded, the editor, Frank B. Ramsey, M.D., was re-elected editor of the *Journal* for 1960—A. W. Cavins, M.D., Terre Haute; L. G. Montgomery, M.D., Muncie; David A. Bickel, M.D., South Bend, and Stephen L. Johnson, M.D., Evansville, were re-elected associate editors for the *Journal* for the year 1960.

Resolutions. The resolutions to be presented to the House of Delegates were reviewed and discussed, and several councilmen volunteered to appear before the reference committees to make themselves available for discussion of these various resolutions.

Gibson County Medical Society. Dr. Robert S. McElroy, Princeton, appeared before the Council as a representative of Gibson County Medical Society and the staff of the Gibson County Hospital for a discussion of local problems.

White County. Dr. David C. Beck and Dr. Nolan A. Hibner appeared before the Council as representatives of White County Medical Society to discuss the problem they were having in White County.

Clinical Session of the AMA. The chairman called attention to the clinical session of the AMA to be held in Dallas, Texas, December 1 to 4.

Midwinter Meetings

Next Meeting of Council. By consent, it was agreed that the mid-winter meeting of the Council be held on Sunday, Jan. 10, at 10 a.m. (CDT) at the Student Union Building.

Adjournment. There being no further business, the Council adjourned to meet again Tuesday morning, October 6, at 7:30 in the Harrison Room of the Columbia Club.

THE COUNCIL

Indianapolis Session, 1959

The Council met for its second meeting immediately following adjournment of the House of Delegates, Wednesday noon, October 9, 1959, in the Ballroom of the Columbia Club, Indianapolis, with Dr. Guy A. Owsley, chairman, presiding.

Thirteen councilors, four alternate councilors, the president, the treasurer, the editor of *The Journal* and the executive secretary were present.

Elections for 1959-60

1. Excutive Committee Members. On motion of Drs. Ross, Glock and Vye, Dr. Don E. Wood, Indianapolis, and Dr. Wendell E. Covalt, Muncie, were re-elected members of the Executive Committee for the ensuing year.

2. Chairman of the Council. On ballot vote, Dr. Maurice E. Glock, Fort Wayne, was elected chairman of the Council for 1959-60.

There being no further business, the Council adjourned to meet again on January 10, 1960.

Scientific Manuscripts

are needed by the

JOURNAL

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House of Delegates Proceedings

INDIANAPOLIS SESSION
October 6-9, 1959

The House of Delegates convened at 9:00 a.m., Tuesday, Oct. 6, 1959, and again at 9:00 a.m., Friday, Oct. 9, 1959, in the Ballroom of the Columbia Club, Indianapolis, with the president, Dr. Kenneth L. Olson, South Bend, presiding.

Dr. Harry P. Ross, of Richmond, gave the invocation at the opening of the first meeting.

Credentials Committee Report

On motion of Drs. Lamey and Wilder, credentials cards presented by the delegates were accepted in lieu of a roll call at the first meeting. Dr. William E. Amy, chairman of the Reference Committee on Credentials, reported 112 delegates, 8 past presidents, 10 councilors, the president, the treasurer, two delegates to the AMA, and the editor of The *Journal,* present.

At the second meeting attendance slips signed by the delegates were accepted as constituting the roll call, on motion of Drs. Glock and Senseny. These slips registered 103 delegates, 8 past presidents, 13 councilors, the president, the treasurer, one AMA delegate, one AMA alternate delegate, and the editor of The *Journal* as present at this meetng.

According to Chapter IV, Section 3, of the Bylaws, 50 delegates constitute a quorum. The House of Delegates, therefore, was declared open and ready for the transaction of business.

The president read Chapter XXXI, Section 1, of the Bylaws, and Article XIV of the Constitution regarding amendments to the Bylaws and Constitution.

In Memoriam

The House stood in silent tribute to the memory of the following physicians who had served as members of the House of Delegates, or in an offical capacity in the Association, and who had passed away since the 1958 annual convention:

O. O. ALEXANDER, Terre Haute. Member of the Council, 1929-1942, and chairman, 1932-1936; member, Budget and Executive Committee, 1932-1936; member, Committee on Medical Education and Hospitals, 1938-1949; member, Committee for the Study of Lay Activity in Medical Practice, 1944-1946; member, Auditing Committee, 1950; member, Committee on Public Relations, 1952-53; member, Medical Care Insurance Committee, 1954.

PERCY M. ALEXANDER, Martinsville. Secretary, Morgan County Medical Society, 1940.

ROBERT E. BAKER, Orleans. Secretary, Orange County Medical Society, 1919; member, Committee on Convention Arrangements, 1926.

THOMAS J. BEASLEY, Indianapolis. Member, Committee on Tuberculosis, 1910-1912; vice-chairman, Medical Section, 1924 and 1926.

JOSEPH R. BLOOMER, Rockville. Secretary, Parke-Vermillion County Medical Society, 1924-1932, and 1941; delegate from Parke-Vermillion counties, 1943, 1945, 1947, 1950, 1953 and 1955; member, Committee on Control of Cancer, 1944.

CLARENCE E. BOYD, West Baden. Secretary, Orange County Medical Society, 1926-1930, and 1943-48; delegate from Orange county, 1936, 1943-48; member, Committee on Convention Arrangements, 1926; co-chairman, Committee on Convention Arrangements, 1945, 1947 and 1950.

ELDO H. M. CLAUSER, Muncie. Member of the Council, 1940-51; member, Executive Committee, 1954-57, and chairman, 1958; member, Committee on Indiana Inter-Professonal Health Council, 1946-52, and chairman, 1946, 1947, 1951 and 1952; member, Committee on Medical Education and Hospitals, 1948, and chairman, 1949; chairman, Committee on Publicity, 1953; chairman, Committee on Constitution and Bylaws, 1955-56; member, Student Loan Committee, 1956-57; member, Auditing Committee, 1957; member, Commission on Special Activities, 1958-59.

JAMES N. COLLINS, Indianapolis. Member, Committee on Convention Arrangements, 1946; member, Committee on Scientific Exhibit, 1946-49.

PORTER J. COULTAS, Tell City. Secretary, the Perry County Medical Society, 1924-27; delegate from Perry County, 1955.

CLAUDE A. CURRY, Terre Haute. President, Vigo County Medical Society, 1954.

EDGAR C. DENNY, Milton. Member of the Council, 1925-27.

BARUCH M. EDLAVITCH, Fort Wayne. Member, Committee on Scientific Exhibits, 1916; member, Committee on Diabetes, 1948-50.

GEORGE ELLERBROOK, Vevay. Delegate from Switzerland county, 1957.

ASA H. FENDER, Worthington. President, Greene County Medical Society, 1957.

HARRY L. FOREMAN, Indianapolis. Member, Auditing Committee, 1944; delegate from Marion County, 1945-46.

DAVID H. FORSYTH, Terre Haute. Secretary, Vigo County Medical Society, 1918.

MAURICE S. FOX, Vincennes. Secretary, Knox County Medical Society, 1934-35; member, Committee on Historical Exhibits, 1949.

JOHN C. GLACKMAN, Sr., Rochester. Member, Committee on Legislation and Public Policy, 1934-35; delegate from Spencer county, 1937-39; member, Committee on Public Relations, 1939-40; delegate from Fulton county, 1954-56.

CARL HENNING, Hanover. Secretary, Jefferson County Medical Society, 1909-11; delegate from Jefferson county, 1950.

CECIL E. JOHNSON, Rensselaer. Secretary, Jasper-Newton County Medical Society, 1930.

WILLIAM F. KING, Indianapolis. Secretary, Marion County Medical Society, 1908-10.

RUSSELL W. KRETSCH, Hammond. Chairman, section on Anesthesia, 1944-45.

GLENN D. LARRISON, Morocco. Secretary, Jasper-Newton County Medical Society, 1917.

HOMER E. LINE, Chili. Delegates from Miami county, 1943.

WILLIAM B. MARTIN, LaPorte. Secretary, 1937, and president, 1954, LaPorte County Medical Society.

MILO G. MEYER, Michigan City. Secretary, LaPorte County Medical Society, 1951.

HARRY E. MURPHY, Franklin. Member, Committee on Public Policy and Legislation, 1948, 1954, 1956-57; member, Auditing Committee, 1949; secretary, Johnson County Medical Society, 1953-54; delegate from Johnson county, 1936, 1957-58; chairman, Section on Preventive Medicine and Public Health, 1958-59.

ABRAHAM M. OWEN, Bloomington. Member, Committee on Physical Fitness, 1946; secretary, Monroe County Medical Society, 1946; secretary, Owen-Monroe County Medical Society, 1947-49; member, Committee on Secretaries' Conference, 1946-49.

CHARLES J. ROTHSCHILD, Fort Wayne. Member, State Board of Health Liaison Committee to deal with Social Security Act, 1940; member, Advisory Committee to the Bureau of Maternal and Child Health of the Indiana State Board of Health, 1941-43.

HARRY M. SHULTZ, Logansport. Secretary, Cass County Medical Society, 1943-45.

HERMAN W. SMELSER, Connersville. Member, Committee on Physical Therapy, 1940-44; delegate from Fayette-Franklin County Medical Society, 1946; member, Committee on Conservation of Hearing, 1956-57.

WILL A. THOMPSON, Liberty. Secretary, Wayne-Union County Medical Society, 1910-15; member, Committee on Health and Public Instruction, 1914-15; member, Committee on Scientific Exhibits 1918-19; chairman, Committee on Prevention of Traffic Accidents, 1942-43; member, Committee on Study of High School Athletics, 1944; member, Committee on Physical Fitness, 1945 and 1946; member of Committee on Public Policy and Legislation, 1949 through 1951; delegate from Union county, 1934 through 1953.

HAROLD O. WILLIAMS, Kendallville. Member of Committee on Veterans' Affairs, 1939 and 1940.

JOHN YARLING, Peru. Secretary of the Miami County Medical Society, 1917, 1926 and 1927.

1958 Minutes

Minutes of the meetings held at Indianapolis Oct, 12, 1958, and Oct. 15, 1958, were approved as printed in the Dec. 1958, *Journal*, by consent.

Introduction of Guests

MR. JOSEPH R. MILLER, Indianapolis, president, Indiana Chapter of Student A.M.A.

IRVIN ABELL, M.D., Louisville, president, Kentucky State Medical Association.

MR. JOSEPH P. SANFORD, Louisville, executive secretary, Kentucky State Medical Association.

MR. LEO E BROWN, Chicago, director, Communications Division, American Medical Association.

CLEON A. NAFE, M.D., Indianapolis, member, Board of Trustees, A.M.A.

MR. THOMAS A. HENDRICKS, Chicago, assistant to the executive vice-president, American Medical Association.

MR. FREMONT POWER, Indianapolis, reporter, *Indianapolis News*.

Mr. Brown addressed the House on legislation pending in Congress.

Physician of the Year

Dr. John K. Kingsbury, Indianapolis, was elected "Physician of the Year" for 1959.

1959 Reference Committees

The chairman announced the appointment of reference committees for the 1959 session as follows:

Sections and Section Work
Wendell C. Stover, Boonville (Warrick), Chairman
William J. Stangle, Bloomington (Owen-Monroe)
Thomas M. Brown, Muncie (Delaware-Blackford)
James V. White, Terre Haute (Vigo)
Claude D. Holmes, Frankfort (Clinton)

Rules and Order of Business
Burton E. Kintner, Elkhart (Elkhart), Chairman
Sam Rotman, Jasonville (Greene)
Forrest E. Keeling, Portland (Jay)
Frank H. Green, Rushville (Rush)
V. Earle Wiseman, Greencastle (Putnam)

Medical Education and Hospitals
Francis L. Land, Fort Wayne (Allen), Chairman
R. Case Hammond, Evansville (Vanderburgh)
Harold C. Ochsner, Indianapolis (Marion)
Merle E. Whitlock, Mishawaka (St. Joseph)
Donald W. Ferrara, Peru (Miami)

Legislation
F. R. N. Carter, South Bend (St. Joseph), Chairman
Eugene F. Senseny, Fort Wayne (Allen)
P. J. Rosenbloom, Gary (Lake)
Paul T. Lamey, Anderson (Madison)
Jack E. Shields, Brownstown (Jackson)

Public Relations
Harry R. Stimson, Gary (Lake), Chairman
Louis C. Bixler, South Bend (St. Joseph)
Robert Seibel, Nashville (Bartholomew-Brown)
E. R. Apple, Salem (Washington)
Frederic W. Brown, Fort Wayne (Allen)

Hygiene and Public Health
Harry Pandolfo, Indianapolis (Marion), Chairman
Robert K. Webster, Brazil (Clay)
John C. Richter, LaPorte (LaPorte)
Ralph C. Eades, Valparaiso (Porter)
Fred Smith, Jr., Tell City (Perry)

Amendments to Constitution and Bylaws
M. C. Topping, Terre Haute (Vigo), Chairman
Herbert P. Sloan, New Albany (Floyd)
Russell J. Spivey, Indianapolis (Marion)
Garvey B. Bowers, Kokomo (Howard)
T. R. Armstrong, Michigan City (LaPorte)

Reports of Officers
R. B. DuBois, Lafayette (Tippecanoe), Chairman
Robert M. Brown, Marion (Grant)
Norman M. Silverman, Terre Haute (Vigo)
James M. Kirtley, Crawfordsville (Montgomery)
Ray Elledge, Hammond (Lake)

Credentials
William E. Amy, Corydon (Harrison-Crawford), Chairman
Marvin L. McClain, Scottsburg (Scott)
Charles P. Schneider, Evansville (Vanderburgh)
O. T. Scamahorn, Pittsboro (Hendricks)
James W. Crain, Williamsport (Fountain-Warren)

Insurance
James M. Leffel, Indianapolis (Marion), Chairman
Guy B. Ingwell, Knox (Starke)
John W. Beeler, Indianapolis (Marion)
Frederick L. Schoen, Fort Wayne (Allen)
David Adler, Columbus (Bartholomew-Brown)

Miscellaneous Business
Truman E. Caylor, Bluffton (Wells), Chairman
D. S. Megenhardt, Indianapolis (Marion)
Lee J. Maris, Attica (Fountain-Warren)
Donald G. Mason, Angola (Steuben)
Daniel M. Hare, Evansville (Vanderburgh)

Reports of Officers Reference Committee

The following matters were referred to the Reference Committee on Reports of Officers. All reports will be found on the pages indicated in the September, 1959, Vol. 52, No. 9, *Journal* of the Indiana State Medical Association.

President's address

President-elect's address

Address of President of Woman's Auxiliary

Executive Secretary (pages 1614-15)

Treasurer (pages 1615-20)

Chairman of Council (1620-22), except resolution concerning payment of AMA dues, which was referred to Reference Committee on Amendments to the Constitution and Bylaws

Councilors' reports (pages 1622-27)

Executive Committee (pages 1628-34)

Journal Editor (page 1634)

Delegates to AMA (pages 1193-1201, July 1959, *Journal*)

President's Address

The address of the president, Dr. Kenneth L. Olson, is printed on pages 2177-94 of the December, 1959, *Journal* of the Indiana State Medical Association. This address was referred to the Reference Committee on Reports of Officers.

REFERENCE COMMITTEE ACTION

Dr. R. B. DuBois, chairman, presented the following report, which was adopted:

Dr. Kenneth L. Olson's address was enjoyed by the audience at the Murat Theater. His review of the activities and achievements of the association for the year 1959 was excellently presented. His very capable leadership made the year of 1959 a year of distinction. This committee especially wishes to commend Doctor Olson's farsighted outlook on the Student Loan Fund and recommends its continued support.

President-Elect's Address

Dr. Earl W. Mericle, president-elect, presented an address, which was referred to the Reference Committee on Reports of Officers (printed on pages 2204-05 of this *Journal*).

REFERENCE COMMITTEE ACTION

Dr. R. B. DuBois, chairman, presented the following report, which was adopted:

The committee reviewed the address of Dr. Earl W. Mericle and wishes to commend him for his excellent presentation of the problems we expect to face in the coming year. It is felt that individual members and the component county medical societies will lend their complete support to his proposed program.

We noted in the president-elect's address the proposition that a building committee be appointed by the House of Delegates or president of the Association. The building committee report, delivered at the first meeting of the House recommended that the chairman of the Council appoint this committee.

Doctor Mericle appeared before the reference committee on reports of officers and stated that he had no objections to any method of selecting a building committee as approved by the House of Delegates, but does feel that this task in its great scope deserves the individual attention of a committee.

Woman's Auxiliary Presidential Address

Mrs. Joe M. Black, Seymour, president of the Woman's Auxiliary to the Indiana State Medical Association, addressed the House of Delegates as follows, her report being referred to the Reference Committee on Reports of Officers:

Dr. Olson, Dr. Mericle, members of the House of Delegates, and guests:

Thank you, doctors, for allowing us to be your auxiliary and for letting us assist you whenever possible. Your Executive Committee advises the auxiliary on matters of policy and activities. I wish personally to express my sincere thanks to Dr. Olson and Dr. Don E. Wood, our ISMA advisor, for their assistance and guidance.

I have just returned this morning from the auxiliary conference in Chicago, where Indiana's first national president, Ethel Gastineau, is presiding. It is with a great deal of pride that we compare Indiana's accomplishments with those of the other states.

Our auxiliary has approximately 2700 members with 73 counties organized into 60 local groups and 48 members-at-large. We welcome our newest auxiliary, La-Porte County, and their president, Mrs. John C. Richter. I hope that the medical societies who haven't an auxiliary will help us add their county to our ranks, so that we may better carry out our national theme, "To accept individual responsibilities for better community health." Without your desire for us to organize and without your words of encouragement, our jobs are impossible. One of the main objects of the auxiliary is "to promote mutual understanding and cultivate friendly relations among the familes of the physcians." *Please* urge your wives to join the auxiliary.

To promote better relations between our neighboring states, this year your auxiliary president has visited the state conventions in Illinois, Kentucky and Michigan, and the Public Relations meeting in Chicago.

Indiana won top honors at national convention in the *Today's Health* contest by securing the most subscriptions for any of the states in group No. 4, which consists of the larger states; and St. Joseph County won first prize for the auxliaries with a membership of over 150 members. Twenty-six of our auxiliaries reached 100% of ther subscripton project contest quota. It was announced at the national convention in Atlantic City that this was the final year for auxiliary participation in a subscription contest and promotion project. The AMA will now send *Today's Health* to every doctor. Mrs. Homer R. Swihart of Elkhart will help answer all questions concerning the discontinuance of this project.

Our energetic legislative chairman, Mrs. Otis Bowen, of Bremen, has worked endlessly keeping us informed on legislation and urging members to contact their senators and representatives. Dr. Olson, in his letter to the auxilary, stated, "Your help in getting out telegrams and letters to the members of the State Legislature this

Lifts depression...



An emotionally balanced patient
Thanks to your treatment and the help of Deprol, her depression is relieved and her anxiety and tension calmed. She eats well, sleeps well, and can return to her normal activities.

as it calms anxiety!

Deprol helps balance the mood by lifting depression as it calms related anxiety

No "seesaw" effect of amphetamine-barbiturates and energizers

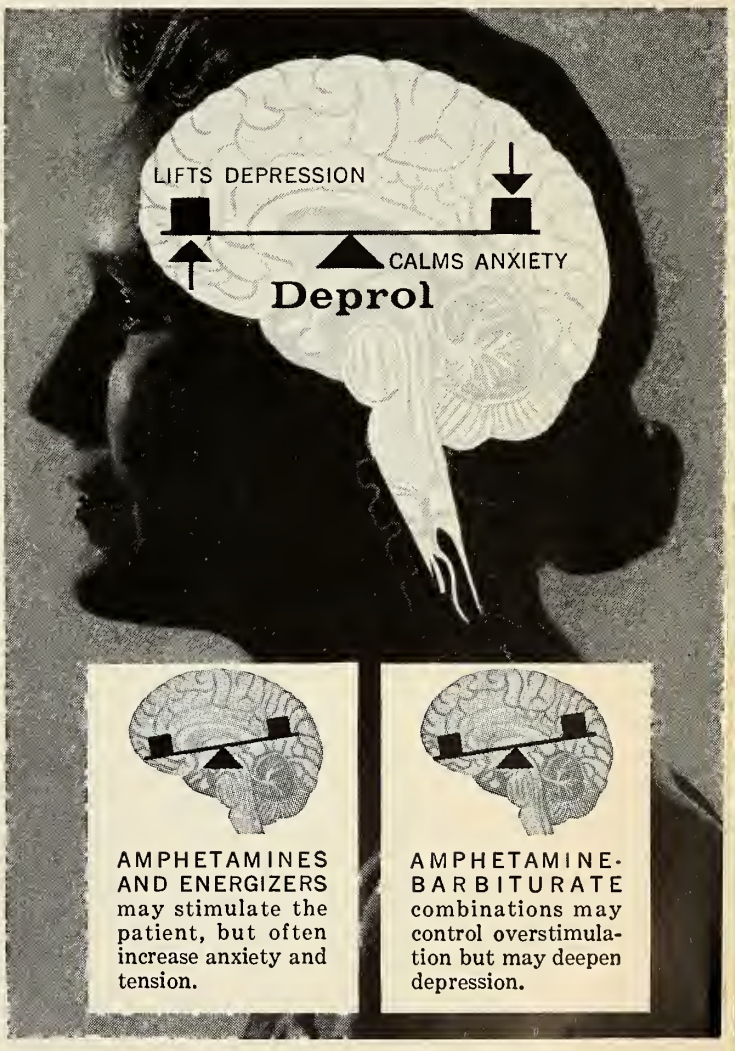
While amphetamines and energizers may stimulate the patient—*they often aggravate anxiety and tension.* And although amphetamine-barbiturate combinations may counteract excessive stimulation—*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety—both at the same time.

Safer choice of medication than untested drugs

Deprol does not produce hypotension, liver damage, psychotic reactions or changes in sexual function.

BIBLIOGRAPHY: 1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N.: Deprol as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy. In press, 1959. **3.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F.: Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **4.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B.: Treatment of depression—New technics and therapy. Am. Pract. & Digest Treat. In press, 1959. **5.** Pennington, V. M.: Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **6.** Rickels, K. and Ewing, J. H.: Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **7.** Ruchwarger, A.: Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:43B, Aug. 1959. **8.** Settel, E.: Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy. in press, 1959.



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DOSAGE: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.

COMPOSITION: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

SUPPLIED: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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year was very important in defeating the Chiropractic Bill." We realize that political participation is one of our most important jobs, since 52% of the voting power in the nation are women and the auxiliary will continue to act promptly and willingly when asked by the ISMA.

Mrs. I. S. Hostetter of Muncie, state public relations chairman, and Mrs. Sam Campbell of Noblesville, state rural and community health chairman, realize the need for the auxiliary to work as a liaison between our husbands and the public. The auxiliary is working in many community projects and striving to keep the respect and confidence of the community. This year, with your help, we would like to give a Health Citation Award to a lay person who by his or her voluntary activities has made an outstanding contribution to the advancement of health and health education in Indiana, or who has contributed to health and health conditions in his or her respective community. Your Executive Committee has approved this award, so we hope that you will all help us with nominations, and perhaps working together, we can receive a lot of favorable publicity.

Mrs. Dwight Schuster of Indianapolis, publicity chairman, is doing a fine job. I am sure that she has helped create a lot of interest in this convention.

Mrs. Eli Rubens of South Bend, state A.M.E.F. chairman, hopes that our $5.00 per capita will be reached for A.M.E.F. this year. She is assisting the ISMA with their exhibit at convention. As of July, the national auxiliary has given $140,500.00 to A.M.E.F. and of this amount Indiana contributed $8,231.93 and ranked sixth in the nation. We are very proud of our record, and hope to continue the good work, particularly since this A.M.E.F. year has been designated by the AMA as the Ethel Gastineau year. Floyd County sponsored a successful boat trip this summer and the proceeds of $350.00 will go to A.M.E.F.

County auxiliaries will give ready cooperation to local Civil Defense groups. Mrs. Kenneth Schneider of Nashville, Civil Defense chairman, had a speaker from the State Civil Defense Office at our four area meetings in May. Approximately 400 of our members have taken a course in home nursing and approximately 500 a course in first aid. We have 25 members that teach these courses.

The Hoosier Doctor's Wife, which is published four times a year, is our official means of communication between auxiliary members. It ranks foremost in the state's publication, and is edited by Mrs. Frank Green of Rushville.

Our Medical Care insurance program has done much to help us educate the public. This year the auxiliary helped in arranging dinners for the husbands and wives in many counties. Indiana Blue-Cross and Blue-Shield have given us continued support in our undertakings. Mrs. Joseph Dudding of Hope, is our insurance chairman.

Mrs. Robert Acher of Greensburg, state safety chairman, has a very active program. Some of our counties have helped sponsor high school driver education, safety in automobile design and equipment, programs on chemical tests for intoxication, and farm and home safety. We have had booths at county fairs and have shown many slides to the public.

Under the guidance of our state mental health chairman, Mrs. Frank Hogle, our members have participated in many mental health activities. We have helped teach new volunteers, been on panel discussions, sponsored classes for state hospital patients, given gifts, and have donated many hours of work in state hospitals.

Recently I received a letter from one of your past-presidents, Dr. M. A. Austin, who asked the auxiliary to help publicize a fund that should be most seriously considered—a retirement home for doctors and their wives.

Mrs. Russell Palmer of Gary, is our state recruitment chairman. The auxiliary helps in many ways with recruitment for paramedical careers. We have organized many future nurses clubs, had field trips to hospitals, county fair health exhibits, a health career day, and have had many teas and coke parties. We give a State 4-H scholarship each year. This past year our auxiliaries gave four loans to students, and 56 scholarships for a total amount of $11,569.55.

Your Executive Committee requested that we designate a member from our auxiliary to serve on the new nursing careers committee. This we did, so that all of our recruitment efforts can be co-ordinated.

Although at times our phones are a bit too insistent, our patients are too demanding, and our dinners are too cold, we still are proud and happy to be your wives and your auxiliary members, and believe that "a task worth doing, and friends worth having, make life worth living."

Isn't it strange
That princes and kings
And clowns that caper
In sawdust rings
and common folks
Like you and me
Are all building for eternity?

To each is given
A bag of tools
A shapeless mass
And a book of rules;
And each must build
'Ere life has flown
A stumbling block
Or a stepping stone.

—Anon.

Working together, as a team, we can build a stepping stone for eternity. Thank you.

REFERENCE COMMITTEE ACTION

Dr. R. B. DuBois, chairman, presented the following report, which was adopted:

The accomplishments of the Woman's Auxiliary to the Indiana State Medical Association were a source of pride to the members of this committee. Mrs. Black's report deserves the praise of the association. The auxiliary is to be complimented on its work with *Today's Health,* A.M.E.F., legislative activities, civil defense, medical care insurance and very many other activities. We are all proud that an Indiana auxiliary member, Ethel Gastineau, is serving as president of the national organization.

Dr. R. B. DuBois, chairman, presented the remainder of the report of the Reference Committee on Reports of Officers, as follows, which was adopted in each separate part and as a whole:

Report of the Executive Secretary

(Page 89 of the Handbook.)

The report of the executive secretary of the Indiana State Medical Association is an excellent review of the many activities of our headquarters and Mr. Waggener should be especially commended for his efficient management of this office. Some of the items in the report should be accentuated.

In the second year of the commission-type of operation, the secretary felt that this method has been very successful and worthwhile and should be continued. The committee work has received a tremendous boost by better interest shown.

It should be pointed out that the membership of the ISMA is at the all-time high of 4,218, a net gain of 525 during the past 10 years.

The field staff of the ISMA headquarters contacted all members of the state legislature prior to the biennial meeting and developed with them a line of communication with the approval of the local medical societies, which was must valuable in gaining successful results.

The field staff also contacted every nursing home in the state to determine the population of those over 65 and to determine who is paying for their care. The survey determined that personal or private funds were providing the care for the majority of the people.

Visitation to every newspaper in the state improved press relations. Many newspapers requested the association to supply them with the weekly health column for their local use.

The Journal of the Indiana State Medical Association received a great favor in being accorded praise by the International Council of Industrial Editors. It also received top ranking by state journals by every organization which reviewed it.

The tape library is fast becoming a most important means of quick distribution of the latest in scientific information and is enjoying an increasing number of uses.

Mr. President, I move the adoption of this section of this report.

(Motion seconded, put to vote and carried.)

Report of the Treasurer

The Treasurer's report, as printed on page 94 of the Handbook, indicated to this committee that the finances were being well handled. The supplemental report presented on the floor was discussed. The association is indeed fortunate to have as its treasurer such a conscientious gentleman as Dr. Sicks.

Mr. President, I move the adoption of this section of this report.

(Motion seconded, put to vote and carried.)

Report of Chairman of the Council

(As printed on page 106 of the Handbook.)

The report of the chairman of the Council was reviewed. The Council is to be commended for their diligent work and discussions of the past yeaar. We especially wish to commend them for their work with the legislature and support of the Science Fair for 1960.

Mr. President, I move the adoption of this section of this report.

(Motion seconded, put to vote and carried.)

Reports of the District Councilors

(As printed on page 112 of the Handbook.)

This committee reviewed the comprehensive reports from each of the 13 councilor districts. These reports show that all districts are active and that the best interests of the medical profession and the public are receiving just consideration. The committee commends the cooperation and efforts of the Woman's Auxiliary in the districts and recommends that their activities be extended.

Mr. President, I move the adoption of this section of this report.

(Motion seconded, put to vote and carried.)

Report of the Executive Committee

(As printed on page 125 of the Handbook.)

This committee reviewed the reports of the numerous meetings of the Executive Committee of the Indiana State Medical Association. The minutes of these monthly meetings were remarkably stated and well written. After a careful review, it is our opinion that never have so few given so much service to the Indiana State Medical Association and its members.

Report of Editor of *The Journal*

The report of the Editor of *The Journal* of the ISMA indicated a very successful year, with the introduction of new features in *The Journal*, and a rating from the International Council of Industrial Editors of excellent. The editor and technical staff of *The Journal* are in line for congratulations.

Report of Delegates to AMA

The report of the delegates to the June, 1959, AMA meeting was published in the July Indiana State Medical Association *Journal*. This report was studied. Several important issues were reported, among them, medical care plans, free choice of physician, medicine and osteopathy, preparation for general practice, social security for doctors and other issues. A highlight of this meeting was an address given at the convention by President Eisenhower.

Sections and Section Work Committee

Dr. Wendell C. Stover, chairman, presented the following report, which was adopted:

Mr. Chairman, our reference committee believes that the work of the Committee on Convention Arrangements and its subcommittee should be commended for their arrangements and the exceptional selection of the outstanding speakers for the scientific program of the convention, the excellent schedule of presentations and discussions of subjects which are of vital clinical importance to the members of the Indiana State Medical Association.

It was the opinion of this reference committee that the executive secretary should be commended for his procurement of the finest display of technical and scientific exhibits in the history of the association.

Medical Education and Hospitals Committee

The following matters were referred to the Reference Committee on Medical Education and Hospitals. All reports will be found on the pages indicated in the September, 1959, Vol. 52, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Medical Education and Licensure (pages 1664-1666)

Commission on Special Activities (page 1669)

Student Loan Committee (pages 1634-1635)

Commission on Inter-Professional Relations supplementary report, as follows, presented by Dr. Joseph B. Davis, chairman:

Because of the increased enrollment in the Indiana University Medical School which increases the demand for anatomical material and because of recent changes in the state welfare laws which have tended to decrease the anatomical material, we recommend that as part of the report of the Committee on Inter-Professional Relations, Dr. E. N. Kime be called to the floor of the House of Delegates to submit the urgency of this very important problem.

(By unanimous consent of the House of Delegates, Dr. Edwin N. Kime, secretary of the Indiana State Anatomical Board, spoke in detail at this time on the shortage of anatomical material at the Indiana University School of Medicine.)

Resolution A on Intern Training from the Council.

Resolution on Outpatient Departments.

Resolution on Re-evaluation of Accreditation Requirements.

REFERENCE COMMITTEE ACTION

Dr. Francis L. Land, chairman, presented the following report:

Anatomical Material

Mr. President, gentlemen. First, the reference committee considered the supplemental report of the Commission on Inter-Professional Relations. This report pertains to the urgency of obtaining adequate anatomical material for use in teaching medical students within this state. This committee recognizes that there is an actual emergency existing concerning this situation, and we recommend that the Commission on Inter-Professional Relations continue and further increase their efforts to obtain necessary anatomical material for our medical schools. Mr. President, I move the adoption of this section of this report.

(Motion seconded, put to vote, and carried)

Outpatient Departments Resolution

(Introduced by P. J. ROSENBLOOM, M.D., LAKE COUNTY MEDICAL SOCIETY)

WHEREAS, An increasing number of general hospitals are establishing out-patient departments, and

WHEREAS, Some of these out-patient departments are needed to meet American Medical Association requirements for residency teaching programs, but

WHEREAS, They are not needed, as is frequently claimed, for intern training programs, nor are they required by the Joint Commission on Accreditation of Hospitals, and

WHEREAS, Out-patient departments are not necessary, or a proper method, for the care of indigent patients, and

WHEREAS, The establishment of these departments in non-teaching hospitals puts such hospitals into the practice of medicine, in conflict with the private practice of medicine by physicians,

NOW, THEREFORE, BE IT RESOLVED, That the Indiana State Medical Association establish itself on record as opposing the establishment of out-patient departments by hospitals except in those circumstances required for teaching hospitals.

(Adopted by the Council of the Lake County Medical Society, October 4, 1959.)

Resolution A: Intern Training

Introduced by: THE COUNCIL.

WHEREAS, The staff of the Council on Medical Education and Hospitals of the American Medical Association the last few years has been placing increasing importance on the value of out-patient service for intern training, and

WHEREAS, This out-patient service is considered by this staff as best obtained in a hospital out-patient department. This encourages the entering of hospitals in the practice of medicine and socialogically such clinics are considered not in the best interests of the patient who can better be served in his own doctor's office, and,

WHEREAS, This staff of the Council on Medical Education and Hospitals apparent prime interest is in Intern training without consideration of other phases of medical practice and ethics, and,

WHEREAS, These efforts are tending to force the setting up of out-patient clinics in hospitals where it may not be necessary or desired,

BE IT HEREBY RESOLVED, That our Delegates to the American Medical Association introduce this Resolution at the December Meeting of the American Medical Association and request that a committee of private practicing physicians of the House of Delegates be appointed to study this problem. Two members of this committee should be from cities of a population of 100,000 to 200,000 who have intern training programs in their community. It should report its findings and recommendations back to the House in June, 1960.

REFERENCE COMMITTEE ACTION

Dr. Francis L. Land, chairman, presented the following report:

Your committee considered the resolution from Lake County concerning internship training and out-patient departments and Resolution A, Intern Training, introduced by the Council, and finds these similar in significance. The Lake County Medical Society is to be commended for pointing out to our House of Delegates a very dangerous practice which continues to beset hospitals in local communities. This committee believes that the resolution by the Council of the Indiana State

Medical Association offers a comprehensive and constructive approach to this problem and would recommend that the House of Delegates approve the same.

Mr. President, I move adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

Re-Evaluation of Accreditation Requirements Resolution

Introduction by: R. CASE HAMMOND, M.D., FOR VANDERBURGH COUNTY MEDICAL SOCIETY

WHEREAS, there has been an increasing demand on the individual physician's time in caring for a greater number of patients and,

WHEREAS, the Joint Commission on Accreditation of Hospitals has added to this problem by imposing additional duties and obligations as requirements for hospital staff membership and,

WHEREAS, hospital records are becoming increasingly burdensome and time consuming (e.g. requiring a signature on every order when a single signature at the bottom of the page would suffice),

THEREFORE, BE IT RESOLVED that the Indiana State Medical Association petition the American Medical Association to instruct its representatives on the Joint Commission to take all possible measures to relieve hospital staff members of as many details as are consistent with good practice.

REFERENCE COMMITTEE ACTION

Dr. Francis L. Land, chairman, presented the following report:

In consideration of the resolution, subject, Re-evaluation of Accrediation Requirements, your committee would recommend that paragraphs 2 and 3 of said resolution be deleted and the resolution would then read:

Subject: RE-EVALUATION OF ACCREDITATION REQUIREMENTS

WHEREAS, There has been an increasing demand on the individual physician's time in caring for a greater number of patients,

THEREFORE BE IT RESOLVED that the Indiana State Medical Association request the American Medical Association to instruct its representatives on the Joint Commission to take all possible measures to relieve hospital staff members of as many details as are consistent with good practice.

Mr. President, I move the adoption of this section of the report.

(Motion seconded, put to vote and carried.)

Medical Education

Dr. Francis L. Land, chairman, presented the following report:

The report of the Commission on Medical Education and Licensure, pages 171 to 175 of the Handbook, was considered by your committee and it is recommended that this report be accepted as printed. It is recommended that the suggestions listed on page 173 be submitted to the next Commission on Medical Education and Licensure for consideration.

Mr. President, I move the adoption of this section of the report.

(Motion seconded, put to vote and carried.)

Special Activities

In considering the report of the Commission on Special Activities, page 184 of the Handbook, the committee approves of the report with the exception of the last paragraph in that we do not feel that an investigation of physicians' activities in civic affairs and interests in medical organizations would be of sufficient importance to warrant expenditure of funds. The committee agrees that physicians should be as active as possible and knows that most physicians are very active, thus further negating reasons for a survey of physicians in this field.

Mr. President, I move the adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

Student Loan

The committee believes that the House of Delegates should note with pride the report of the Committee on Student Loan Fund on pages 143 and 144 of the Handbook, and we move the adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

Dr. John VanNuys appeared before this committee and announced, effective July 1, 1960, a two-year general practice training program will be initateid at the Indiana University Medical Center with four positions available. This program is established in accordance with the princples of the A.M.A. Committee on Preparaton for General Practice as approved by the House of Delegates of the A.M.A. in June, 1959. This is the only approved program of this type in any medical school in the United States.

The chairman wishes to thank the members of the committee and those individuals appearing before the committee for their time and effort devoted to this subject.

Mr. President, I move the adoption of this report as a whole.

(Motion seconded, put to vote and carried.)

Legislation Committee

The following matters were referred to the Reference Committee on Legislation. All reports will be found on the pages indicated in the September, 1959, Vol. 52, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Legislation (pages 1636-1637).

Resolution No. 4. Determination of Cause of Death.

Resolution No. 5. Immunization of School Children.

Resolution No. 8. Emergency Care at Scene of Accident.

Resolution B. H. R. 4700, The Forand Bill.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny, a member of the committee, presented the following report, in the absence of Dr. F. R. N. Carter, chairman:

Your Reference Committee on Legislation met at 2 p.m. on Tuesday, Oct. 6, 1959 in the basement of the Murat Temple, all members being present.

The committee wishes to compliment all the local societies for their earnest endeavor and sincerity in sub-

mitting resolutions to better organized medicine in this state and our nation.

The following resolutions were considered: Number 4, 5, 8B and the report of the Legislative Commission and will be reported in that order.

Resolution No. 4

Introduced by: LAKE COUNTY MEDICAL SOCIETY

Subject: DETERMINATION OF CAUSE OF DEATH

WHEREAS, the present laws of the State of Indiana governing the determination of cause or causes of death involving violence are inadequate, and

WHEREAS, there is reason to believe that violent deaths, including homicide and suicide, can and do occur in the State of Indiana without detection, and

WHEREAS, there is further reason to believe that undetected criminal cases in the State of Indiana provoke more criminal acts of violcnce and the perpetrators are unpunished, and

WHEREAS, there is sufficient reason to believe that "natural deaths" are signed unknowingly by health departments as heart disease or cerebral hemorrhages instead of homicides or suicides, now therefore

BE IT RESOLVED, that the Indiana State Medical Association seek the adoption of appropriate legislation in the 1961 General Assembly requiring a more thorough medical investigation of all deaths from violent causes, suspicious deaths, or deaths without medical attendance, and

BE IT FURTHER RESOLVED, that unattended natural deaths and those deaths which the attending medical doctor deems investigation is necessary be delegated to the respective county coroner.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny presented the following report:

Resolution 4 (as presented on page 86 of the handbook) concerning the determination of cause of death was discussed at some length, both by members of the committee and other interested association members. This problem has existed for some time and has been discussed at the House of Delegates on numerous occasions. Previous resolutions requiring the coroner to be an M.D. have been rejected because such would require an amendment to the Indiana State Constitution. It was hoped and thought that the Forensic Science bill would help solve part of the problem by giving coroners a place to secure more help or aid in determinations of cause of death.

Your committee, however, felt that the above measure was not adequate and, therefore, suggests the acceptance of a long-term program involving a change in the State Constitution.

It is further suggested that this change be implemented by the next coming General Assembly and thus this matter should be referred to the legislative committee immediately for appropriate action.

The committee also recommends that in the meantime all county societies make every effort possible to have M.D.'s seek the office of coroner in their local counties.

It should be understood that the legislative change would make all coroners M.D.'s It should be further understood that such a change will require six years.

Mr. President, the committee moves the adoption of this section of this report.

(Motion seconded, put to vote, and carried.)

Resolution No. 5

Introduced by: LAKE COUNTY MEDICAL SOCIETY

Subject: IMMUNIZATION OF SCHOOL CHILDREN

WHEREAS, the medical profession and health educators have for many years urged the immunization of children against smallpox, diphtheria, whooping cough, tetanus, and other diseases without complete success, and

WHEREAS, the public response to our recent urgings for polio immunizaton has again pointed out the indifference of many parents to their responsbility in this respect, and

WHEREAS, the neglect of such protection constitutes a threat against all children in our schools, now therefore

BE IT RESOLVED, that the Indiana State Medical Association seek the adoption of appropriate legislation in the 1961 General Assembly to require prior and effective immunization of all children before admission to the first year of school, exempting only the conscientious religious objectors and those persons where a medical reason contraindicates the immunizations, and

BE IT FURTHER RESOLVED, that such immunizations be done at the individual parent's expense, except that appropriate means be adopted to immunize those children whose parents are determined to be indigent.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny presented the following report:

Resolution No. 5 (as printed on page 87 in the handbook) concerns immunization of school children. After due deliberation on this issue, your committee honestly felt that to make immunization compulsory actually meant legislating the practice of medicine, despite the well-intended meaning of such a resolution. The committee further felt that as written this resolution was basically and fundamentally in opposition to the voluntary concept of the American way of life.

Your committee instead recommends a more intensive educational program be entered into in which parents have children immunized by the family doctor in his office. Further, that appropriate means as always be adopted to care for those determined indigent. We urge all physicians to stress a full immunization program to their patients. Your committee thus does not recommend the adoption of this resolution but suggests the above program.

Mr. President, the committee moves the adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

Resolution No. 8

Adopted by: SEVENTH DISTRICT MEDICAL SOCIETY, SEPTEMBER 23, 1959

Introduced by: HAROLD C. OCHSNER, M.D.

Subject: EMERGENCY CARE AT SCENE OF ACCIDENT

WHEREAS, the duty of a physician in time of emergency is clearly defined by the Hippocratic oath, and

WHEREAS, the exercise of this responsibility has been hazardous because of medico-legal complications on such medical services,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association seek legislation which would provide that: No person licensed to practice the healing art in the State of Indiana, who in good faith renders emergency care at the scene of an accident, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny presented the following report:

Resolution No. 8 concerning care at scene of accident. After consultation with legal counsel, your committee recommends the acceptance of this resolution with the following rider: "if such legislation can be constitutionally sustained."

Mr. President, the committee moves the adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

Resolution B

Introduced by: THE COUNCIL

Subject: H. R. 4700, THE FORAND BILL

WHEREAS, there has been introduced into the Eighty Sixth Congress, a bill known as House Resolu- 4700, and

WHEREAS, the sponsor of this bill claims the benefits are necessary to solve the problem of providing hospital and medical care for those who are recipients of old age benefits, and

WHEREAS, careful analysis of this legislation shows it would serve very few of the total population, and it would be a tax burden upon the total population, and

WHEREAS, this increased tax burden for this program on social security having this expense added to it might cause the failure of the entire social security program, and

WHEREAS, this legislation would prove too expensive, would be of little value to the majority of the people, would not permit free choice of hospital or physician and would lead to the socialization of the health care of this Nation,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association, assembled this 9th day of October, 1959, does hereby go on record as being opposed to this legislation as being ineffective and unrealistic, and

BE IT FURTHER RESOLVED, that a copy of this Resolution be sent to each Senator and Congressman from the State of Indiana, and to each member of the House Ways and Means Committee of the Congress, and

BE IT FURTHER RESOLVED, that the members be implored to use their influence to see this legislation is not adopted and that communities be commended and encouraged for their efforts to solve any problem which might exist without Federal intervention.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny presented the following report:

Resolution B concerning the Forand Bill submitted by your council is endorsed wholeheartedly. It is recommended by your committee that county societies pursue a similar course as laid out in this resolution.

Mr. President, the committee moves the adoption of this section of this report.

(Motion seconded, put to vote, and carried.)

Legislative Commission

Last, the report of the Legislative Commission was reviewed, discussed and accepted. The committee wishes to commend the Commission on Legislation for its diligence and perseverance during the past year and for its many accomplishments on a local, state and national level.

Mr. President, the committee moves the adoption of this section of the report.

(Motion seconded, put to vote and carried.)

Mr. President, the committee moves the adoption of this report as a whole.

(Motion seconded, put to vote, and carried.)

Public Relations Committee

The following matters were referred to the Reference Committee on Public Relations. All reports will be found on the pages indicated in the September, 1959, Vol. 52, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Grievance Committee (pages 142-143, Handbook)

Commission on Public Information (pages 1637-1639, *Journal*)

Resolution on Physicians' Listings in Classified Section of Telephone Directory.

REFERENCE COMMITTEE ACTION

Dr. Harry R. Stimson, chairman, presented the following report:

Mr. President, the matters referred to this reference committee were three:

1. Report of Grievance Committee (pages 142 and 143, Handbook).

2. Report of Commission on Public Information (pages 149 to 152, Handbook)

3. The resolution from Allen County regarding physicians' listings in classified section of the telephone directory.

Grievance Committee

This committee has reviewed the report of the Grievance Committee and recommends its approval to the

House as printed on pages 142 and 143 of the Handbook without change.

Mr. President, I move the adoption of this section of this report.

(Motion seconded, put to vote, and carried.)

Public Information

Also this committee has reviewed the report of the Commission on Public Information as printed on pages 149 to 152 in the Handbook and also recommend its approval without change to the House of Delegates.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded, put to vote, and carried.)

Resolution on Telephone Listings

Introduced by: FREDERICK W. BROWN, M.D., ALLEN COUNTY MEDICAL SOCIETY

Subject: PHYSICIANS' LISTINGS IN CLASSIFIED SECTION OF TELEPHONE DIRECTORY

REFERENCE COMMITTEE ACTION

Dr. Harry R. Stimson, chairman, presented the following report:

Since the resolution from Allen County regarding telephone listing is not printed in the Handbook, I shall read this resolution at this time. It is as follows:

WHEREAS, some physicians have recently expressed dissatisfaction with the practice of physicians' listings in the classified section of telephone directories according to categories of practice, and

WHEREAS, as a result of this criticism some directory services have made the decision to abandon classification according to the various types of practice, and

WHEREAS, we believe that listings as to appropriate categories in the classified section results in a definite service to patients seeking medical care, and

WHEREAS, we believe that listings as to type of practice result in fewer unnecessary calls on physicians who desire to limit their practice,

NOW, THEREFORE BE IT RESOLVED, that this Association go on record as of approving the listing of physicians in the classified sections of telephone directories, according to categories of practice, subject to approval of the local medical society in the county in which the directory is published.

After long and conclusive discussion, your committee recommends the acceptance of this resolution.

Mr. President, I move the adoption of this portion of this report.

(Motion seconded, put to vote, and carried.)

Mr. President, I move the adoption of this report as a whole.

(Motion seconded, put to vote, and carried.)

Hygiene and Public Health Committee

The following matters were referred to the Reference Committee on Hygiene and Public Health. All reports will be found on the pages indicated in the September, 1959, Vol. 52, No. 9, *Journal* of the Indiana State Medical Association.

Commission on Public Health (pages 1641-1644).

Commission on Voluntary Health Agencies (pages 1644-1645).

Maternal Mortality Report for 1957. (Copy handed to each delegate).

REFERENCE COMMITTEE ACTION

Dr. Harry Pandolfo, chairman, presented the following report:

Mr. President, members of the House of Delegates, the reference committee on Hygiene and Public Health met at the appointed time and place and all members were present at the meeting. The matters referred to this reference committee were:

1. Report of Commission on Public Health.
2. Report of Commission on Voluntary Health Agencies.
3. Maternal Mortality Report for 1957.

Public Health

The report of the Commission on Public Health, which is on page 159 of your Handbook, was referred in its entirety to this reference committee. We wish to recommend that this report be adopted as presented.

The members of this commission are to be commended for their extensive study of the problems dealing with public health.

Mr. President, I move acceptance of this portion of our report.

(Motion seconded, put to vote, and carried.)

Voluntary Health Agencies

The commission report on Voluntary Health Agencies, page 167 of your Handbook, was reviewed and it is recommended that the report be adopted as presented. This commission had no major problems presented to it for consideration.

Mr. President, I move acceptance of this portion of the report.

(Motion seconded, put to vote, and carried.)

Maternal Mortality Report for 1957

The reference committee reviewed the Indiana Maternal Mortality Study Report for 1957. We wish to thank this committee for this fine report and recommend that the report be adopted as presented. The following comments seem to be indicated at this time:

1. That a continuing study of maternal mortality be conducted in order to reduce maternal deaths to a minimum.
2. It is also recommended that future reports deal more specifically with deaths classified as preventable; in this way, measures to reduce this category can be instituted when possible.
3. It is also recommended that copies of this report be submitted to county medical societies for their information.
4. It is also recommended that the names of the members of the committee for the study of maternal mortality be added to their report.

Mr. President, I move adoption of this section of our report.

(Motion seconded, put to vote, and carried.)

Mr. President, I move the adoption of this report as a whole.

(Motion seconded, put to vote, and carried.)

Amendments to Constitution and Bylaws Committee

The following matters were referred to the Reference Committee on Amendments to Constitution and Bylaws. All reports will be found on the pages indicated in the September, 1959, Vol. 52, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Constitution and Bylaws (pages 1666-1669) and following resolutions contained in this report:

Resolution on Composition and Appointment of Reference Committees

Resolution on Filing County Society Constitution and Bylaws Not Later Than May 1 with Executive Secretary

Amendment to Article V of Constitution on Composition of House of Delegates

Amendments to Bylaws to Change Fiscal Year of Association

Constitutional amendment on Election in Absentia

Resolution No. 2 on Specialty Journals as Benefit of AMA Membership

Resolution from the Council Making AMA Membership Mandatory

Amendments to Constitution and Bylaws Providing for Speaker and Vice-Speaker of the House of Delegates (pages 1669-1670)

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, presented the following report:

Mr. President, Doctor Mericle, Doctor Owsley, this is the report of Commission on Constitution and Bylaws.

Speaker and Vice-Speaker

The first order of business referred to this committee concerned the proposed change in the Constitution providing for the offices of speaker and vice-speaker.

This is contained in Paragraph I of the Resolution printed on pages 82 and 83 of the Handbook, as read at the 1958 session of the House of Delegates. I quote:

"Be it Resolved, that Article IX, Section 1, of the Constitution of the Indiana State Medical Association, be amended by inserting in Line 3 of Section 1, after the word 'Treasurer' and before the word 'and' the following words: 'A Speaker and a Vice-Speaker of the House of Delegates'."

Your committee is in agreement with this amendment if it be implemented by also amending Article V of the Constitution as follows: by inserting the words, "the Speaker and Vice-Speaker of the House of Delegates," after the words, "The Treasurer of this Association," and before the words, "and the Delegates,"

and by amending

Article VI of the Constitution as follows: add after the word "vote," in sentence one, "and the Speaker and Vice-Speaker without power to vote."

As these would add a change in the amendment as presented in open meeting at the previous annual convention, in that they would make the speaker an ex-officio member of the House with power to vote in case of a tie, we present these amendments in open meeting for publication twice in the JOURNAL and to be acted upon at the next annual convention. We believe it would be better to have this delay than to create the office of speaker without defining his powers and status. We are also recommending certain changes in the implementing bylaws in the next part of this report, which will prevent action upon them at this meeting.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

The remainder of this resolution deals with proposed changes in the bylaws implementing these proposed newly created offices.

The bylaws may be changed at any regular meeting if the proposal has laid on the table one day.

After hearing much evidence indicating proposals for changing this portion of the resolution to a more realistic appraisal of the qualifications and duties of the speaker, and no evidence in support of the resolution as specifically worded, it is the opinion of your committee that you desire some changes made in the wording of this proposal.

It is noted that if the recommendations of this committee are adopted in reference to this portion of the report, it will constitute a preliminary reading of substantive changes into the bylaws and cannot be voted on at this meeting, but must be tabled for one day. Since this is the last regular meeting of the House of Delegates, it will in effect postpone action for one year.

It is recommended that paragraph 2 of the resolution, on page 82, be amended to read as follows:

"Be It Further Resolved, that Chapter VI, Section 1, of the Bylaws of the Indiana State Medical Association be amended by deleting the phrase at the end of the first sentence, reading, 'and of the House of Delegates'."

Section 12, Chapter VII of Bylaws be amended as follows: delete the word, "and" after the word "Treasurer." Add, after the words "Chairman of the Council," the words, "and the Speaker and Vice-Speaker of the House."

It is further recommended that the proposed new Section 4 of Chapter VI be amended to read as follows:

"The speaker and vice-speaker of the House of Delegates shall be elected by the House of Delegates from its members at that time and shall remain a member of the House during his term by virtue of that office. He shall preside at all meetings of the House of Delegates and shall conduct the business of the House of Delegates, but shall not have a vote therein except in case of a tie. He shall be an officer of the Association with the right to participate in the discussion in the meetings of the Council and of the Executive Committee, but without power to vote in either of such meetings. If the speaker is absent, or for other reason wishes to delegate his duties, the vice-speaker shall perform them."

Your committee recommends no change in paragraphs IV, V and VI of the resolution.

It is recommended that the last paragraph of the resolution be deleted in its entirety..

Mr. President, I move the acceptance of this portion of our report.

(Motion seconded, put to vote, and carried.)

Reference Committees

Dr. M. C. Topping, chairman, presented the following report:

The resolution having to do with the naming of members of reference committees, as published on page 176 of the Handbook, is endorsed by your reference committee. The proposed change in the Bylaws concerns the first sentence of paragraph 3 of Section 1 of Chapter XXIV and I quote, "Each committee shall consist of five members, at least three of whom shall be members of the House of Delegates. The chairman shall be named by the president from among those who are members of the House of Delegates."

Mr. President, I move the adoption of this section of the report and of said resolution.

(Motion seconded, put to vote, and carried.)

Filing County Society Constitution and Bylaws

Dr. M. C. Topping, chairman, presented the following report:

The resolution proposing a revision of Section 15 of Chapter XXV of the Bylaws, as published on page 177 of the Handbook, is endorsed by this committee. It reads as follows, and I quote: "Each component Medical Society shall have its own Constitution and By-Laws, which shall not be in conflict with the Constitution or By-Laws either of this Association or of the American Medical Association. An up-to-date copy thereof shall be filed with the Executive Secretary of the Indiana State Medical Association not later than May 1 of each calendar year, or where such copy is so on file and no change has been made, then it shall be sufficient to file a certificate to that effect with said Executive Secretary."

It is noted that the commission did not recommend a penalty clause, but did submit one for your consideration of you wish to penalize a county society for not complying with the above resolution. This clause would constitute an amendment to Section 15 of Chapter XXV of the Bylaws and is printed in italics on page 178 of the Handbook.

It is the feeling of your reference committee that this change would be undesirable in that it would penalize a while society for the possible dereliction or omission of one of its members. It is also deemed unconstitutional to deny a duly constituted delegate seating in the House for failure of his society to comply with what is in effect only a secretarial assignment. We therefore recommend your rejection of this penalty as alternately presented by the commission.

Mr. President, I move the adoption of this portion of the report and of the resolutions amending Section 15 Chapter XXV of the Bylaws.

(Motion seconded, put to vote, and carried.)

Fiscal Year

Dr. M. C. Topping, chairman, presented the following report:

It has been recommended by the executive committee and the council, upon advice of the Wolf Management and Engineering firm that the fiscal year of the Association be changed to be from Oct. 1 to Sept. 30. In order to implement this bookkeeping change, it is necessary to change Section 2 of Chapter IX of the Bylaws referring to the executive committee, which reads as follows, and I quote: "It shall prepare a budget for the ensuing calendar year." This is recommended by the commission to be amended by changing the word, "calendar" to "fiscal."

Section 12 of Chapter XXV should be amended as follows: Sec. 12. "The fiscal year of the Association shall be from October 1 to September 30 of the succeeding year. The dues shall be collected by the calendar year and payable in advance."

Considerable discussion was heard relative to the desirability of changing the date for payment of dues to the beginning of the fiscal year. To do this would require many changes in the Bylaws as noted on pages 179, 180, 181 and 182 of the Handbook. Mr. Bixby, of the Wolf Manaagement concern, appeared before the committee and stated that there was no necessity to change the date of payment of dues and there was no intent on their part to initiate the many changes necessary to do this. His only thought in suggesting a change in the fiscal year was to make it conform to the terms of the officers and delegates. It is, therefore, recommended that those resolutions amending the Bylaws to implement the change in time for payment of dues be rejected.

Mr. President, I move the acceptance of this portion of the report, and the adoption of the amendments to Section 2 of Chapter IX and Section 12 of Chapter XXV above set forth relating to changing to a fiscal year and the rejection of all changes in the line of paying dues.

(Motion seconded, put to vote, and carried.)

Elections in Absentia

Article IX—Officers—Sec. 3, Constitution, now reads as follows: ". . . no person shall be elected . . . who is not in attendnce on that Annual Convention, and who . . ."

The change in this section of the Constitution, as proposed by the Commission on Constitution and Bylaws, follows:

BE IT RESOLVED, that that part of Section 3 of Article IX of the Constitution of the ISMA which now reads "and no person shall be elected to any such office who is not in attendance on that Annual Convention and who has not been a member of the Association for the preceding two years," be amended by substituting therefor the following: "and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years."

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, presented the following report:

The proposed change in the Constitution, as set out in the resolution, as published on page 183 of the Handbook, was approved by your committee and its passage recommended.

Mr. President, I move the acceptance of this portion of the report and the adoption of this resolution.

(Motion seconded, put to vote, and carried.)

Mr. President, I move the adoption of the entire report of the Commission on Constitution and Bylaws, as amended.

(Motion seconded, put to vote, and carried.)

Resolution No. 2

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: SPECIALTY JOURNALS AS BENEFIT OF AMA MEMBERSHIP

WHEREAS, The AMA has this year included in the annual dues a subscription to one of its specialty journals as an added benefit of membership, and

WHEREAS, The primary function of the AMA is not the publishing of journals, and

WHEREAS, Anything which fosters the glut of medical writing which already inundates the profession should be critically appraised, and

WHEREAS, The portion of annual AMA dues thus diverted to subsidize such journal publishing might be devoted to other constructive purposes, now therefore be it

RESOLVED, That the Indiana State Medical Association urge the American Medical Association to reconsider its decision to include specialty journals as a benefit of membership and to ascertain the preference of members generally, and be it

FURTHER RESOLVED, That this resolution be introduced in the House of Delegates of the Indiana State Medical Association in Indianapolis, October 1959, and presented at the Clinical Session of the AMA House of Delegates in Dallas, December 1959.

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, presented the following report:

Resolution No. 2, on specialty journals as benefits of AMA membership, as printed on page 85 of the Handbook was considered by the Committee. After hearing testimony, both in support of and against this resolution, it was the feeling of this committee that the resolution should be rejected and we so recommend.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Mandatory AMA Membership

(Special Resolution from the Council)

WHEREAS, organized medicine is faced with the necessity of being fully organized at all levels, and

WHEREAS, physicians, to present a united front, and to be fully aware of measures affecting them at all levels, and

WHEREAS, the Council is of the belief that every physician should wholly support, not only his County Society and his State Association, but also his national organization, and

WHEREAS, the physicians of many other states have banded themselves together to lend their support to their county society, State Association and American Medical Association, by declaring that all who are members of the county and State Medical Societies shall also be a member of the American Medical Association;

NOW, THEREFORE, BE IT RESOLVED, that effective with the next dues year no physician be granted membership by a county society or the Indiana State Medical Association unless such membership also includes membership in the American Medical Association, and

BE IT FURTHER RESOLVED, that the Constitution and By-laws be amended to conform with this Resolution."

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, presented the following report:

Resolution making AMA membership mandatory, printed on pages 110 and 111 of the Handbook. The committee feels that this is a problem more properly to be considered by each county medical society. It doubts the propriety of action by this House to require AMA membership to be compulsory for county society membership. The committee agrees in principle with the desirability of membership in the American Medical Association for all Indiana State Medical Association members, but feels that no constitutional compulsion should be necessary.

We recommend the rejection of this resolution.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Mr. President, I move the adoption of this report as a whole.

(Motion seconded, put to vote, and carried.)

Insurance Committee

The following matters were referred to the Reference Committee on Insurance. All reports will be found on the pages indicated in the September, 1959, Vol. 52, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Medical Economics and Insurance (pages 1645-1664)

Report of Special Committee on Transfer of Professional Fees From Blue Cross To Blue Shield, copy of which was handed to each delegate, and which follows

Resolution No. 1 Opposing the Relative Value Scale

Resolution No. 6 on Relative Value Scale

REFERENCE COMMITTEE ACTION

Dr. James M. Leffel, chairman, presented the following report:

The following matters were referred to the Reference Committee on Insurance:

1. Report and Recommendations from the Committee for study and planning for Transfer of Professional Fees from Blue Cross to Blue Shield.

2. Report of Commission on Medical Economics and Insurance.

3. Resolution No. 1, Introduced by Madison County Medical Society, subject, Resolution Opposing the Relative Value Scale.

4. Resolution No. 6, Introduced by Seventh District Medical Society, subject, Relative Value Scale.

Your Reference Committee on Insurance met at 2 p.m., Oct. 6, 1959, in the basement dining room of the

Murat Temple. Members present were, Guy B. Ingwell, John M. Beeler, Frederic L. Schoen, David Adler and James M. Leffel, Jr. A large number of interested members of the association were present, as well as representatives of Blue Shield.

There was a marked difference of opinion expressed on certain issues, but your committee was most favorably impressed by the honest and sincere attitudes of all. We are most grateful to those who attended the meeting and do very sincerely thank them for their fine participation.

Transfer of Professional Fees from Blue Cross to Blue Shield

The report from the Committee for Study and Planning for Transfer of Professional Fees from Blue Cross to Blue Shield, copy of which was handed to each delegate, follows:

Subject: REPORT AND RECOMMENDATIONS

Reference: ACTION OF THE HOUSE OF DELEGATES OF 1958 WITH RESPECT TO RESOLUTIONS NO. 2, NO. 3, AND NO. 4 (JISMA p. 1769 DEC., 1958)

Pursuant to instruction contained in the action of the House referred to above, a committee of ten members was appointed by the President.

This committee believes that whatever physicians do in the course of their duties in the care of the sick is the practice of medicine. Control, even remotely by non-medical persons is not in the best interests of the patient or of the public. Physicians, therefore, cannot permit the sale of their services by any non-medical organization. Therefore, sale of the physicians services must not be provided in any hospital service contract.

For the above reasons, the following plan is offered to provide for the orderly transfer of whatever medical services Blue Cross may now be offering to the public from Blue Cross to Blue Shield. Assurance is given that there is no intent to produce or foreseeable possibility of monetary gain to physicians or harm to the patient, the public, hospitals or to the insurance plan.

1. Blue Cross will discontinue issuing contracts providing medical coverage on and after March 1, 1960.

2. Blue Shield will offer coverage to fulfill the provisions of Blue Cross contracts now in existence containing these medical services of equal or better provision.

3. Blue Cross will pay to Blue Shield whatever portion of premiums hereafter collected on existing certificates as are ascribable to such coverage.

4. When new or different contracts are issued by Blue Cross no coverage will be offered for physicians services. Subscribers desiring such coverage will be offered this coverage through either a Blue Shield rider attached to Blue Cross policies or by separate Blue Shield policy.

5. Blue Shield will provide benefits for transferred medical services on the basis of fee schedules in effect with Blue Cross participating hospitals as of March 1, 1960. Changes in fee schedules, if any, will be arranged with Blue Shield in the same manner as they have been arranged with Blue Cross.

6. Participating hospitals will submit charges for medical services in which they have an interest (radiology, pathology, possibly electrocardiography) in the same Blue Cross claim form currently in use. Blue Cross will transmit these charges to Blue Shield where checks will be written to the appropriate physicians.

7. All checks for medical services will be drawn in the name of the appropriate physician. Blue Shield will transmit these checks along with appropriate accounting information to the physician with duplicate accounting information to the hospital involved. It is assumed that the hospital information will accompany the Blue Cross check drawn to the hospital covering hospital services thereby precluding the necessity for multiple posting procedures.

8. All parties conversant with the problem recognize that unforeseen questions will arise from time to time. It is expected that these will be arbitrated in a sincerely cooperative manner not injurious to the public good.

The committee calls attention to the fact that the plan submitted is, for all practical purposes, identical with the mechanics of a similar transfer currently in operation in Iowa. It is further expected that all parties involved will draw heavily on the experience of the Iowa group. In this manner the program can be expedited, and perhaps unnecessary mistakes avoided.

Respectfully submitted:

David L. Adler, M.D.
William E. Bayley, M. D.
John Beeler, M.D.
Robert A. Burger, M.D.
Joseph L. Haymond, M.D.
John Lionberger, M.D.
Harold Ochsner, M.D.
A. W. Ratcliffe, M.D.
Joseph Weber, M.D.
By: Wallace D. Buchanan, M.D., Chairman

REFERENCE COMMITTEE ACTION

Dr. James M. Leffel, Chairman, presented the following report:

The first item considered was the report and recommendations of the committee for study and planning for transfer of professional fees from Blue Cross to Blue Shield. Your committee approved the entire report and recommends such transfer from Blue Cross to Blue Shield as soon as feasible.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Medical Economics and Insurance

Dr. Leffel continued with the report of the Reference Committee on Insurance:

The second item considered was the report of the

Commission on Medical Economics and Insurance. We wish to commend this commission for their untiring efforts and conscientious work. For reasons of clarity, we wish to consider this item in three sections . . . the first, Relative Value Index study. Along with this portion of the report, we deliberated upon resolutions numbers 1 and 6 in that they were related to that portion of the commission report.

Resolution No. 1

Introduced by: THE MADISON COUNTY MEDICAL SOCIETY

Subject: RESOLUTION OPPOSING THE RELATIVE VALUE SCALE

WHEREAS, the determination of a physician's fees is an individual matter, to be arrived at by mutual understanding between the physician and his patient, and

WHEREAS, any attempt by any other party, including organized physician-groups, to influence the conduct of the individual patient-physician relationship, in the matter of arriving at a satisfactory charge for service, is unjustified and endangers personal liberty, and

WHEREAS, there has been devised and promulgated, by organized physician-groups, a coding of weights of several medical and surgical procedures, known as the Relative Value Scale, and

WHEREAS, the use of the Relative Value Scale, in conjunction with a conversion factor, to be determined by the organized physician-groups in given geographic or political areas, results in creating a Fixed Fee Schedule, and

WHEREAS, such a Scale and its companion, the conversion factor, which are announced by organized physician-groups themselves, serve the interests of unions, insurance companies and other groups both as a club to promote their insistence on the acceptance of a fixed set of physicians rates, and as a wedge to divide those physicians unwilling to participate from their colleagues, and

WHEREAS, such a Scale, with its conversion factor, in the face of organized group and general public pressures against justifiable rate increases, would impose undesirable economic restrictions, which with continuing inflationary trends, would prove to be a financial hardship to physicians from which the only hope for relief would be in the direction of bargaining with representatives of labor, the insurance companies and others.

THEREFORE, BE IT RESOLVED that the Madison County Medical Society condemns the Relative Value Scale as a dangerous device capable of doing great harm to patients, physicians and the medical profession, and

BE IT FURTHER RESOLVED, that a copy of this Resolution be sent to the Indiana State Medical Association for presentation to the House of Delegates at the annual meeting, October, 1959.

Resolution No. 6

Adopted by: SEVENTH DISTRICT MEDICAL SOCIETY
SEPTEMBER 23, 1959

Introduced by: HAROLD C. OCHSNER, M.D.

Subject: RELATIVE VALUE SCALE

WHEREAS, there is need for a schedule of relative values between the various procedures done by doctors of medicine and surgery, and

WHEREAS, doctors should write this schedule since they are best prepared to determine the relationship, and

WHEREAS, there exist schedules in other states which, with minor revisions, could be made to suit our state, and

WHEREAS, any doctor may set his own fees by varying the conversion factor, thus making no change in our traditional custom of setting our own fees,

THEREFORE BE IT RESOLVED that the Insurance and Medical Economics Committee of the Indiana State Medical Association be instructed and empowered to continue its study of the Relative Value Scale and to prepare material on the pros and cons of this question for study by our component County Medical Societies during the coming year, so that delegates to the State Convention in 1960 may have a basis on which to accept or reject this plan.

REFERENCE COMMITTEE ACTION

Dr. James M. Leffel, chairman, presented the following report:

In spite of the extensive study already made by the commission, your committee feels that the entire membership of our Association is inadequately informed. We feel that the adoption or rejection of the Relative Value Scale at this time would be ill advised. We feel that the membership should be further acquainted with the advantages and the disadvantages of this plan during the coming year, not with the purpose of selling this plan, but with the idea of having an informed membership intelligently accept or reject a Relative Scale. We therefore suggest the adoption of that portion of the commission recommendation that this be made a continuing study. To implement this, we recommend the rejection of Resolution No. 1 and the adoption of Resolution No. 6.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Dr. Leffel continued with the report of the Reference Committee on Insurance:

The second portion of the report of the Commission on Medical Economics and Insurance has to do with prepaid insurance. It is the considered opinion of your committee that this section of the commission report contains much valuable information and should be studied and evaluated by all. However, we do wish to make two recommendations from this section of the report at this time, namely: (1) The further study of insurance coverage for outpatient diagnostic procedures including x-ray and pathology, and (2) that the "Simplified Claim Forms" prepared by the Health Insurance Council, 1958, and a committee of the American Medical Association, a copy of which is appended hereto, be accepted as the standard claim forms for use in the state of Indiana, and, in addition, that all health and accident insurers who do business in Indiana be so notified.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Dr. Leffel continued with the report of the reference Committee on Insurance:

The third portion of the report of the Commission on Medical Economics and Insurance has to do with double coverage, a subject upon which this commission has offered a resolution entitled, "Resolution on Blue Shield Indemnities."

Resolution on Blue Shield Indemnities

The sub-committee recommends that the following resolution supplant the resolution on issuance of two checks by Mutual Medical Insurance, Inc. adopted by the House of Delegates in 1952:

WHEREAS the Board of Regents of the American College of Surgeons has endorsed the following principles concerning medical care insurance plans as being in the best interest of the patient, the profession and the public: (1) every physician involved in the care of the patient is entitled to compensation commensurate with both the value of indicated and necessary services rendered, and with the reasonable ability of the patient to pay; (2) the fee designated for the service of one physician should not be shared with any other physician; (3) insurance plans should not pay to one physician the fee earned by another; (4) medical care insurance plans should not establish fee schedules which interfere with the obligation of the physician to give the best possible care to his patient; (5) the fee schedule for physicians' services, if established by any medical care insurance plan, should not fix the physicians' fee for all patients in that locality, and

WHEREAS the Joint Commission on Accreditation of Hospitals disproves nurses, or others who are not graduates of medicine, acting as first assistants on a major surgical case, and

WHEREAS the Joint Commission on Accreditation of Hospitals further holds that inasmuch as the surgeon should consider both the safety of the patient and his responsibility for the education of junior surgeons, he should, when performing major surgery, have a capable physician assistant who is competent and ready to continue the operation at any moment in case of necessity. In this instance, major surgery should be considered as any procedure in which there is considered to be hazard to life or any procedure in which a major body cavity is opened, and

WHEREAS few of the hospitals in Indiana where major surgery is performed have a resident house staff of medical graduates available to serve as assistants at major surgical procedures, such necessary surgical assistants must be enlisted from the rolls of local private practicing physicians; therefore

BE IT RESOLVED that the Board of Directors of Indiana Blue Shield be instructed to issue a new schedule of indemnities wherein the indemnities for major surgical procedures are set up as "Schedule Indemnities for the Cooperative Care of the Surgical Patient" listing in separate columns (1) The total indemnity payable for the procedure; (2) the indemnity (75% or 80%) of the total indemnity payable jointly to the certificate holder and the operating surgeon on submission of the proper claim form by the operating surgeon, and (3) the indemnity (20% or 25% of the total indemnity) payable jointly to the certificate holder and the "cooperating physician"—for his services as surgical assistant or physician providing a necessary supplemental skill—on submission by the "Cooperating Physician" of proper and separate claim form; further,

BE IT RESOLVED that the Board of Directors of Indiana Blue Shield take steps promptly to bring their schedule of indemnities into conformity with the ISMA Relative Value Schedule just as soon as such a Schedule is prepared and adopted.

REFERENCE COMMITTEE ACTION

Dr. James M. Leffel, chairman, presented the following report:

Your committee agrees with the intent of this resolution, but because of opposition to some portions, wishes to alter the wording to read as follows:

WHEREAS, the Board of Regents of the American College of Surgeons have endorsed the following principles concerning medical care insurance plans as being in the best interest of the patient, the profession and the public, (1) every physician involved in the care of the patient is entitled to compensation commensurate with both the value of indicated and necessary services rendered, and with the reasonable ability of the patient to pay; (2) The fee designated for the service of one physician should not be shared with any other physician; (3) insurance plans should not pay to one physician the fee earned by another; (4) medical care insurance plans should not establish fee schedules which interfere with the obligation of the physician to give the best possible care to his patient; (5) *the fee schedule for physicians' services, if established by any medical care insurance plan, should not fix the physicians' fee for all patients in that locality, and,*

WHEREAS, the Joint Commission on Accreditation of Hospitals disapproves nurses, or others who are not graduates of medicine, acting as first assistants on a major surgical case, and,

WHEREAS, the Joint Commission on Accreditation of Hospitals further holds that inasmuch as the surgeon should consider both the safety of the patient and his responsibility for the education of junior surgeons, he should, when performing major surgery, have a capable physician assistant who is competent and ready to continue the operation at any moment in case of necessity. In this instance major surgery should be considered as any procedure in which there is considered to be hazard to life or any procedure in which a major body cavity is opened, and

WHEREAS, few of the hospitals in Indiana where major surgery is performed have a resident house staff of medical graduates available to serve as assistants at major surgical procedures such necessary surgical assistants must be enlisted from the rolls of local private practicing physicians, and

WHEREAS, there are many instances when a surgeon may need medical advice and/or consultation during a patient's postoperative care, therefore

BE IT RESOLVED, that the Board of Directors of Indiana Blue Shield be respectfully requested to issue a new schedule of indemnities for the assisting or cooperating physician, listing these indemnities for procedures now listed in the schedule of Surgical Indemnities, payable to the assisting or cooperating phy-

sician and the certificate holder jointly on submission by the assisting or cooperating physician proper and separate claim forms.

BE IT FURTHER RESOLVED, that the Board of Directors of Indiana Blue Shield be respectfully requested to make available an endorsement to Blue Shield policies which will provide in-hospital indemnity for a cooperating physician for necessary diagnostic and medical care, not only preceding but also following surgery for the same condition.

BE IT FURTHER RESOLVED, that the above be started as a pilot study.

Mr. President, I move that this portion of the report be adopted.

(Motion seconded, put to vote, and carried.)

Mr. President, I move this report be approved in its entirety.

(Motion seconded, put to vote, and carried.)

Miscellaneous Business Committee

The following matters were referred to the Reference Committee on Miscellaneous Business. All reports will be found on the pages indicated in the September, 1959, Vol. 52, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Convention Arrangements (no printed report).

Commission on Governmental Medical Services (pages 1639-1641).

Commission on Inter-Professional Relations (pages 1663-1664).

Resolution No. 3. Construction of Building to House Indiana State Medical Association.

Resolution on honorary membership for I. S. Ravdin, M.D.

Report of Building Committee.

Building Committee Report

The Building Committee met through the year to consider the business with which it was charged by the resolution passed by the 1958 House of Delegates.

The questions to be answered were: Does the membership want a building? Should a headquarters building be built for our own need alone, or provide rental space for other organizations? Does a reliable business consultant believe we can afford to build?

The committee received the investigations and actions on the subject of building by previous committees, by the Executive Committee, the Council and the House of Delegates. In addition, they examined the present ISMA headquarters office, and in their opinion, found that it was inadequate and inefficiently arranged. They considered renting additional space in the Hume Mansur Building, and other available office space. One particularly attractive office was investigated and did not meet our needs and it cost too much.

During the year there were two significant developments affecting the course of action of the Building Committee.

A consultant firm, the Wolf Management Engineering Company, employed by the association to investigate the functions of the ISMA office, recommended that the present headquarters office space be enlarged and more efficiently arranged to care for immediate needs. In addition, they recommended that the association's invested securities be re-invested in a more lucrative manner to prevent depreciation of this sum through inflation. It recommended that a substantial portion be invested in a new building, which it felt we could afford.

After working over plans for remodeling the present office, it was found that the cost increase in excess of the original estimate was to the point that remodeling was less attractive.

It was felt that the entire membership of the association should be polled by mail to determine their position on whether to remodel or to use invested securities in a new office building. Of a total of 4,100 ballots sent out to the membership, 1,645 were returned, which we understand is a good return. Of the balance returned, 1,220 (74%) voted to build a new building and 373 (17%) voted against building. The remaining 4% were non-committal, or voted for both provisions, or otherwise rendered their ballot uncountable.

It was felt that the answer to the first question asked by the House of Delegates, "Does the membership want a building?" was "Yes."

Another development of significance during the course of our investigation was the offer by the Board of Directors of the Marion County Medical Society (also the directors of the Levey Memorial Foundation) to share office space with the Marion County Medical Society at their building at 2902 N. Meridian Street. The property was inspected by members of the Council and by members of the committee. After consideration of the proposition, it was felt that there were too many unavoidable uncertainties involving the property to further consider the proposition at this time.

The Building Committee again returned to consider building a new building.

In summary, the Building Committee offers the following conclusions from its studies:

The membership desires a new Headquarters Office Building.

Such a building should meet our own needs and not include rental space for other organizations.

It should be large enough for present and the immediate future needs of the association.

It should provide meeting rooms for committees and the Council, and accommodate the needs of the ISMA Auxiliary, plus providing adequate parking space and space for future expansion.

This would require about one acre of land and an estimated 8000 square feet of office space. It should be built at a total cost not to exceed $250,000, which includes cost of building and lot. It should be located in a non-depreciating neighborhood that is convenient for members of the association and has easy access to the business area of Indianapolis and to motel and hotel accommodations.

The committee felt that these factors should guide the final selection of the site and not cost alone.

The committee expressed opinions favoring selection of a site in the north, or northwest of downtown Indi-

anapolis, but did not rule out considering sites in other directions.

The committee has available a list of building sites which fulfill these requirements and the list is appended to this report. Some of these have asking prices, while others are to be negotiated.

In addition, appended to this report are suggested floor plans, together with floor plans of office buildings built by other medical associations. However, the committee feels that none of these floor plans should be chosen as the final floor plan and building design can only be worked out after the architect is chosen to design the building in consultation with the final building committee.

This report is presented with the hope that it provides the answers needed by the House of Delegates to take decisive action on housing our headquarters office.

The details of the points considered by the committee in arriving at these conclusions are available to the House for its further action.

Also, the members of this Committee are ready to help in any way possible the consideration of the House of Delegates.

We wish to thank the House of Delegates for this opportunity to serve them.

Mr. Chairman, I move that the Council of the Indiana State Medical Association be empowered by the House of Delegates to carry on the business of the construction of a Headquarters Office Building, at a cost not to exceed $250,000, including procuring a site, an architect, a floor plan, and other matters necessary to provide a new ISMA office. The chairman of the Council shall appoint a committee of not more than 5 members of the Council to act as the Building Committee.

BUILDING COMMITTEE OF THE HOUSE OF DELEGATES

Burton E. Kintner, M.D., Chairman
James M. Leffel, M.D.
Irvin W. Wilkens, M.D.
Howard Williams, M.D.
Ramon B. DuBois, M.D.
Glen Ward Lee, M.D.
Guy B. Ingwell, M.D.
Basil M. Merrell, M.D.
Harry R. Stimson, M.D.
Paul R. Tindall, M.D.
Jack Shields, M.D.
Frederic Brown, M.D.
Truman Caylor, M.D.

REFERENCE COMMITTEE ACTION

Dr. Truman E. Caylor, chairman, presented the following report:

Your reference committee had referred to it the report of the Building Committee of the House of Delegates. Your committee wishes to commend this committee for the excellence and thoroughness of its work. We accept the report with the exception of the last paragraph for which our reference committee has prepared a substitute paragraph. The report as presented by the building committee reads as follows:

"That the Council of the Indiana State Medical Association be empowered by the House of Delegates to carry on the business of the construction of a headquarters office building at a cost not to exceed $250,000, including procuring a site, an architect, a floor plan and other matters necessary to provide a new Indiana State Medical Association office. The chairman of the Council shall appoint a committee of not more than five members of the Council to act as the Building Committee."

The reference committee substitutes the following motions:

We move that the Council of the Indiana State Medical Association be empowered by the House of Delegates to proceed with the business of the construction of a headquarters office building at a total cost not to exceed $250,000.

Mr. President, we move the adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

Dr. Caylor continued with the report of the Reference Committee on Miscellaneous Business:

We move that the chairman of the Council shall appoint, with the concurrence of the Council, a board of five members from the Indiana State Medical Associtaion, who will be known as the "Building Committee," with authority to obtain real estate for, and to construct an office building for the Indiana State Medical Association; this committee subject to the help and direction of the Executive Committee. This committee to have a duration of appointment coinciding with the time necessary for the completion of this project.

Mr. President, we move the adoption of this section of the report.

Dr. Wood is recognized.

Dr. Don E. Wood: May I ask a question about the word "direction" of the Executive Committee. Should that word be included since you did require that the Council be the Building Committee. I would like clarification about that word.

Dr. Caylor: As we attempted to set this thing up, Dr. Wood, we attempted to put the responsibility so that the group, the five-man committee, would have power enough to go on and build this building. We felt, however, that if we put the appointment to the Council, the appointment of these five men to the Council, that it would tend to spread it. Then we felt that if we give its construction, the supervision of its construction, to the Executive Committee, we would have a check upon it so that in the event something might down through two or three years take place, we might be able to check on this committee or have some logical check. It wouldn't be free . . . it would have somebody it would have to report to.

President Olson: Dr. Glock?

Dr. Maurice E. Glock: May I ask the chair for a little clarification, please?

President Olson: Yes.

Dr. Glock: As I understand it, a previous report was accepted. This would be in conflict. Am I correct in that or not? I forget which report was accepted . . . one of the committees which you appeared before.

President Olson: No. Dr. DuBois, I believe, presented that. Did you refer in regard to Dr. Mericle's statement in regard to this? You better get up here.

Dr. DuBois: We noted in the president-elect's address the proposition that a building committee be appointed by the House of Delegates or president of the association. The building committee report, however, recommended that the chairman of the Council appoint this committee from the Council. Dr. Mericle appeared before the reference committee on Reports of Officers and stated that he had no objection to any method of selecting a building committee as approved by the House of Delegates, but does feel that this task in its great scope deserves the individual attention of a committee.

President Olson: Does that clarify it?

Dr. Glock: Yes, it does.

Mr. President, we move the adoption of this section of the report.

(Motion seconded, put to vote and carried.)

Dr. Caylor continued with the report of the Reference Committee on Miscellaneous Business:

We move that the Council be advised by the House of Delegates to implement the financial procedure necessary for the construction of this building.

Mr. President, we move the adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

Dr. Caylor: Mr. President, we move the acceptance of the report of the Building Committee as a whole, as amended.

(Motion seconded, put to vote and carried.)

Dr. Caylor continued with the report of the Reference Committee on Miscellaneous Business:

Convention Arrangements

We have received an invitation to hold the 1960 meeting at French Lick both from the hotel and the Orange County Medical Society. After due consideration, this reference committee recommends the acceptance of this invitation, and moves that the meeting be held in 1960 at French Lick.

Mr. President, we move the acceptance of this portion of our report.

(Motion seconded, put to vote, and carried.)

Dr. Caylor continued with the report of the Reference Committee on Miscellaneous Business:

This committee recommends that in the future, one meeting in three be held at French Lick.

Mr. President, we move the acceptance of this portion of this report.

(Motion seconded. On hand vote, motion defeated.)

Dr. Caylor continued with the report of the Reference Committee on Miscellaneous Business:

Governmental Medical Services

Report of Commission on Governmental Medical Services, on pages 153 to 158 inclusive in the Handbook. This reference committee moves the acceptance of their recommendations, which are as follows:

1. That activities on
 (a) Maternal and Child Welfare
 (b) Liaison with State Board of Health, and
 (c) Alcoholism

be transferred to the Commission on Public Health.

2. Continuation of representation to the Liaison Committee on Veterans' Affairs.

3. A study of the commitment laws in regard to mental patients to obtain some type of legislation for commitment to local, county or general hospital.

4. Continued effort both on state and local levels for disaster planning.

5. Setting up of a program for indoctrination and clarification on completing Medicare forms.

We would certainly like to commend these gentlemen upon the excellence of their work and suggest that we accept this work in its entirety. And we so move. We move the acceptance of the report as printed in the Handbook 153 to 158. Accept it in its entirety.

(Motion seconded, put to vote, and carried)

Resolution No. 3

Introduced by: THE TIPPECANOE COUNTY MEDICAL SOCIETY

Subject: CONSTRUCTION OF BUILDING to HOUSE THE INDIANA STATE MEDICAL ASSOCIATION

BE IT RESOLVED that the Tippecanoe County Medical Society wishes to go on record as favoring the construction of a building to house the Indiana State Medical Association on or adjacent to the medical campus in Indianapolis.

REFERENCE COMMITTEE ACTION

Dr. Truman E. Caylor, Chairman, presented the following report:

RESOLUTION NO. 3 on Construction of Building to House ISMA. (Pages 85 and 86 of the Handbook.) We suggest that no action be taken on this resolution, in view of the fact that this simply states a conclusion of the Tippecanoe County Medical Society, and further than that we have already taken care of the provisions that it asks to be cared for. We ask the acceptance of this report.

(Motion seconded, put to vote, and carried.)

Dr. Caylor continued with the report of the Reference Committee on Miscellaneous Business:

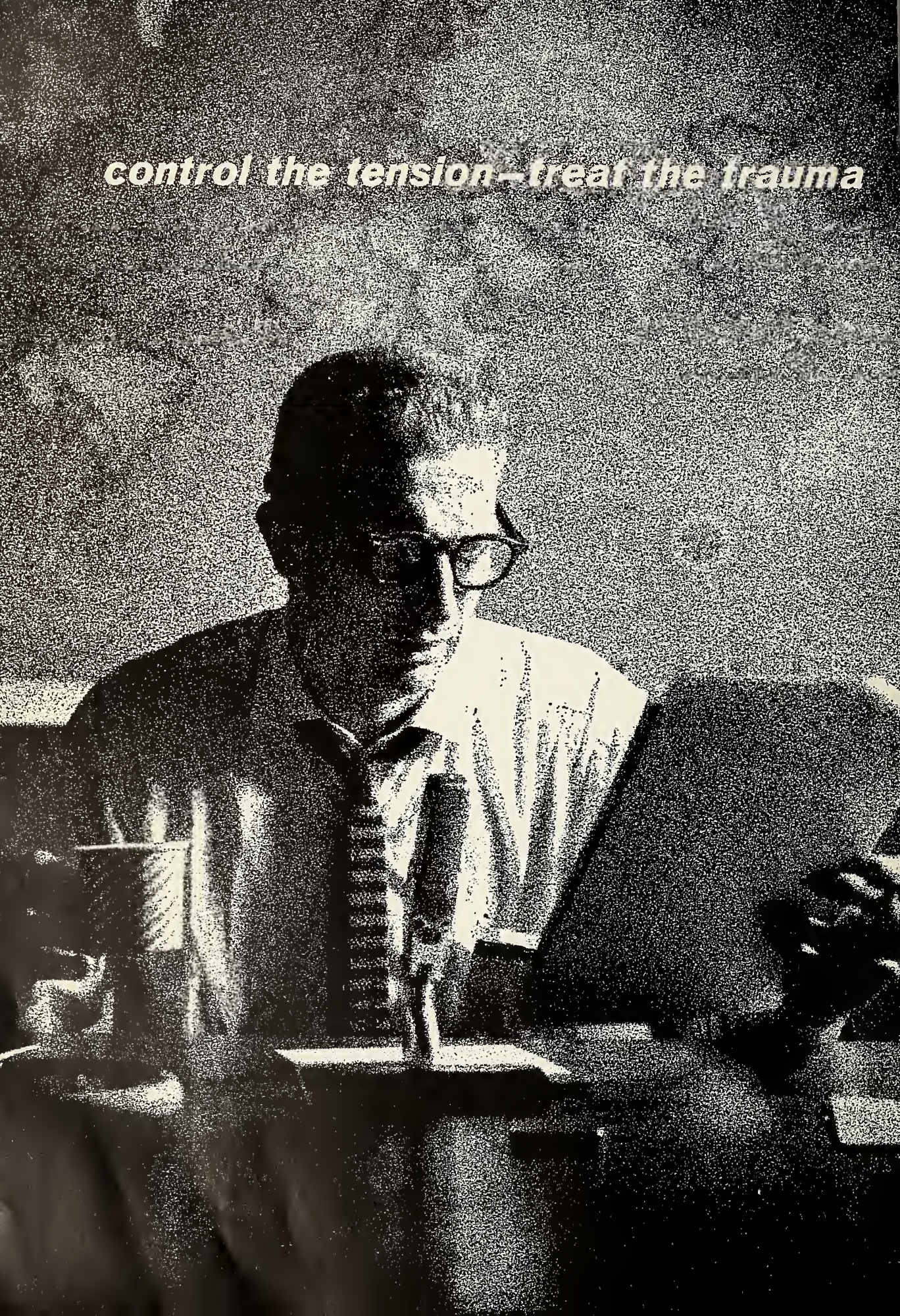
Inter-Professional Relations

Report of the Commission on Inter-Professional Relations, pages 168 to 170 of the Handbook.

We move that the first five paragraphs of this report be referred to the Council for further and delayed consideration.

These problems are real questionable as to what should be done with them. They are in such a state that we think it would be just as well if we could avoid their discussion at this particular moment. We move the reference of this to the Council for further consideration . . . the first five paragraphs.

(Motion seconded, put to vote, and carried.)


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meprobamate with PATHILON® tridihexethyl chloride Lederle

greater flexibility in the control of tension, hypermotility and excessive secretion in gastrointestinal dysfunctions

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PATHILON (25 mg.)—anticholinergic noted for its peripheral, atropine-like action, with few side effects.

The clinical advantages of PATHIBAMATE have been confirmed by nearly two years' experience in the treatment of duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Because of individual variation in the intensity of stimuli in gastrointestinal disorders, adequate dosage for optimum control may be expected to vary as well. The dosage strengths of PATHIBAMATE-400 and PATHIBAMATE-200 facilitate individualization of treatment in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: PATHIBAMATE-400—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride, 25 mg.
PATHIBAMATE-200—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: PATHIBAMATE-400—1 tablet three times a day at mealtime and 2 tablets at bedtime.
PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.
Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

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We further move that the eighth paragraph of this report be modified to:

"BE IT RESOLVED, That the House of Delegates recommend to the Council that a sum of not more than $500.00 be appropriated for the use of the Joint Committee for Financing and Expanding Nursing Education. This money to be used by this organization for the purpose of conducting a conference designed to further the establishment of courses of nurses-training in the college and universities of the State of Indiana."

Mr. President, we move the adoption of this section of our report.

(Motion seconded, put to vote, and carried.)

Dr. Caylor continued with the report of the Reference Committee on Miscellaneous Business:

The later sections of the report of the Commission on Inter-Professional Relations were referred to another reference committee.

Mr. President, we move the acceptance of the report of the Commission on Inter-Professional Relations, as amended as a whole.

(An off mike question)

Dr. Caylor: That you have already approved. The last paragraph of the report. Yes, of the Commission, you've already approved that in whose report? Who gave that? That's already been approved. We went down to that. Those parts were referred to us down to that point.

President Olson: I don't believe that, Dr. Caylor, the last paragraph says, "The commission again goes on record as recommending that all efforts be made to influence the legislature to revise the state law to provide for more than one physician member of the Council on Hospital Licensure. The difficulties encountered in the most recent legislature are known; however, the recommendation is again repeated well in advance of the next session of the Legislature." I think you were referring the other time to the Anatomical Board.

Dr. Caylor: That's right.

President Olson: But this is a different matter. You approve of this? This motion now would include that last paragraph.

Dr. Caylor: That's right.

(Motion seconded, put to vote and carried.)

Dr. Caylor continued with the report of the Reference Committee on Miscellaneous Business;

Floyd County Resolution on Honorary Membership

WHEREAS, I. S. Ravdin, M.D., is a native of Indiana and has made many contributions to the advancement of medicine and surgery, we, the Indiana State Medical Association wish to honor these achievements by offering Dr. I. S. Ravdin permanent honorary membership to the Indiana State Medical Association.

REFERENCE COMMITTEE ACTION

Dr. Truman E. Caylor, chairman, presented the following report:

Dr. John Paris, of New Albany, appeared before our reference committee and withdrew the resolution from Floyd County.

Mr. President, we move the adoption of the report of this reference committee as a whole.

(Motion seconded, put to vote, and carried.)

Election of Officers

The following officers were elected:

President-elect—Guy A. Owsley, M.D., Hartford City

Treasurer—Okla W. Sicks, M.D., Indianapolis

Assistant Treasurer—Harry Pandolfo, M.D., Indianapolis

AMA delegates and alternates for term expiring December 31, 1961:

Delegates

Gordon B. Wilder, M.D., Anderson

Wendell C. Stover, M.D., Boonville

Alternates

Walter L. Portteus, M.D., Franklin

John M. Paris, M.D., New Albany

Address of President-Elect Owsley

"There are no words to express one's gratitude at a time like this because the honor that you have just extended to me is the highest honor, in my opinion, that an Indiana physician can receive. I accept that honor with a deep sense of humility, but at the same time, I recognize that to whom much is received, much will be required. The responsibilities of the next few years, I think, are clear to all of us and I ask, and I know I will receive, your help in fulfilling those responsibilities. Thank you." (Applause.)

Place of 1961 Annual Convention

Dr. Harold C. Ochsner, on behalf of the Marion County Medical Society, extended an invitation to the Association to meet in Indianapolis in 1961. By a hand vote the House accepted the invitation to hold the 1961 annual convention in Indianapolis.

Resolutions of Appreciation

On motion of Dr. Guy A. Owsley, the House of Delegates went on record commending Dr. Wendell C. Stover for his work on the Committee on Medical Facilities of the American Medical Association, in accordance with the following letter received by the executive secretary from J. Lafe Ludwig, M.D., chairman of the Council on Medical Service of the AMA, which Doctor Owsley read:

"I know you are familiar with the structure of the Council on Medical Service which has seven committees working on various phases in the medical service area. At a recent meeting the Council discussed the possibility that sometimes physicians serve on these committees and devote a great deal of time and energy in working for the profession without our having apprised the state society of their contribution.

"In view of the foregoing, the Council on Medical Service would like to call the attention of the officers of the Indiana State Medical Association to the splendid service Dr. Wendell C. Stover, of Boonville, Indiana, has given to the profession as a member of the Committee on Medical Facilities. This committee, as you may remember, has worked on such projects as the Hill-Burton report, and a report on private practice by medical school faculty members. It is currently working on nursing home surveys, surveys of public health activities, a study of physicians' offices

owned by or adjacent to hospitals, and a study of organizational and professional relationships between physicians in private practice and those not in private practice.

"I know you are aware that the AMA councils and committees must rely on the gratuitous service of physicians such as Dr. Stover, at the state and local level. Medicine can be proud of such physicians, and it is our hope that during your forthcoming annual meeting the Council's sincere expression of appreciation of Dr. Stover's contribution can be relayed to the ISMA officers." (Applause.)

The following resolution, presented by Dr. Maurice E. Glock, was adopted unanimously:

Appreciation of Convention Arrangements Committees, Officers of the Indianapolis Medical Society, The Press, Radio and Television Industry

WHEREAS this 110th annual convention has been an inspiring and successful event, and

WHEREAS the extremely fine scientific program and programs of entertainment were fully enjoyed and appreciated by the membership, and

WHEREAS this meeting has received widespread publicity by the press, radio and television industry,

BE IT RESOLVED that the official thanks of this House of Delegates be extended to members of the Convention Arrangements Committee, the press, the radio and the television industry for their help in assuring the success of this meeting.

Dr. G. O. Larson presented the following resolution, which was adopted by acclamation:

Appreciation of Retiring President

WHEREAS, Dr. Kenneth L. Olson has given unselfishly of his time and energy to the voluminous duties that befall the high office of president of the Indiana State Medical Association, and

WHEREAS, he has fulfilled these duties faithfully, with dispatch and precision, with service to many,

BE IT RESOLVED that we recognize his untiring efforts in behalf of organized medicine and in furthering the high ideals and traditions of the medical profession, and

BE IT FURTHER RESOLVED, that this House of Delegates print on the record their sincere thanks and appreciation for the many accomplishments attained during the past year under his efficient and loyal leadership.

(Applause.)

Dr. Gordon B. Wilder presented the following resolution, which was adopted unanimously:

Appreciation of General Motors and Dr. Richard C. Swan

WHEREAS, the managers of General Motors plants in Indiana and Dr. Richard C. Swan, Medical Director of Delco-Remy Division of General Motors in Anderson, Indiana, through their generosity have contributed a Corvair automobile as a prize at the 110th Annual Meeting of the Indiana State Medical Association, and

WHEREAS, this generous gift has resulted in increased interest in the Annual Meeting.

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association, take this means of expressing its sincere appreciation to the General Motors managers in Indiana, and to Dr. Swan for their generosity.

Dr. M. C. Topping presented the following resolution, which was adopted:

Appreciation of Association Attorney

WHEREAS, Mr. Robert Hollowell has been closely associated with us, as counsel for many years during which his devotion to the medical profession in general and to the Indiana State Medical Association in particular has far exceeded his required duty, and during this convention, though he has labored under great emotional stress because of the serious illness of his wife, he has nevertheless worked heroicly with the reference committee, furnishing opinions as to the legality of many propositions before this body and in directing the parliamentary procedure of these meetings.

NOW, THEREFORE, BE IT RESOLVED, that this Convention, in sympathy with his current concern and admiration for his devotion to our cause, does hereby express its thanks to Mr. Hollowell for his many services and its hope for the speedy recovery of Mrs. Hollowell.

World Medical Association

Dr. E. S. Jones addressed the House on behalf of the World Medical Association, saying: "It is one of our very great methods of disseminating the type of medicine which is practiced in the United States to the various other countries of the world. This has developed into quite a large organization. It is a very fine organization and is doing a very excellent job. The American Medical Association has approved it and has recommended that every member of the American Medical Association be a member of the World Medical Association.

"A great many states have done a very excellent job. I'm ashamed to say that Indiana has not held up its part as compared to a great many of the other states. With your $10.00 membership fee you receive a journal. It's the one journal which is published that gives papers from all over the world on various forms and various types of medical care, etc. There are two or three meetings a year here, and one of the finest meetings that any of you have ever attended is the World Medical Association meeting abroad. . . . They have some very excellent papers . . . and the entertainment which you get is wonderful. I am sure that there isn't any place or anywhere that you can spend $10.00 that will bring you back more for it than the World Medical Association. And I know of nothing that would please the World Medical Association more than to have almost a unanimous membership from the State of Indiana."

Adjournment

The House of Delegates adjourned, *sine die,* at 12:15 p.m., Friday, October 9, 1959.

Lighter Vein—



"I don't blame you far being mad, sir! You say you landed an your Saucer in a busy diner and someone spilled hat caffee on you?"

After the doctor checked the patient over, the physician asked, "Have you been living a normal life?"

"Yes, doctor," replied the patient.

"Well, you'll have to cut it out for a while."—*Powerfax.*

———

A juke box placed near the city crematorium at Gobo, Japan, plays requested tunes during the cremations. At a later date, when the service becomes better known, no doubt many of the tunes will be by "special request" asked for by the deceased before his death.—*Tit-Bits, London.*

———

A popular song is one that makes us all think we can sing.—*Arnold H. Glasow, quoted in Quote.*

———

Political office, like the fig leaf, conceals much!—*Illustrated Weekly of India, Bombay.*

———

After saying our prayers we ought to do something to make them come true.—*William Feather Magazine.*

———

Want ad (personal) in Oregon newspaper: "Joe W. Get in touch with me at once. Bring 3 rings—engagement, wedding and teething. Have news for you, Betty."—*Automotive Dealer News.*

———

A young North of Boston mother of seven, carrying her eighth-to-be, was in continual trouble with her check book. She happened to sit next to her banker one evening at dinner and told him her financial troubles. He explained patiently the ins and outs of a check book and said finally, "After all, it's only a simple matter of adding and subtracting."

"I know," she said. "But you see, I'm so busy multiplying!" —*Food Market in New England.*

There's the one about the Texas rancher who was asked what he did between the time he got out of his air-conditioned car and into his air-conditioned house.

Replied the Texan: "I run like hell!"—*Quote.*

———

Another optimist was the fellow who first called it free love. —*Cy N Peace.*

———

Some women sweep dirt under the rug. Others sweep it over the fence.—*J. C. Salak, Quote.*

———

The condition a man is in can best be judged from what he takes two at a time—stairs or pills.—*F. G. Kernan, Quote.*

———

A moralist points out that the golfers with the lowest scores are the ones who do not swear. Of course, those with low scores have very little reason to swear!—*Jack Herbert, Quote.*

———

The trouble with the average budget is that it's hard to fill up one hole without digging another.—*Dan Bennett, Quote.*

———

The young doctor and his friend, walking along, met a girl whom he greeted rather cooly in spite of her obvious interest. "Do you know that beautiful thing?" asked the friend.

"Yes, I do," said the doctor slowly. "But I would hate to see you, a friend, get involved with her. You see, I took advantage of my wife's absence one day and invited the lovely to my house for supper. We have an excellent cook, so it was an excellent dinner. There she sat, eating my oysters, my chicken, drinking my champagne, my liquors . . . all sorts of expensive things . . . when suddenly she had violent indigestion pains. And, can you imagine! She asked to use my phone to call a 'good' doctor!"—*Pourquoi Pas?, Brussels* (Quote translation).

———

An adult Western is one in which the lady who runs the gambling joint invariably shows the goodness and location of her heart.—*Pep Mealiffe, Quote.*



"Why, yes, I graduated fram Med Schaal in Texas . . . how did you know?"

SCIENTIFIC ARTICLES

Abortion, Habitual, Its Causes and Treatment (Baldwin-Greenblatt) ---- 1945

Actifed, a Combination of Pseudoephedrine with an Antihistamine in the Symptomatic Treatment of Resistant Allergic Rhinitis (Feinberg-Feinberg-Fisherman) ---- 2137

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